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- members of the PIR Expert Reference Group
- staff of the Department of Health responsible for managing PIR
- management and staff of all PIR Organisations, particularly the 12 visited in the second round of site visits
- staff from Flinders University responsible for the PIR Capacity Building Project, for assistance with attendance at National and State conferences and related matters
- Gail Winkworth and Michael White, for allowing us to draw on their work from The Collaboration Rubric
- and most importantly, the clients and carers engaged with PIR who have been willing to share their stories.
### Acronyms

<table>
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<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
</tr>
<tr>
<td>CANSAS</td>
<td>Camberwell Assessment of Need Short Appraisal Schedule</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>ERG</td>
<td>Expert Reference Group</td>
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<td>MDS</td>
<td>Minimum Data Set</td>
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<tr>
<td>MHRS</td>
<td>Mental Health Recovery Star</td>
</tr>
<tr>
<td>NDIA</td>
<td>National Disability Insurance Agency</td>
</tr>
<tr>
<td>NDIS</td>
<td>National Disability Insurance Scheme</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government Organisation</td>
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<td>PHN</td>
<td>Primary Health Network</td>
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<tr>
<td>PIR</td>
<td>Partners in Recovery</td>
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<tr>
<td>PHaMS</td>
<td>Personal Helpers and Mentors Programme</td>
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<tr>
<td>RAS</td>
<td>Recovery Assessment Scale</td>
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1 Executive Summary

1.1 THIS REPORT

In March 2013, Urbis was commissioned by the (then) Department of Health and Ageing to conduct an evaluation of Partners in Recovery: Coordinated Support and Flexible Funding for People with Severe, Persistent Mental Illness and Complex Needs (PIR). The key aims of the evaluation are to:

- examine the implementation and delivery of PIR
- assess the impact on PIR clients, carers, PIR Organisations, other service providers and the wider health service-delivery system
- evaluate PIR's effectiveness in improving the system and care available to people with severe and persistent mental illness that have complex multi-agency needs
- identify implications and develop recommendations to inform the ongoing roll-out of the initiative.

The evaluation is being conducted over a three year period from 2013 to 2016.

This is the Annual Evaluation Report for 2014-15, the second in a series of three reports. It includes the evaluation methodology, the evaluation activities conducted to date and analysis based on consultations with organisations, clients and carers, and analysis of programme data. The key focus of this report is on the early evidence of outcomes for clients as a result of PIR. The 2015-16 Final Evaluation Report will have an increasing focus on the outcomes that are being achieved both for individuals and across the broader service system, as well as recommendations for ongoing programme scenario planning as PIR is transitioned into the NDIS from 1 July 2016.

1.2 KEY EVALUATION ACTIVITIES CONDUCTED IN 2014-15

This evaluation report is based on activities conducted in 2014-15 which included:

- consultations with over 350 people conducted between October 2014 and March 2015 through a series of five regional evaluation workshops with PIR Organisations, site visits to 12 PIR Organisations and in-depth telephone interviews comprising PIR Organisation management and staff, consortium members, external stakeholders, PIR clients and carers
- the client and carer portal, an online survey which offers all clients and carers involved with the programme a chance to provide feedback on their experience
- analysis of PIR documentation emerging throughout the year, including materials from the Capacity Building Project and the sector more broadly
- analysis of data from the Minimum Data Set (MDS)
- attendance at the 2014 national PIR conference and a number of Expert Reference Group meetings convened by the Capacity Building Group.

1.3 PIR IS AN EFFECTIVE MODEL TO IMPROVE OUTCOMES FOR THE TARGET GROUP

PIR is proving to be an innovative model that is delivering transformational change for many clients with severe and persistent mental illness with multiple complex needs via a recovery based approach that is person centred and focused on coordinating and integrating services to deliver improved outcomes. PIR has been increasingly effective in supporting the target group, who are traditionally very difficult to reach and engage. The evaluation has uncovered emerging evidence that PIR is creating an opportunity for clients to experience significant change. This is based on reports from clients, carers, PIR Organisations and other stakeholders of a range of improved personal, social and health and wellbeing outcomes for clients and carers alike. While there were a small number of clients dissatisfied with their PIR experience,
the overwhelming majority of the more than 80 clients and carers consulted in 2014-15 strongly support the PIR model, often describing the programme as life-changing.

The flexibility embedded within the PIR model with regard to client service is critical in creating change for PIR clients. The evaluation uncovered four key domains of activity when it comes to engaging with PIR clients: presence; needs assessment; advocacy; and funding. All four of these domains of activity, and subsequently the journey towards recovery, benefit from the flexible programme design.

PIR staff, consortia members and many external stakeholders (including some members of the clinical mental health sector) have seen evidence that the recovery based PIR model delivers real change for clients. While establishing and operating PIR in a changing and complex environment has been a challenge for PIR Organisations, there remains a high level of commitment among most PIR staff to the programme, a strong indicator of the belief in the model that staff and others hold. Evidence reveals that the programme architecture and design enable the programme to meet its objectives, underpinned by a strong shared vision and tight focus on improving client outcomes.

In evaluating PIR, it is important to distinguish between the value of the model and the implementation nationally. There are a small number of examples of poorly functioning consortia where the PIR Organisation has consequently struggled to achieve expectations – with regard to staff engagement and retention and progress with system reform activity – compared to the higher performing PIR Organisations. In the main, most consortia are functioning well and partnerships have endured within a complex operating climate. This is a measure of the strong leadership skills and commitment of PIR staff. In cases of inconsistent delivery, this is often a reflection of inexperienced staff and/or poor fit for the PIR roles, particularly among PIR Managers and Support Facilitators. The success of the programme is contingent upon high quality and highly skilled staff, working on both the service coordination and system reform elements of PIR.

1.4 PIR SHOWS PROMISE WITH REGARD TO IMPROVING THE SYSTEM OF CARE

PIR has potential to be a system-reforming programme, although it is too early to measure the impacts of system reform activities. There are high levels of system reform activities underway at consortia and regional service system levels, and some evidence of sustainable change underway. New referral pathways are in place and collaborations are underway across the sector to address service gaps. Given the volume of system reform planning and activity across the PIR network nationally, there is strong potential for PIR to create sustainable change across the wider service system with time.

The evaluation revealed two main approaches to system reform. The parallel approach tends to conceptualise system reform as part of all PIR roles, and considers system reform as a holistic cultural change in addition to the investment in specific projects and activities. The isolated approach to system reform tends to confine system reform thinking within specific roles or projects. While it is too early to determine if one approach is more effective than the other, early signs suggest higher performing PIR Organisations tend to adopt a parallel approach.

1.5 KEY FACILITATORS OF PIR’S SUCCESS

The flexibility of the PIR programme design creates strong opportunities to achieve outcomes both for individuals and across the service system.

The consortia model of the programme provides the flexibility to design partnerships best suited to local conditions in order to achieve the objectives of PIR. There is evidence this high degree of flexibility is delivering results with regard to establishing partnerships that are effective in collaborating for improved individual and systemic outcomes. In particular, this consortia model has been critical in establishing new and effective referral pathways to target clients most in need, and in building an organisational focus on recovery oriented and person centred service delivery via shared training and resources.

The flexibility afforded to Support Facilitators, with regard to engaging, coordinating services and providing funding, is vital to the success of PIR. This flexibility allows Support Facilitators to be present in a way clients have often never experienced before, while the funding can be catalytic in establishing trust and rapport with clients, as well as in overcoming immediate barriers to their recovery.
The Support Facilitator is the key mediator of the PIR programme experience. The Support Facilitator is at the heart of the PIR model and the importance of their skill cannot be underestimated. The evaluation has begun to paint a clearer picture of the multi-dimensional skillset, preferred experience and interpersonal skills of an effective Support Facilitator, which will assist PIR Organisations to plan and recruit for successful outcomes.

The evaluation will be better placed to describe the features of effective PIR Organisations in 2015-16, although there is an emerging picture of well-functioning consortia. There is some early evidence to suggest that diverse consortia (ideally including representation from the clinical sector) and medium to large size consortia are achieving better results compared to their peers. However, the single strongest predictor of high performing PIR Organisations is sophisticated PIR leadership. What constitutes sophisticated leadership has become clear through the 2014-15 evaluation research and is detailed in this report.

PIR is a programme heavily dependent upon strong partnerships. These partnerships underpin well-functioning consortia, and are critical in establishing and developing relationships with the wider service system. Strong partnerships support new and improved referral pathways and lay the foundation for effective and sustainable system reform. The evaluation draws on the work of White and Winkworth’s *The Collaboration Rubric* to identify the key elements of successful partnerships, including the importance of shared vision, the provision of support and authority and high levels of capability.  

High performing PIR Organisations demonstrate a very strong commitment to servicing the correct client group and have designed a range of specific strategies to target those with severe and persistent mental illness with complex needs. These highly successful PIR Organisations acknowledge a continuum of need exists even within the eligible target group and maintain an organisational commitment to servicing those most in need, especially as waitlists grow. While a wide range of measures to target the correct client group exist nationally, outplacement of Support Facilitators and assertive outreach have shown significant return on investment in reaching and engaging the most hard to reach clients.

There is considerable goodwill and collaboration at both an operational and strategic level between the NDIA and PIR. This foundation is important as the interaction between PIR and the NDIS will become increasingly important over the next 12 months. Stakeholders increasingly expect PIR to be partially or wholly rolled into the NDIS. Fundamental questions remain in terms of programme design, including the degree of programme overlap, reconciling the philosophical underpinnings of PIR and the NDIS, and how the service experience will roll-out for clients.

1.6 KEY CHALLENGES FOR PIR

As a programme, PIR survives or fails based on the skills and experience of its people and their ability to deliver a consistent and high quality service. Where there are examples of flawed and/or inconsistent implementation of PIR they are most often related to capacity gaps among individuals, mainly PIR Managers and Support Facilitators. It is important to make the distinction between the strength of the PIR model, and these examples of flawed implementation, and ensure highly developed staff induction, staff and consortia training and ongoing supervision procedures are in place to support consistent delivery.

The level of commitment and interaction within consortia contributes to the level of success of PIR Organisations in delivering the programme in their region. While the vast majority of partnerships have endured the recent complexities and changes in the sector and remain well-functioning, some partnerships have stalled, often due to lack of shared vision and capacity gaps at a senior level. Where strong partnerships are not in place, there is a weak foundation for the successful operationalisation of the programme.

The complex and changing policy setting in mental health, disability and the wider health and social services sectors in Australia has created a number of barriers for PIR.

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Staff engagement, recruitment and retention have been a challenge in a climate of significant uncertainty regarding the future of PIR. PIR Organisations have attempted to provide clarity and support for Support Facilitators and other staff where possible. While the Primary Health Network (PHN) structure has now been announced and the National Mental Health Commission Review has been released, the fluid policy setting is likely to persist for some time. The Commonwealth Government’s response to the National Mental Health Commission’s Review is yet to be announced which will inform future funding for mental health programmes. While PIR Organisations are being supported to continue with the programme during a time of significant change for the sector, the complex and changing environment is likely to represent a significant ongoing challenge for the programme.

The enthusiasm and commitment to system reform projects among some PIR Organisations has reportedly also been undermined by the complex and changing climate in the sector. Some have reportedly found it difficult to commit to projects and motivate staff and partners across the sector to drive system reform.

The lack of publicly available findings from the national evaluation has created hurdles for PIR Organisations eager to continuously improve their practice. Nearly all PIR Organisations reported a desire to plan for continuous improvement using the evaluation findings which has not been possible, although some local evaluation findings are beginning to be finalised. Many PIR Organisations understand and acknowledge the changing policy environment has been the driver for not releasing evaluation findings.

A small number of PIR Organisations and external stakeholders noted the potential overlap of PIR with other service coordination services available at a state/territory level. These cases of potential duplication were confined to smaller jurisdictions. While there was some potential overlap with some aspects of other service coordination services, the flexibility inherent in the PIR model to customise the programme based on existing services available enabled any significant duplication to be avoided.

1.7 SUGGESTIONS FOR STRENGTHENING PIR

Suggestions for improving the delivery of PIR are outlined below.

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>SUGGESTIONS FOR STRENGTHENING</th>
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<tbody>
<tr>
<td>PIR Organisations</td>
<td>1. Clearly articulate to staff and partners the ongoing commitment of the Department to PIR to 30 June 2016, in order to reduce fears among staff regarding job security and to maintain momentum and commitment to system reform projects.</td>
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<td>2. Continue to develop partnerships, focusing on the importance of shared vision, support and authority, and capacity in operating highly effective partnerships.</td>
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<td>3. Ensure clients are aware they can change Support Facilitators if desired. It may be necessary to develop criteria and guidelines for these instances.</td>
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<td>4. Utilise evaluation findings with regard to the skills and experience of effective Support Facilitators and PIR Managers in recruitment decisions.</td>
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<td>5. Review and if necessary refine the staff and partner induction, engagement, training and supervision procedures to support consistent and high quality service delivery.</td>
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<td>6. Continue to develop and strengthen policies and procedures for engaging clients and carers in governance arrangements, to ensure engagement is meaningful and drives improved outcomes.</td>
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<td>7. Continue to develop and strengthen measures to target the correct client group, utilising assertive outreach and outplacement as appropriate.</td>
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<td>8. Develop and share strategies/approaches for targeting and assisting PIR clients in key equity groups including Indigenous or culturally and linguistically diverse (CALD)/refugee clients.</td>
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<td>9. Commence or continue investment into a strong collaborative relationship with the NDIA at both operational and strategic levels as the staged roll-out of the NDIS continues.</td>
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<tr>
<td>AGENCY</td>
<td>SUGGESTIONS FOR STRENGTHENING</td>
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<tr>
<td>The Capacity Building Project</td>
<td>10. More emphasis should be placed on building capacity for partnership development and strengthening.</td>
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<td>11. Work with consortia to ensure the evaluation findings regarding the skillsets of effective PIR Managers and Support Facilitators are applied throughout recruitment processes.</td>
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<tr>
<td>Department of Health</td>
<td>12. PIR Organisations require as much information and guidance as possible regarding the potential programme transition from PIR to the NDIS to reduce anxiety in the sector regarding the future of PIR.</td>
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<td></td>
<td>13. As much as possible, the Department should release the findings of the 2013-14 and 2014-15 evaluation Annual Reports, given the potential to use the findings to improve practice and outcomes.</td>
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2 Introduction and methodology

2.1 THIS REPORT

In March 2013, Urbis was commissioned by the (then) Department of Health and Ageing to undertake a three-year evaluation of PIR. The evaluation seeks to provide the Department of Health with an evidence base for the effectiveness of the programme, with this report, the second of three Annual Evaluation Reports to be prepared. This report reflects on changes and progress since the first Annual Evaluation Report 2013-2014, as well as early evidence of impacts of PIR on clients and carers. Specifically, the report details:

- some of the operational successes and challenges PIR Organisations have experienced in the last 12 months
- how PIR consortium and partnership arrangements are working
- the client and carer experience of the programme
- system reform activities that PIR Organisations are undertaking
- issues that PIR Organisations are facing implementing the programme in various geographical settings and strategies they are using to address these issues.

2.2 EVALUATION AND MONITORING PROJECT

The PIR Evaluation and Monitoring Project being conducted from 2013 to 2016 aims to:

- examine the implementation and delivery of PIR
- assess the impact of PIR on clients, carers, PIR Organisations, other service providers, and the wider service system
- evaluate PIR’s effectiveness in improving the system of care available to people with severe and persistent mental illness that have complex multi-agency needs
- identify implications and develop recommendations to inform ongoing roll-out of the initiative.

2.3 EVALUATION ACTIVITIES AND REPORTING

Figure 1 below outlines the nature of the evaluation activities to be undertaken over the course of the evaluation, and the reporting timeline.
## INTRODUCTION AND METHODOLOGY

### FIGURE 1 – OVERVIEW OF PIR EVALUATION METHODOLOGY

<table>
<thead>
<tr>
<th>TIMEFRAME</th>
<th>PLANNING</th>
<th>PRIMARY DATA COLLECTION</th>
<th>ANALYSIS AND REPORTING</th>
</tr>
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<tbody>
<tr>
<td>March 2013 –</td>
<td>Commencement meeting</td>
<td>12 site visits to consult with PIR Organisations, partners and local services (including 6 longitudinal sites)</td>
<td>Progress Report 1</td>
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<td>June 2013</td>
<td>Project plan</td>
<td>PIR Organisations and key stakeholder telephone consultations</td>
<td>PIR Client Minimum Data Set</td>
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<td>Communication and stakeholder engagement strategy</td>
<td>Online partnership survey of PIR consortium members</td>
<td>Reporting Framework</td>
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<td>Preliminary knowledge review</td>
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<td>Evaluation Framework</td>
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<td>Initial key informant interviews</td>
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<td>Development of the evaluation and monitoring framework</td>
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<td>Development of PIR Client Minimum Data Set</td>
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<td></td>
<td>Development of PIR Reporting Framework</td>
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<tr>
<td>July 2013 –</td>
<td>Development of research tools</td>
<td>Qualitative analysis (site visits and telephone consultations)</td>
<td>Qualitative analysis (site visits and telephone consultations)</td>
</tr>
<tr>
<td>June 2014</td>
<td>Commencing negotiation with data custodians regarding data access and linkage</td>
<td>Analysis of first partnership survey</td>
<td>Analysis of PIR MDS data (included in 2014 Annual Report)</td>
</tr>
<tr>
<td></td>
<td>Ethics application</td>
<td></td>
<td>Case studies on implementation (included in 2013-14 Annual Report)</td>
</tr>
<tr>
<td></td>
<td>Fieldwork planning</td>
<td></td>
<td>2014-15 Annual Report</td>
</tr>
<tr>
<td></td>
<td>Communication to stakeholders regarding consultation processes</td>
<td></td>
<td></td>
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<tr>
<td>July 2014 –</td>
<td>Review evaluation framework and project plan</td>
<td></td>
<td></td>
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<tr>
<td>June 2015</td>
<td>Fieldwork planning</td>
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<tr>
<td></td>
<td>Communication to stakeholders regarding consultation processes</td>
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PIR ANNUAL REPORT 2014-15_FINAL_31JULY2015

INTRODUCTION AND METHODOLOGY
### TIMEFRAME

|-----------------------|

### PLANNING
- Review framework and project plan
- Fieldwork planning
- Communication to stakeholders regarding consultation processes

### PRIMARY DATA COLLECTION
- 12 site visits to consult with PIR Organisations, partners, local services, clients and carers
- PIR Organisations and key stakeholder telephone consultations
- Online partnership survey of PIR consortium members
- Client and carer satisfaction surveys
- Client and carer portal

### ANALYSIS AND REPORTING
- Qualitative analysis (site visits, client and carer portal and telephone consultations)
- Analysis of second partnership survey
- Consumer and carer satisfaction survey
- Economic analysis
- Progress Report 4
- Analysis of PIR MDS data
- Case studies on specific consumer groups (included in 2015-16 Annual Report)

This report is based on data from the regional workshops, 12 site visits, 66 stakeholder telephone consultations and MDS analysis.

### 2.4 EVALUATION ACTIVITIES IN 2014-15

Key evaluation activities undertaken in 2014-15 included:

- five state and territory evaluation workshops held in October and November 2014
- 12 site visits to consult with PIR Organisations and their partners, local services, clients and carers in November and December 2014
- PIR Organisation and key stakeholder telephone consultations between January and March 2015
- MDS analysis.

Each of these four key activities is discussed in more detail in the sections below.

### 2.5 STATE AND TERRITORY EVALUATION WORKSHOPS

Five state and territory evaluation workshops were held in October and November 2014. The key purpose of these workshops was to gather information and facilitate discussion on approaches to the implementation and adaptation of the PIR model nationally, with a focus on evidence of early outcomes of the programme.

The workshops helped to document emerging good practice and successful ways of addressing some of the barriers to consumer engagement and participation. The regional workshops also provided an opportunity for PIR Organisations to meet face to face and to share ideas and strategies across the sector.
The five workshops were held in the following locations and involved the following jurisdictions:

<table>
<thead>
<tr>
<th>WORKSHOP LOCATION</th>
<th>ATTENDEES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sydney</td>
<td>New South Wales and Australian Capital Territory PIR Organisations</td>
</tr>
<tr>
<td>Brisbane</td>
<td>Queensland PIR Organisations</td>
</tr>
<tr>
<td>Adelaide</td>
<td>South Australia and Northern Territory PIR Organisations</td>
</tr>
<tr>
<td>Melbourne</td>
<td>Victoria and Tasmania PIR Organisations</td>
</tr>
<tr>
<td>Perth</td>
<td>Western Australia PIR Organisations</td>
</tr>
</tbody>
</table>

Over 50 people attended the evaluation workshops and notes from the workshops were distributed to participants in December 2014.

2.6 SITE VISITS TO PIR ORGANISATIONS

The second annual round of 12 site visits was undertaken between October 2014 and December 2014. The site visits provided the first opportunity to interview clients and carers following the project receiving ethics approval in May 2014.

The fieldwork sites are listed in Table 3 – 2014 Fieldwork sites. Each year, six new sites will be selected for a site visit. Six sites have been selected as longitudinal sites and will be visited three times over 2013 – 2016.

<table>
<thead>
<tr>
<th>2014 SITES</th>
<th>LONGITUDINAL SITES (2013 – 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Far North Queensland (QLD)</td>
<td>Australian Capital Territory (ACT)</td>
</tr>
<tr>
<td>Frankston Mornington (VIC)</td>
<td>Bentley-Armadale (WA)</td>
</tr>
<tr>
<td>Loddon Mallee Murray (VIC)</td>
<td>Hunter (NSW)</td>
</tr>
<tr>
<td>Hunter (NSW)</td>
<td>Metro North Brisbane (QLD)</td>
</tr>
<tr>
<td>Western NSW (NSW)</td>
<td>Northern Territory (NT)</td>
</tr>
<tr>
<td>Perth Central East and Metro (WA)</td>
<td>Sydney South West (NSW)</td>
</tr>
</tbody>
</table>

These sites were selected applying criteria to ensure that they encompassed a range of characteristics including:

- representation of all jurisdictions
- both large and small regions
- a range of geographies including metropolitan, peri-urban, regional, rural and remote
- the proportion of the population who identify as Indigenous Australians
- the proportion of the population who are from culturally and linguistically diverse (CALD) populations
- a variety of Lead Agency organisations and service models – Medicare Local lead, mental health or other NGO lead, or joint lead
- a range of size of consortia
- different stages of progress through the PIR establishment and implementation phases
- early interface with the National Disability Insurance Scheme (NDIS).

Each nominated site was visited for up to two days and involved a series of interviews with key stakeholders. Across the 12 field visits, 152 individual interviews and group discussions were conducted, involving 270 people. A further 66 telephone interviews with 81 people were also conducted. In total, 318 interviews and discussion groups were conducted with over 351 people. These were conducted using tailored interview guides (see Appendix A) and were audio-recorded with consent of the participating individual(s). Recordings were transcribed for analysis purposes.

We would like to take this opportunity to thank all the PIR Organisations visited for the considerable assistance and cooperation they provided in organising consultations and providing documentation on their operations.

2.7 KEY STAKEHOLDER TELEPHONE CONSULTATIONS

A total of 66 stakeholder telephone consultations were conducted between January and March 2015. These organisations included Commonwealth stakeholders, state and territory mental health representatives, strategic and operational staff from the National Disability Insurance Agency, members of the PIR Expert Reference Group, representatives from a range of peak bodies and the PIR Organisations not included in the 2014 site visits. These interviews followed tailored interview guides (see Appendix A) and were audio-recorded with the consent of the participants. Recordings were transcribed for analysis purposes.

2.8 MDS ANALYSIS

Analysis of the client activity reporting, or MDS data, is included in this report at Section 7.

2.9 BACKGROUND TO PIR

More information on the background of the programme is contained in Appendix B.
3 The policy landscape

There have been a number of changes in the delivery of mental health and related services in the last year that have had an impact on PIR Organisations. These key changes to the policy landscape are detailed below.

3.1 PRIMARY HEALTH NETWORK TRANSITION

In the 2014-15 budget the Australian Government announced the establishment of 30 Primary Health Networks (PHNs) to replace 61 Medicare Locals. The key objective behind establishing PHNs was to increase the efficiency and effectiveness of medical services for patients, particularly in relation to the coordination of care for patients at risk of poor health outcomes. The announcement of the establishment of PHNs followed a Review of Medicare Locals undertaken by the former Commonwealth Chief Medical Officer, Professor John Horvath AO, which found that in general, Medicare Locals had failed to appropriately involve and engage GPs.

PHNs will be introduced from 1 July 2015. The invitation to apply to become a PHN operator was released in November 2014 and successful applicants were announced in April 2015.

3.1.1 IMPACT ON PIR ORGANISATIONS

As nearly three quarters (73%) of PIR Organisations are led by Medicare Locals the transition from Medicare Locals to PHNs has caused a great deal of anxiety and uncertainty among PIR Organisations. Particular issues identified by PIR Organisations included:

- uncertainty about who will become the lead agency for the PIR Organisation after the transition, and in particular concern that there may be more than one PIR Organisation per PHN which could impact on working arrangements and relationships
- difficulty retaining and recruiting staff due to an uncertain operating environment, particularly staff employed by Medicare Locals and those in PIR manager roles
- perceived difficulty entering into contracts as PIR Organisations led by Medicare Locals can only enter into contracts until the 30th June 2015
- difficulty undertaking system reform projects which extend past 30 June 2015
- competition between PIR Organisations applying to become PHNs.

While there has been some competition between different Medicare Local led PIR Organisations wishing to become PHNs, there is also evidence of PIR Organisations collaborating to apply for PHN status.

3.2 THE NDIS

The National Disability Insurance Scheme (NDIS), administered by the National Disability Insurance Agency (NDIA), was launched in July 2013 and is being trialled in the following seven locations:

- Tasmania, for youth aged 15-24
- South Australia, for children aged 13 and under (on 1 July 2014)
- the Barwon area of Victoria for people up to age 65

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• the Hunter area in NSW for people up to age 65
• the Australian Capital Territory for people up to age 65
• the Barkly region of the Northern Territory for people up to age 65
• the Perth Hills area of Western Australia for people up to age 65.

Western Australia differs from other states taking part in the NDIS trial because the state government has also introduced its own disability service model, My Way. My Way was introduced in the Lower South West on 1 July 2014 and will be implemented in Cockburn and Kwinana on 1 July 2015.4

3.2.1 IMPACT ON PIR ORGANISATIONS

While there are currently four PIR Organisations operating in NDIS trial sites (the Hunter region of NSW, Perth Central and East Metro in WA, Barkly region of the NT and the ACT), PIR Organisations in areas outside the NDIS trial sites also reported a degree of uncertainty about the changes to the service system as a result of the NDIS. In particular, PIR Organisations were concerned about the future role of PIR in relation to the NDIS – specifically the difference between a programme which incorporates a recovery orientated approach compared to one which focuses on permanent impairment or likelihood of permanent impairment.

More detail regarding PIR and the NDIS can be found at section 11.

3.3 NATIONAL MENTAL HEALTH COMMISSION REVIEW

In 2014 the National Mental Health Commission conducted a review of federally funded mental health programmes and services, across all levels of government and the private and non-government sectors. The Review focused on the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill health, as well as ways in which families and other support people could assist people with mental illness to live productive lives.

The final report was provided to the Commonwealth Government in December 2014 and was made public in April 2015.

3.3.1 IMPACT ON PIR ORGANISATIONS

Although the National Mental Health Commission Review has yet to lead to any direct changes to the policy landscape, the anticipation of future changes following the Review has contributed to a state of considerable uncertainty among almost all mental health service providers, including PIR Organisations. It is expected the Review will inform the future funding for mental health programs nationally.

*It is too hard to tell you what might strengthen PIR as a programme given we haven’t heard from the National Mental Health Commission’s review, which will significantly influence the shape of PIR.*

State/territory mental health representative

*I know until the Review of Mental Health Services comes out they’re sort of a bit in limbo.*

PIR Manager

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3.4 STATE MENTAL HEALTH COMMISSION REVIEWS

A number of states across Australia have recently undertaken a review of their mental health services including Victoria, New South Wales and Queensland.

Victoria has embarked on significant reform to its mental health services under Victorias priorities for mental health reform 2013-2015. Under its reform agenda, new mental health legislation has been introduced (the Victoria Mental Health Act 2014) and sweeping changes have been made to community mental health support services including a defunding and recommissioning of the community mental health sector.5

In New South Wales the Mental Health Commission undertook a two year consultation process with more than 2,000 people and developed Living Well, A Strategic Plan for Mental Health in NSW 2014-2024 and Living Well – Putting People at the Centre of Mental Health Reform in NSW: A Report.6

As a result of their review, Queensland has undergone a decentralisation of the state’s mental health services, with the aim of encouraging a more localised response.

3.4.1 IMPACT ON PIR ORGANISATIONS

In Victoria, the recommissioning of services has increased competition between community mental health services for funding which has reportedly had a negative impact on relationships. A number of PIR consortia members are no longer operating due to the defunding of services which has added an extra layer of complexity for the PIR Organisations to manage.

With regards to the recommissioning of mental health services I think the biggest impact of that has been that some of the reference group members have been very much engrossed in what’s happening there and that’s taken up a lot of physical and mental time for their agencies and it’s created some sector tensions which has meant there’s been a lot of spinning of wheels but no real traction.

PIR Manager

PIR Organisations in New South Wales spoke positively about State’s emphasis on people with mental illnesses lived experiences and its recovery based approach. However, there were some concerns about the future of acute mental health services. Some PIR Organisations also reported that the introduction of a number of new state based programmes under the Living Well reforms was impacting on the number of client referrals to their organisation.

In Queensland, the changes have reportedly made it more difficult for PIR Organisations to influence change at a state wide level.

3.5 COMMUNITY MENTAL HEALTH PROGRAMMES

The future of a number of Commonwealth Government funded community mental health programmes was in doubt until announcements regarding continued funding (until 30 June 2016) made in April 2015. One of these programmes is the Personal Helpers and Mentors programme (PHaMs) which provides one on one support for people with a mental illness, and has a high level of interface with PIR.

3.5.1 IMPACT ON PIR ORGANISATIONS

The question regarding the future of PHaMs and other programs, and the subsequent availability of necessary services with which to link clients, has caused significant concern amongst some PIR Organisations. The Commonwealth Government’s recent announcement that funding for PHaMs will continue may have alleviated some of this anxiety, however, at the time of the site visits in November and

December 2014, a number of PIR staff reported being concerned about community mental health programmes being defunded or cut and the impacts on PIR. Many suspected in the absence of programs such as PHaMs, Support Facilitators would be under increasing pressure to provide case management services.

3.6 SUMMARY OF IMPACTS

The changes to the mental health sector in the last year have created a significant degree of uncertainty in the operating environment for PIR Organisations. While some PIR Organisations have acknowledged this uncertainty has slowed their progress in relation to programme rollout, specifically in relation to recruitment and retainment of staff and system reform, others who tended to be higher performing PIR Organisations have recognised the continuing success of their organisation rests on their ability to effectively equip their organisation and staff to manage this change.

4 PIR process and operations

Most PIR Organisations have made significant progress in the last year and many of the operational issues identified in the PIR Annual Report 2013-14 are no longer a concern. In particular, most PIR Organisations have made progress with staff recruitment, although some organisations are reportedly now having difficulty recruiting and retaining staff due to the uncertain policy setting.

All PIR Organisations have developed organisational policies, procedures and protocols, as well as IT systems to record and report on the MDS and other data. PIR Organisations have also developed promotional/branding material and all are now seeing increasing numbers of clients engaging with their organisation.

In the PIR Annual Report 2013-14, the role of the Support Facilitator was still evolving. In 2014-15 it has become clear how critically important to the success of PIR Support Facilitators are. There is now an increased understanding of the skills and attributes needed to be an effective Support Facilitator.

Potentially the biggest challenge for PIR is consistent delivery and an examination of the process and operations reveals the importance of staff induction, training, support and supervision to deliver a consistent programme nationally.

4.1 SUMMARY OF ISSUES IDENTIFIED IN THE 2013-14 ANNUAL EVALUATION REPORT

<table>
<thead>
<tr>
<th>ISSUES IDENTIFIED IN THE 2013-14 ANNUAL REPORT</th>
<th>PROGRESS IN 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex contracting arrangements with funded agencies for the Support Facilitator positions, including competitive tendering processes which slowed down the establishment of some PIR Organisations.</td>
<td>Most PIR Organisations have now completed recruitment of Support Facilitator positions or are in the process of finalising the last stage of a staggered recruitment process.</td>
</tr>
<tr>
<td>Communication and branding of the programme was delayed in some cases as PIR Organisations waited for national leadership.</td>
<td>Communication and branding of the programme no longer appears to be an issue and all PIR Organisations have either developed their own communication and branding material or adapted material from other PIR Organisations.</td>
</tr>
<tr>
<td>High staff turnover in some PIR Organisations had led to a loss of organisational knowledge, affected relationships with external agencies/stakeholders and created a sense of instability.</td>
<td>Staff retention continues to be an ongoing issue, particularly following the announcement of the transition to PHNs and as PIR approaches the date for transition into the NDIS.</td>
</tr>
<tr>
<td>Little use made of flexible funding as many PIR Organisations had not started engaging with clients or because they were still developing internal guidelines for the use of flexible funding.</td>
<td>Most PIR Organisations are now using their flexible funding, though some continue to be reticent about spending their flexible funding. Part of this reticence is because some consortia members are unaccustomed to having a pool of funds at their discretion, some Support Facilitators are also uncomfortable with the process, particularly as there is some ambiguity in the PIR Operational Guidelines regarding when (and for how long) flexible funding can be used.</td>
</tr>
</tbody>
</table>
4.2 STAFF STRUCTURE

As noted in the PIR Annual Report 2013-14 PIR Organisations have adopted various approaches to the staffing structure of their organisation. Most PIR Organisations have centralised positions, including a PIR Manager, a System Reform Coordinator and an administrative or operational position which helps to provide quality assurance and consistency of practice. In many cases, PIR Organisations also have Team Leader positions employed centrally or in Host Agencies to support and supervise Support Facilitators.

In the second year of the evaluation most PIR Organisations felt their staffing structure was working well, though some PIR Organisations identified issues with aspects of their staffing structure. In particular, a number of PIR Organisations reported that it was a challenge to have a PIR Organisation wide culture when Support Facilitators are employed by host agencies, as staff tend to identify as an employee of the host agency. As a result, where Support Facilitators are employed by host agencies, there can be differing approaches to servicing the client group, and subsequently inconsistent practices across the PIR Organisation.

And there have been issues, certainly where I am, I feel there’s very much a different culture within the host organisation that I work in than [the lead agency] culture and that certainly caused some significant issues early on.

Support Facilitator

Some PIR Organisations also thought that placing Support Facilitators in host agencies without other Support Facilitators had contributed to staff feeling isolated and consequently resigning from their positions. Instead of co-locating staff or placing individual staff in host agencies, some PIR Organisations thought it would have been better to base a group of Support Facilitators in one centralised location and do outreach.

…if we were to do it again we’d probably base them all in the one location and outreach. Now that comes with its own set of challenges but I think that sense of team and being able to do things not in isolation on a day to day basis and bounce ideas off each other and have corridor conversations would probably make for a stronger service response.

PIR Manager

In contrast, a few PIR Organisations thought they had employed too many Support Facilitators in one region and that it would have been better to disperse the Support Facilitators more broadly to ensure they were easily accessible in areas where there is the greatest demand for PIR.

4.3 STAFF RETENTION AND RECRUITMENT

In the PIR Annual Report 2013-14 staff recruitment and retention was identified as an issue among some PIR Organisations, particularly for those PIR Organisations operating in rural and remote areas where there is a smaller pool of potential staff to recruit from. In the second year of fieldwork it was identified that retention of staff continues to be an issue for many PIR Organisations given the changes and complexities across the policy landscape. Several PIR Organisations also reported that while staff retention was not currently an issue they were worried about their ability to hold onto staff going forward as the date for the transition of PIR into the NDIS draws closer.

Those PIR Organisations who had adopted a staggered recruitment approach reported receiving noticeably fewer applications for Support Facilitator positions in the last recruitment round.

I think it has made it much tougher to recruit and if I reflect on our, probably first two or three rounds of recruitment, we received 30 to 40 applications in each round. The last couple of rounds I think we might have received one application in one and none in the most recent one, so certainly that truncating to June 2015 in terms of what we can offer has made a big difference.

PIR Manager
With the transition from Medicare Locals to PHNs, many PIR Organisations with a Medicare Local as a lead agency reported difficulty retaining and recruiting staff due to their perceived inability to offer employment contracts beyond 30 June 2015. The coming transition has also reportedly contributed to high staff turnover in the PIR Manager role. A number of the PIR Managers interviewed mentioned they had resigned or had recently replaced a former PIR Manager.

_You’re not going to get quality staff leaving other jobs to come to a job that can only offer security until 30 June next year._

PIR Manager

Some PIR Organisations speculated that PIR could cease a year early due to the findings of the National Mental Health Commission’s Review. To prepare for possible scenarios, some PIR Organisations are developing plans for staff terminations and redundancies. In some cases, PIR Organisations appear to be using uncertainty about future of PIR as an excuse to delay implementing system reform activities.

_We’d love to get moving full steam ahead but the rumour, the innuendo, [in the sector] it undermines us and makes things very difficult._

PIR Manager

High staff turnover is also related to the fact that some people employed as Support Facilitators were not a good fit for the role, either because the position was not what they expected, or because they did not have the appropriate skills or capabilities.

_The total number of resignations has been four. But a couple of those were only in the door for three weeks. They were not appropriate people and they were identified very, very quickly. So yeah it’s been pretty stable._

PIR Manager

Several PIR Organisations have sought to overcome difficulties recruiting appropriately skilled Support Facilitators by trialling innovative approaches such as a sub-contract model, where private providers are paid to provide Support Facilitation work to clients on an hourly basis (this issue is explored in more detail in section 11).

4.4 SUPPORT FACILITATOR ROLE

At the time of the PIR Annual Report 2013-14, the Support Facilitator role was still evolving. There was considerable diversity in the level and nature of skills of Support Facilitators and it was difficult at that stage to identify the most effective mix of skills and experience for the role. There is now an increased understanding of the skills and attributes needed to be an effective Support Facilitator. Figure 2 below illustrates some of the characteristics that Managers and Support Facilitators report Support Facilitators need, though some recognise that not all these characteristics/skills need to be present in one individual, and that the most important thing is ensuring a good mix of skills and experience across the team.
SUPPORT FACILITATOR PRACTICE

A high performing Support Facilitator requires leadership skills, with the ability to manage stakeholder relationships and run care-coordination meetings. They also need to be good researchers so they can effectively assist clients to navigate the service system. Both Support Facilitators and clients consider the Support Facilitator role to require strong negotiation skills to advocate on clients’ behalf.

_I see this role so closely linked to advocacy in many, many ways. Its advocacy with a pool of funding, we’re continually advocating. If the client isn’t happy with the service, we would get the client in, we would call that service and then we would try and mitigate further problems through doing that; so it’s an advocacy role._

Support Facilitator

But what I was surprised about was how much she or they advocated for me, for something I’ve been battling by myself for literally 10 years, we got something done in six months.

Client

A number of PIR Managers also felt that Support Facilitators need to understand and accept that the role is multidimensional and have the ability to operate in different domains such as service coordination and system reform. PIR Managers felt that the ability to do this effectively varied across different Support Facilitators, with some people being more comfortable with the system reform aspect of the role than others.

The Support Facilitator role can be seen as operating along a continuum from initial engagement – where a case management approach is often needed to develop the relationship and rapport with clients, to one which is progressively involved in service coordination, service integration and systems change (see Figure 3 below.)
The diagram above has been adapted from work by Metro North Brisbane PIR. The semi-circle reflects where Brisbane North Metro expects Support Facilitators to operate – with the bulk of the Support Facilitator role engaged in service coordination and service integration. However, consultations with Support Facilitators and PIR Managers suggest that the bulk of work undertaken by most Support Facilitators is focused on initial engagement with clients and service coordination, with only a few Support Facilitators actively involved in system reform activities, represented by the purple dotted line above.

PERSONAL SKILLS OF SUPPORT FACILITATORS

The interpersonal skills of Support Facilitators are crucial for developing effective relationships with clients, carers and service providers. In many ways the Support Facilitator role is viewed as the face of PIR.

Effective Support Facilitators reportedly persist in the face of challenges, are resilient and have a positive attitude. They are also required to be lateral thinkers, able to respond to opportunities as they arise, and develop creative and innovative solutions within service system constraints. It is also vital that Support Facilitators are patient as sometimes it can take some time to develop an effective relationship with a client and to see progress towards meeting their objectives in their Action Plan. Support Facilitators also need to be independent and non-judgemental in their approach with clients.

Being unbiased because there are lots of times that our clients do things that you think are completely inappropriate, but you sort of have to be unbiased and still represent their best interests.

Support Facilitator

We’re not linked to any sort of restrictive practice so we’re not obligated to the Adult Guardian; we’re not obligated to mental health legislation as such. We work within the parameters of those things of course but our role really is to give the client a voice.

Support Facilitator
EXPERIENCE OF A SUPPORT FACILITATOR

PIR Organisations have the flexibility to determine the appropriate skills and experience necessary to implement their model regionally. However, Support Facilitators require a base level of skills including knowledge of the health and welfare sectors and experience working with people with mental illness.\footnote{Department of Health 2015 PIR Initiative FAQ What type of skills should Support Facilitators have? Accessed 7 April 2015}

As a result of this flexibility, the qualifications and experience of Support Facilitators varies. Some Support Facilitators are clinically trained in mental health, while others have community development or other services experience.

The PIR Annual Report 2013-14 report noted that PIR Organisations varied in their requirement for Support Facilitators to be clinically trained. At that time, no particular issues with this difference in requirements was identified. However, during the second round of consultations some PIR Organisations suggested clinical training in mental health should be a mandated requirement of both the Support Facilitator role and intake officer to ensure staff had the appropriate knowledge and skills to manage risks.

4.4.1 CHALLENGES OF THE SUPPORT FACILITATOR ROLE

While there is a clearer understanding of the characteristics and skills required to be an effective Support Facilitator, there still continues to be some uncertainty around the actual responsibilities of the role. A number of Support Facilitators interviewed as part of the second year of consultations admitted they initially struggled to fully understand what it is they are required to do, with some mentioning that it took up to six months to really develop an understanding of how PIR operates given the uniqueness of the programme.

Particular challenges identified by Support Facilitators include:

- **The flexibility of the role** – Support Facilitators reported that flexibility of the Support Facilitator role could be confusing at times. While most Support Facilitators saw the flexibility of PIR as one of its key strengths, they also considered that greater consistency and guidance is sometimes required, especially for Support Facilitators new to the role.

- **Lack of consistency** – issues with lack of consistency appear to primarily occur when Support Facilitators are employed in host agencies and supervised by Team Leaders from that host agency. Often the different host agencies have slightly different understandings or interpretations of the PIR Organisation’s operational policies. This has an impact when Support Facilitators share their practices and experiences with other Support Facilitators across their organisation and discover that they have been given contrary advice. These experiences foster uncertainty about the role and the belief clients are being supported inconsistently. One of the most common examples of this lack of consistency is in how host agencies interpret the flexible funding guidelines. Some Support Facilitators are given relative freedom in how they can spend the funds (up to a certain amount), while others have to demonstrate that they have exhausted all other options (even for relatively small amounts of funds) before they are given approval.

- **The multidimensional aspects of the Support Facilitator role** – Support Facilitators reported difficulty meeting the multidimensional aspects of the role, such as service coordination and system reform activities. This is particularly the case for Support Facilitators with high client caseloads and those who do not feel confident in undertaking system reform activities. Several Support Facilitators noted that within their teams there are some people who are better at system reform activities than others, and in some cases only the more skilled Support Facilitators were expected to undertake system reform activities.

- **Responding to clients in crisis** – while Support Facilitators recognised that their client target group is people with severe and persistent mental illness there are conflicting views on whether it is the Support Facilitators’ role to respond to clients in crisis. Several Support Facilitators reported that a large proportion of their time is spent responding to clients in crisis and that they cannot move forward with a person until they have addressed their crisis needs. Support Facilitators reported that a
number of clients have been referred to them with little to no connection with services. This is either because no services exist, or because clients have ‘burnt bridges’ with service providers and they no longer want to work with them. There is also the view that some service providers treat PIR as a service of last resort for difficult clients. In these situations, many Support Facilitators feel they have no alternative but to try and respond to the client’s crisis despite feeling they may not have adequate training and it may not strictly be their job.

4.5 SERVICE COORDINATION VERSUS CASE MANAGEMENT

According to the PIR Operational Guidelines, Support Facilitators are to coordinate the service system – not actually deliver services. However, the PIR Operational Guidelines do state that Support Facilitators can undertake a case management role where sufficient or effective case management functions do not exist, on an interim basis only:

*Where sufficient or effective case management functions do not exist for the client, Support Facilitators could undertake the case management role on an interim basis only, with a view to establishing this function and identifying a substantive case manager early in the implementation of the PIR Action Plan.*

PIR Operational Guidelines

In the PIR Annual Report 2013-14 few PIR Organisations had accepted clients so service coordination activities had yet to develop. At that time, most PIR staff were clear in stating that the Support Facilitator role does not involve case management, although a number of staff had difficulty articulating the difference between case management and service coordination.

During the second round of consultations, some PIR staff did acknowledged that in certain circumstances the Support Facilitator role involves some element of case management, with a number of PIR staff identifying that some Support Facilitators are finding it challenging to resist adopting a case management approach at times, especially where case management services are unavailable or during the initial stage of client engagement in the programme.

This issue is particularly prevalent among Support Facilitators working in rural and remote areas where there are fewer services to coordinate. In these situations, PIR staff feel it is a legitimate response (and within the PIR Operational Guidelines) for Support Facilitators to provide case management. Support Facilitators also reported that some service providers do not have a good understanding of the Support Facilitator role and are referring clients to PIR expecting a case management response.

Support Facilitators spoke about the difficulty splitting case management from service coordination, as often an element of case management is needed to build trust with clients in order to be able to do service coordination. At the same time many PIR staff noted how important it is to avoid fostering dependency among clients and that a vital part of the recovery principles underpinning PIR is that clients are empowered to take greater responsibility for themselves.

*Like PIR is only short term support so I always think about how I can set it up for the client when PIR ends… so you don’t want anything to fall apart or anything to change after you step back from the role so you basically want to…think about what is everything I can do to make it long-term sustainable for that client, so they are getting what they want and they’ve developed skills for themselves or know what service they can contact for support.*

Support Facilitator

Some Support Facilitators also identified the difficulty they experienced in judging the appropriate way to support to clients and that sometimes it was not until after they had supported the client that they realised the dependency it had created.

Figure 4 illustrates the two competing aspects of the Support Facilitator role. Many PIR Organisations noted that Support Facilitators are trying to balance providing individual support to clients and the use of flexible funding for individuals with service coordination and the system reform requirements of PIR and that this is often a difficult balancing act.
While there is a consistent view across PIR Organisations that Support Facilitators should delivering a service coordination role, many acknowledged there can be a range of pressures to perform some element of case management at times. Case management, while outside the job description of Support Facilitators, was often required where no existing case management services were in existence or available. Support Facilitators also identified that different clients need different approaches and that some are more equipped to drive their own recovery than others.

*It depends on the individual. If they can’t we will walk alongside of them. That’s what we say pretty much ‘you’re in charge but we will walk alongside of you’. Sometimes we will go to some of those meetings a few times to build up that confidence and for them to connect to somebody. I suppose our role is not to be living in their lounge room. Our role is to be able to link them into those services and for them to build that rapport with those services and to find those key people that they build that rapport and trust from and so I think, if we are doing everything with them we are case managing, so our role is to really work close with that person to build up that rapport. And check in, how’s everything going, we’ve linked you in with that agency is that working well for you and how can we support you to make that work better?*

Support Facilitator

Several factors assist Support Facilitators to resist stepping into a case management role. One is organisational clarity regarding the role of PIR as an initiative. PIR Organisations which have managed to make it clear PIR is not a case management service tend to have a common understanding across the PIR Organisation of the focus of the programme. One PIR Organisation has developed a compendium on the rationale of PIR and what collective impact means to ensure potential staff are adequately familiar with the philosophy underpinning PIR.

*In terms of interviews with the Support Facilitators, rather than take the traditional recruitment process, what I’ve done is put together a compendium of absolutely everything you’d ever want to know about collective impact, PIR and all the rest of it and I give that to people two or three weeks out from the interview on the understanding that they read it, understand it and are then subject to interrogation.*

PIR Manager

A second factor that has helped PIR Organisations stay true to the PIR mission and resist stepping in to fill gaps in services, is purchasing case management services rather than providing them. Support from PIR Managers in holding services accountable to their responsibilities was also identified as another factor that helps Support Facilitators resist adopting a case management approach.
Well they’ve just had to be really tough and have felt terrible about it sometimes. One guy, he’d been admitted to the psychiatric hospital and the psychiatrist decided on admission that he didn’t have a mental illness after all, he had a substance problem so he could no longer stay in the hospital even though he was going to be homeless when they discharged him. So the Support Facilitator had to work really hard to say to the psychiatrist that they had a responsibility not to discharge someone into homelessness instead of trying to find him somewhere to go. She had to make the psychiatrist and the social workers and the allied health people in the hospital look for accommodation for him. It would be easier for her just to have done that but then that wouldn’t be the point so that’s just an example of how hard it is not to fall into the whole case management type model.

Support Facilitator

The PIR service coordination approach is not necessarily appropriate for all clients. Several Support Facilitators and PIR Managers noted that people with Borderline Personality Disorder (BPD) are more suited to an intensive one on one approach rather than a service coordination model as they tend to play services off against each other.

4.6 WORKLOAD

The Department of Health provided a document ‘Clarification of key issues for PIR Organisations’ in February 2014 which outlines the expected client load of Support Facilitators. According to the document, Support Facilitators are expected to have at least 20 clients, and anything less than that should be cause for review. However, client loads per Support Facilitator vary across the different PIR Organisations. Some Support Facilitators are managing to successfully assist 20 clients or more, while others appear to be struggling with 10 or less. A few Support Facilitators reported having over 35 clients. Such high client loads were identified as having a negative impact on Support Facilitators’ ability to provide effective support to people. High client loads are also reportedly contributing to staff burnout and high staff turnover.

In some cases, there is discrepancy within a PIR Organisation, with some Support Facilitators in host agencies receiving large numbers of client referrals, while Support Facilitators in other host agencies receive noticeably less. While Support Facilitators recognise that some areas have a higher demand for PIR than others, some also feel the unequal distribution of clients is also partly due to poor client allocation from the centralised intake position.

According to a number of Support Facilitators and PIR Managers the ideal client load is between 15 and 20 clients, though how manageable that ultimately is depends on the individual needs of the client and where the client is located. In rural and remote regions where the travel requirements are greater and there are few existing services, Support Facilitators and PIR Managers consider it is appropriate for Support Facilitators to have a smaller client load.

The difficulty experienced by some Support Facilitators in supporting their client load is often related to how much case management support they are providing clients. Support Facilitators who engage in direct individual service or case management are less able to service a high number of clients than those who are more focused on service coordination. According to some PIR Organisations, in the initial implementation phase of PIR when client caseloads were relatively light, it was not a problem that a number of Support Facilitators provided case management support to clients. However, as the number of clients has increased, it has become increasingly difficult for Support Facilitators to continue to give each of their clients the same level of attention and more Support Facilitators are now taking a service coordination approach. Conversely, in areas where Support Facilitators continue to have light client caseloads it remains hard for PIR Managers to ensure Support Facilitators do not slip into a case management role given their available capacity.

High client loads (and intensive client support) is also having an impact on Support Facilitators ability to undertake system reform, with a number of Support Facilitators commenting that they had no time to undertake system reform activities.

There’s no time. We’re too busy, on the ground, at the coalface.

Support Facilitator
See section 9 for more in-depth discussion on the Support Facilitator’s role in system reform.

4.7 STAFF TRAINING AND SUPERVISION/MENTORING

The PIR Annual Report 2013-14 identified the variety of training that different PIR Organisations had provided their staff. These included: training on PIR processes and reporting mechanisms, the Recovery Model and the Support Facilitator role. No specific gaps in training were identified during the first round of site visits and consultations. However, at the time, many PIR Organisations were still in the process of recruiting staff and establishing teams. During the second round of site visits and consultations some PIR staff reported that the initial extensive training provided by their PIR Organisation for the first cohort of Support Facilitators had not always continued for subsequent cohorts of Support Facilitators, with some Support Facilitators having to rely on informal training provided-on-the-job- by existing Support Facilitators.

A number of Support Facilitators also identified issues with the level of supervision or support they receive from their Team Leader or supervisor. While some PIR Organisations are providing regular fortnightly meetings with Support Facilitators to discuss clients, some Support Facilitators receive very little supervision. There is less likely to be a uniform approach to supervision among PIR Organisations where Support Facilitators are employed by a host agency, as host agencies often adopt their own approach to providing supervision, and some do not have a tradition of providing this level of support to their staff. Some Support Facilitators also reported that they would like the opportunity to receive independent supervision, so they can discuss any interpersonal issues with experience in their role.

To address this gap in supervision a working party has been developed to highlight the benefits of supervision to PIR Organisations. The Capacity Building Project has also developed a mentor programme for Support Facilitators. Those who have participated in the programme report feeling more confident in their role, however, uptake to the programme has been slow.

4.8 THE CLIENT FLEXIBLE FUNDING POOL

In the PIR Annual Report 2013-14 few PIR Organisations had started using their flexible funding pool. In 2014-15, it is apparent that flexible funding for clients is a powerful tool for engagement between Support Facilitators and clients, which has the ability to address significant barriers to improved outcomes quickly and effectively. Flexible funding is highly aligned to the recovery orientation of the PIR model, as the flexibility allows the client to drive their action plan and associated spending (within prescribed limits).

*For me it’s one of the essential components of the programme which actually makes it stand aside from other programs. I’m an old community girl so having access to those funds to meet a consumer or a carer need I just think it’s fantastic because there are so many times where an individual might just need assistance in one aspect of their life and that will provide it for them.*

PIR consortia member

*It’s that innovative way of being able to access funding which can make a big difference - and it might be just $50 here or $100 there that can make this enormous difference. It helps to look at people not as a person who’s got this long term mental illness, but somebody who can recover and who can lead a much better life.*

Carer

Support Facilitators and other PIR staff were very supportive of the flexible funding and its capacity to create significant change for clients. They consistently reported how critical flexible funding was to achieving good outcomes for clients, given it is often lack of access to financial resources that can prevent consumers from being able to surmount barriers and move forward with their lives.

*I think it’s brilliant because it really does help dissolve that financial crisis stuff that’s exacerbating their mental illness.*

Support Facilitator
The funding has been widely used to address immediate needs, which may resolve a crisis for clients, such as securing accommodation, providing other logistical support or addressing acute health needs. Another key use for flexible funding was on spending to assist clients meet their personal goals – which may be related to self-image or more tangible personal development activities.

The most powerful impact of flexible funding is its ability to build rapport and trust between clients and Support Facilitators. The ability to address even small needs, such as purchasing a haircut or a pair of shoes, was often the first time in a very long time clients had their request from a service granted – and this positive experience is very powerful in providing tangible evidence to clients that PIR is responsive to their needs and is often taken by clients as a demonstration that they are a worthwhile investment.

I bought a bed for a guy, a big sufferer of depression… He was sleeping on a pile of books and he asked to put a bed on the action plan. He got the bed and it provided the momentum for him to start taking more risks in terms of facing his fears about what needs to happen to return to work, facing his ex-wife, a whole raft of other things just by virtue of the fact that flexible funds says yes instead of no.

Support Facilitator

While all PIR Organisations are now using their flexible funding, a small number continue to be reticent about the usage. This hesitation is driven by individuals and organisations being unaccustomed to having a pool of funds at their discretion and some Support Facilitators reporting feeling uncomfortable with the process due to perceived ambiguity in the PIR Operational Guidelines regarding spending.

Some potential clients were reported to have come to the programme with specific financial requests after hearing about the availability of flexible funding, meaning communication regarding the funding needs to be managed carefully.

4.8.1 EXAMPLES OF FUNDING USE

To date flexible funds have been used for a variety of ends. This reflects the flexibility of the funding which PIR staff report as essential in helping them to meet the individual needs of clients. The main ways in which flexible funding is being used include:

- primary health care needs including dental, optical and chronic disease
- communication devices including mobile phones, SIM cards and phone credit which can be essential in order to contact clients
- crisis accommodation, from motels to tents
- transport solutions, including bikes or assistance with driving lessons and licenses in the absence of good public transport
- clubs/programmes/activities to create meaningful ways for consumers to feel socially active and included
- cleaning/removal services to support clients experience squalor/hoarding issues
- formal training and education support to assist clients meet their personal development or employment goals
- a wide range of incidental items related to improving self-image or personal development such as musical instruments, personal grooming services, weight loss assistance
- purchase of additional care and services such as private carers, psychiatry or psychology services.
We have another two people who have children in foster care who are vying to have their children returned to their care, both of them really struggle with cooking meals so we’ve put in a mentor to show them how to do budget cooking and make a stew or make a soup, something that will go a long way for their families because there would be no other service in my town that would do that and these people don’t feel comfortable in groups.

Support Facilitator

4.8.2 THE CRITICAL IMPORTANCE OF CREATING SUSTAINABLE CHANGE FOR CLIENTS

While Support Facilitators and PIR staff are enthusiastic about the power of flexible funding to create positive change quickly for clients, they did caution against flexible funding being used to create changes that were not sustainable beyond clients’ involvement with the programme. Most Support Facilitators reported applying strict criteria to their use of flexible funding to ensure the programme doesn’t cultivate dependence among clients, although some did report concern not all Facilitators applied this process.

I’m very careful with the funding because I realise it’s Federal Government funding and I don’t like it to become a prop to people, so I’m very considerate and caring how I spend that money.

Support Facilitator

4.9 SUMMARY OF NEW ISSUES IDENTIFIED IN THE 2014-15 ANNUAL EVALUATION REPORT

<table>
<thead>
<tr>
<th>NEW ISSUES IDENTIFIED IN THE 2014-15 ANNUAL REPORT</th>
<th>PLANNED ACTION IN 2014-15</th>
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<tbody>
<tr>
<td>Staff training and supervision of Support Facilitators is inconsistent across the PIR Organisations. Recent appointments to Support Facilitator positions have received less formal training than the first cohort of Support Facilitators. In some PIR Organisations, Support Facilitators receive regular fortnightly supervision, however in some PIR Organisations, Support Facilitators receive none, resulting in variable and inconsistent quality of support facilitation services.</td>
<td>A working party has been developed to highlight the benefits of supervision to PIR Organisations. The Capacity Building Project has also developed a mentor programme for Support Facilitators, though to date uptake to the programme has been slow.</td>
</tr>
<tr>
<td>Some PIR Organisations are finding it difficult to determine appropriate spending of flexible funding given the degree of subjectivity in the guidelines.</td>
<td>Several PIR Organisations have developed systems to ensure consistency in the application of flexible funding including electronic forms and a common flexible funding framework. The Capacity Building Project also recently held a webinar on flexible funding and the Department of Health is currently preparing a fact sheet on flexible funding to remove some of the ‘grey areas’ in the guidelines.</td>
</tr>
<tr>
<td>PIR Organisations with a Medicare Local Lead Agency have been affected by uncertainty following the Commonwealth Governments review of Medicare Locals and decision to transition to PHNs.</td>
<td>No planned activity to address this issue.</td>
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<tr>
<td>Some concern regarding the dependency developed on PIR Support Facilitation services</td>
<td>Ongoing concern</td>
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5 Partnerships, governance and management

PIR is a programme heavily dependent upon successful partnerships – within consortia, with the broader service system, and the wider community – to deliver change at an individual and systemic level. The evaluation has found strong organisational cohesion is essential to building a well-functioning PIR Organisation, and maintaining momentum for service delivery and system reform. While in 2013-14 partnerships were still being established, in 2014-15 almost all PIR Organisations report well-functioning partnerships that have endured the high level of change in the sector.

Well-functioning partnerships are supported by sophisticated PIR leadership. While it is too early to determine the specific characteristics of high performing PIR models, strong leadership is the strongest predictor of success and a clear picture of the skills and experience associated with strong leadership has emerged.

5.1 SUMMARY OF ISSUES IDENTIFIED IN THE 2013-14 ANNUAL EVALUATION REPORT

<table>
<thead>
<tr>
<th>ISSUES IDENTIFIED IN THE 2013-14 ANNUAL REPORT</th>
<th>PROGRESS IN 2014-15</th>
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<tr>
<td>The tension between PIR's clear emphasis on partnerships and the increasingly competitive nature of many of the involved service systems.</td>
<td>This continues to be an issue, with several PIR Organisations acknowledging the increasingly competitive tensions with the transition from Medicare Locals to PHNs.</td>
</tr>
<tr>
<td>Less than two thirds (63%) of those who responded to the 2013-14 Partnership Survey reported that lines of communication, roles and expectations of partners are clear.</td>
<td>PIR Organisations with less cohesive consortiums still report there are issues with clarity of communication, roles and responsibilities – although qualitative evidence suggests this has significantly improved since 2014-15.</td>
</tr>
<tr>
<td>Maintaining diverse partnerships can be challenging.</td>
<td>The maintenance of highly diverse consortium groups continues to be a challenge. The strength and skills of the PIR leadership is critical to keeping partnerships engaged and meaningful.</td>
</tr>
<tr>
<td>Lack of consumer and carer involvement in PIR Organisation design, decision-making and monitoring – with one in four consortium members surveyed indicating that this was not occurring sufficiently at the time.</td>
<td>More PIR Organisations are now actively engaging consumer and carers in the governance arrangements of their PIR Organisation, however, not all PIR Organisations have consumer and carer representatives at this stage and the scope of consumer and carer involvement is limited in some cases.</td>
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<tr>
<td>Concern was expressed about the Capacity Building Project website with most PIR staff describing it as being difficult to navigate.</td>
<td>A number of PIR staff commented that the useability of the Capacity Building Project website had improved, though some still thought it was ‘clunky’ and difficult to navigate.</td>
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5.2 THE IMPORTANCE OF STRONG LEADERSHIP

Strong governance arrangements and well planned partnerships are merely process and structure in the absence of strong leadership. The most reliable predictor of higher performing PIR Organisations was sophisticated leadership. As outlined in Figure 5 below, partnership within PIR consortia, PIR Organisation partnerships with the wider service system, sustainable system reform by PIR Organisations and shifts in community attitudes and behaviour can all be seen as contingent upon strong leadership of PIR Organisations.
Features of sophisticated leadership can be understood in relation to skills and experience, and are outlined below.

### TABLE 7 – FEATURES OF SOPHISTICATED LEADERSHIP OF PIR ORGANISATIONS

<table>
<thead>
<tr>
<th>SKILL</th>
<th>EXPERIENCE</th>
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<tr>
<td><strong>Relational expertise</strong> – the ability to engage based on their own expertise, as well as the capacity to recognise and respond to what others might offer across systems of distributed expertise⁹.</td>
<td><strong>Community sector leadership</strong> – most high performing PIR Managers have significant experience working at senior levels in the community sector, often with some clinical experience also.</td>
</tr>
<tr>
<td><strong>Highly developed communication and facilitation skills</strong> – to develop, agree and communicate a shared vision across the PIR Organisation and wider system.</td>
<td><strong>Existing networks across multiple sectors</strong> – strong leaders in PIR Organisations more often than not entered the role with significant existing networks across the community and clinical sectors.</td>
</tr>
<tr>
<td><strong>Responsive leadership skills</strong> – the ability to navigate a complex system and to effectively function in a dynamic operating and policy context.</td>
<td><strong>Existing vision for system reform</strong> – given the depth and breadth of experience of strong PIR leaders, most approached the role with an existing vision for system reform (although possessed the ability to adjust this vision based on collaboration with partners).</td>
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The presence of this high quality leadership varies considerably across PIR Organisations, with some consortium members reporting significant capacity gaps among PIR leaders. Where the PIR Manager lacks support, it is very difficult to engage the consortium, hampering operational and strategic progress.

5.3 PIR CONSORTIUM STABILITY AND RETENTION

The majority of PIR Organisations have managed to retain all original consortium partners and continue to work together in driving the strategic direction of the programme – a significant achievement in the face of the complexities and changes in the sector. Partnerships appear to have endured due to a tight focus by PIR Organisations on improving outcomes for PIR clients, a measure of the strong faith PIR staff have in the ability of the programme to deliver real change for individuals.

In a few cases, PIR consortia members have been lost following a period of disengagement, or due to partners ceasing operations (often due to structural change in the sector such as the defunding and recommissioning process undertaken in Victoria).

There was evidence of a wide range of engagement levels among consortium partners across PIR Organisations. High engagement tended to be predicted by a few key factors:

- **Hosting of Support Facilitators** – agencies hosting Support Facilitators and/or Team Leaders tended to be more engaged members of consortia, based on a higher level of day to day collaboration, opportunity to share learnings and build a culture around the PIR programme

- **Communication with the lead agency** – this communication may be driven by the Team Leaders, the PIR Managers or other roles within the lead agency, but it was critical for engaged consortia members to have an open dialogue with the lead agency outside of the regular consortia meetings to share knowledge and seek advice in order to drive their commitment and engagement

- **Strength of the PIR vision** – more engaged consortia members tended to have a sense of the PIR vision and culture as the primary unifying vision for PIR staff, as balanced against the vision and culture of host agencies

- **Geographic location** – given vast distances in some PIR regions, in some cases it was harder to keep strong engagement with geographically isolated consortium members.

  There were consortium partners who didn’t get a Support Facilitator, and they’ve dropped away to a degree.

  PIR Manager

  *From my perspective there seems to be a high level of accountability and transparency, and the lead agency I think has been very diligent in organising the information that is requested and also organising additional meetings where we can meet some of the operational staff and some of the other advisory groups that have also been put together to help ensure that the information is relevant and timely and reflecting the needs of the group to be serviced.*

  PIR consortium member

  *It’s a sophisticated consortium and it approaches things in a shared way, a shared vision and we do tend to spend a lot of time talking about what that is.*

  PIR consortium member

  *Everyone has that purpose of supporting someone with a severe and persistent mental illness so all the organisations there are like minded and they have that ability to get together and have that focus that needs to be there rather than people being there for the sake of it.*

  PIR consortium member
In this consortium there is a whole range of different members, and they do have different models and they might be different in how they operate, but when you actually come together you’re actually a very strong and powerful force for the aid of people in the programme.

PIR consortium member

In particular, where consortia members had bid to host Support Facilitators at the inception of PIR and were unsuccessful, these organisations tended to be more disengaged with the consortium group. Higher performing PIR Organisations reported being successful in re-engaging these organisations within their consortia, either based on targeted relationship building or as a result of the programme delivering strong results for clients and the partner seeking to be more involved.

The original consortium, some have waned a little bit with their involvement. What’s interesting now is that post establishment period, now that we’ve got our feet well and truly on the ground we’re now starting to go back to those agencies and they’re coming back in with a greater degree of interest and involvement.

PIR Manager

5.4 WELL-FUNCTIONING CONSORTIA

There is a variety of PIR models that are currently delivering strong results in terms of client and carers outcomes, and early signs of successful system reform. While there is no single structure, consortium type or size that was delivering stronger results than others, there were some consistencies in terms of factors that drive well-functioning consortia.

5.4.1 FEATURES

Winkworth and White’s Collaboration Rubric provides a useful framework for understanding the enabling factors for strong performance of PIR consortia which has been adapted for analysis purposes in Figure 6.10 Three enablers of success are identified: support and authority; shared vision and outcomes; and capability. The specific elements underpinning each of these key themes relevant to success when it comes to well-functioning PIR consortia are outlined in more detail below.

11 The PIR Partnership Survey conducted in 2014, to be repeated in 2016, asks consortium members to rate their PIR Organisation partnership based on a Partnership Analysis Tool developed by John McLeod for Vic Health for partners in health promotion. The White and Winkworth tool provides another useful frame for analysis to assess, monitor and maximise effectiveness of partnerships.
You have a very broad range of members who sit on the consortium who have come from
great backgrounds and it’s just that ability to have really good governance, really good input
into directing the programme and expanding and as a group we can actually look at what
are the opportunities that we can take with the funds.

PIR consortium member

5.4.2 STRUCTURE

The figure above highlights the enabling factors of high performing PIR Organisations. With regard to the
specific structural elements of these high performers, there is some early evidence to say that higher
performing PIR Organisations tend to involve:

- A diverse consortium - including a range of community organisations, as well as representation
  from at least three to four of the following:
  - employment service providers
  - housing services
  - carer and consumer representatives and/or peak bodies
  - clinical mental health services
  - specialist organisations dedicated to specific equity groups such as Aboriginal and Torres Strait
    Islander or refugee services
  - drug and alcohol services.

- Medium to large size consortia – larger consortia provide an opportunity to cover much of the
  regional service system within the PIR Organisation and allow for diverse perspectives and
  experience in service delivery.
At this stage of the evaluation, there was no consistency with regard to high performing PIR Organisations being either Medicare Local or NGO led. Higher performers exist among both Medicare Local and NGO lead consortia. The quality of leadership and cohesion of the consortium transcend the structural advantages and disadvantages associated with the nature of the lead agency.

There was also no common pattern in 2014-15 of higher performing PIR Organisations’ employment models. The most successful PIR Organisations vary in terms of their model across direct employment of staff by the lead agency, employment of Support Facilitators, Team Leaders and some other support staff by host agencies, as well as a hybrid of these two approaches. However, PIR Organisations that have adopted a highly decentralised provider / purchaser model appeared to be lower performers – struggling to operate well-functioning consortia, maintain staff and gain traction with system reform.

5.4.3 CHANGE MANAGEMENT

PIR Organisations operate in a changing environment where the interface with other programmes such as the NDIS, local and regional service systems and in many cases their staff is often evolving. Some PIR Organisations have found this degree of change to be inhibiting to implementing the programme successfully, reporting subsequent difficulties with regard to engaging consortia partners, staff and gaining traction with regard to system reform planning and implementation due to the contextual uncertainty.

At the moment the climate is quite uncertain, so there’s an uncertainty out there in the sector which is potentially why we hear that there is waitlists and people are not recruiting within organisations. So that has a flow on effect.

PIR team leader

On the other hand, some PIR Organisations demonstrated a strong capacity with regard to adjusting to change in their operating environments. Some examples of this ability to rapidly recalibrate in a changing context include:

- accelerating or decelerating the employment of additional Support Facilitators and other roles to respond to client need
- usage of innovation funding to provide training for staff specifically focused on building resilience in the face of rapidly changing environments
- conscious acknowledgement among PIR Organisation leadership that the mental health sector is almost permanently subject to policy change of some sort, to support partners who may feel anxious at the degree of change underway.

Programme managers have developed risk registers where they’re trying to second guess I suppose a range of scenarios that might happen at the end of this. One of them is that PIR might close next June rather than the year after so we’re doing a lot of preparatory work around that in case that is the scenario because the PIR is included in mental health service review. So we’re doing lots of preparation with our service providers and legal and working out if that happens, terminations, redundancies what that might look like. We’re not really planning to do anything until we categorically know from the Department what we’re actually facing next year, but we’re doing all that preparation.

PIR Manager
5.5 POOR-FUNCTIONING CONSORTIA

Just as there is no single PIR model, consortia type or size that predicts success, there is also no precise formula for predicting lower performing PIR Organisations, although as mentioned above provider / purchaser models did appear to consistently struggle with successful implementation.

5.5.1 FEATURES

There were consistencies with regard to barriers to success. Unsurprisingly, given sophisticated leadership is a strong predictor of successful PIR Organisations, the consistent barriers to success tended to focus on leadership – specifically a lack of the necessary support and authority, and difficulty in developing and sharing a vision for the consortia.

Factors contributing to poor-functioning consortia are outlined in Figure 7 below.

FIGURE 7 – FEATURES OF POOR-FUNCTIONING CONSORTIA

Some consortia members of poorer functioning groups reported that the PIR leadership didn’t appear to have adequate skills in relation to implementing a collective impact model. In these cases, while programme implementation may have progressed, development of strong partnerships and progress with system reform had often stalled due to this lack of capacity at a senior level.

“We have been very frustrated as a group – there seem to be serious capacity gaps among the programme management here that are required to roll-out a collective impact model. We need less talk, more action.”

PIR consortium member

5.5.2 STRUCTURE

In some cases the barriers to success were structural and related to the geographical setting, rather than operational, often meaning the issues were more difficult to address. Specifically, where consortium members were spread out across a region, often without regular contact with their PIR colleagues, this presented barriers with regard to implementing a shared PIR vision and model of practice.

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12 More information regarding the Department of Health’s objectives and expectations regarding the collective impact model can be found in the Operational Guidelines for PIR Organisations.
5.5.3 CHANGE MANAGEMENT

In some cases, poor-functioning consortia appeared ill prepared to adjust to the significant reform underway in the sector. In some cases this reform, specifically the Medicare Local transition to PHNs, had created competitive tensions among consortium partners which had undermined the work of the PIR Organisation.

While for other PIR Organisations, it was the leadership that was unable to guide and motivate the consortium through this period of change, citing significant sectoral reform as a reason for lack of progress.

5.6 NATIONAL PROGRAMME GOVERNANCE AND MANAGEMENT

National programme managers, the Commonwealth Department of Health, established an Expert Reference Group to provide advice and guidance on programme design and delivery. The membership of the Expert Reference Group is attached at Appendix D. Three national projects were also established to support the implementation of PIR:

- a Resources project to identify the best available resources and tools to utilise in PIR which has now concluded (Siggins Miller)
- a Capacity Building Project to support the development of PIR nationally (Flinders University)
- this three year evaluation of PIR, including the development of a PIR MDS to support ongoing and monitoring and evaluation (Urbis).

In the PIR Annual Report 2013-2014, PIR Organisations reported being relatively satisfied with these projects, though some areas for improvement were identified. These primarily related to the timing of the training/workshops by Siggins Miller, the use of the CANSAS tool in the MDS and the usability of the Capacity Building Project website by Flinders University.

5.6.1 THE CAPACITY BUILDING PROJECT

Flinders University has been engaged as the PIR Capacity Builder from 2012-13 until 2015-16. In the PIR Annual Report 2013-2014 PIR Organisations generally expressed support for the Capacity Building Project. However, there were a range of views.

The second round of consultations identified similar views, with some PIR Organisations identifying a number of valuable aspects, while others identified a number of areas to be improved.

TABLE 8 – FEEDBACK ON THE CAPABILITY BUILDING PROJECT

<table>
<thead>
<tr>
<th>STRENGTHS</th>
<th>WEAKNESSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>The website and webinars - several PIR Managers commented that the Capacity Building Website is a great portal for resources and has helped them overcome challenges by providing them with examples of best practice and solutions other PIR Organisations have developed.</td>
<td>The website – some PIR Managers felt that the website was still difficult to navigate despite the recent improvements that had been made.</td>
</tr>
<tr>
<td>The forums - a number of PIR Organisations said the forums have helped them connect with other PIR Organisations and to recognise the differences and similarities each region is facing.</td>
<td>The forums - a number of PIR Organisations said the forums seem to involve a lot of discussion about issues but that there was not enough leadership or strategic direction provided.</td>
</tr>
<tr>
<td>Flinders role as conduit to the Department of Health - several PIR Organisations commented that Flinders University has played a valuable role in acting as a conduit to the Department of Health if they need clarification on the operational requirements of PIR.</td>
<td>Flinders role in relation to the Department of Health – several PIR Managers felt that Flinders role as the middle man between PIR Organisations and the Department was not all together satisfying and that Flinders had not been able to progress things with the Department as much as they would have liked.</td>
</tr>
</tbody>
</table>
Those PIR Organisations favourable in their comments regarding the Capacity Building Project noted Flinders’ willingness to listen to advice and improve their practices.

I think they have matured along the journey, they have listened to us when we have told them that their website isn’t particularly friendly – they fixed it up. I find that anything you need is within their portal.

PIR Manager

Those PIR Organisations who were more negative in their feedback on the Capacity Building Project, tended to feel that Flinders University staff did not have the appropriate background or experience for the role, or that there were missed opportunities due to the limited scope of the Capacity Building Project.

A number of PIR Organisations would have liked to have seen more opportunities for state based PIR Managers to come together to discuss strategies.

At a state level we have really missed out opportunities…while we are local, there is a need for us to consolidate at the state level, but what I keep hearing is that [it] is out of project scope.

PIR Manager

5.6.2 THE DEPARTMENT OF HEALTH

In 2013-2014 PIR Organisations were mindful that the programme was a major new initiative, involving considerable complexity and that it was implemented during a period of policy reform and political change, which impacted on the Department of Health’s ability to make timely decisions.

In the second round of consultations, PIR Organisations reflected on how the lack of timely provision of tools and resources in the very early stages of PIR impacted on the implementation of the programme.

I think key lessons for me would have been that we would have had a lot of the development tools, resources, policies and procedures and systems in place prior to commencing. I think that would have caused a lot less anxiety in the first six months.

PIR Manager

A number of the operational issues that were a concern to PIR Organisations in 2013-2014 have been successfully addressed by the Department and PIR staff were no longer concerned about client eligibility requirements, marketing material, or reporting requirements.

The templates now I feel are easily available, we have settled into a format which helps during the reporting period.

PIR Manager

While a number of the governance issues affecting PIR Organisations in 2013-2014 are no longer a concern, a number of new issues relating to the governance and management of the PIR programme were identified, these primarily related to:

- The release of evaluation results to support continuous improvement – nearly every PIR Organisation interviewed mentioned they would value receiving the evaluation results to help support continuous improvement in PIR practice and service delivery. Many PIR Organisations understand and acknowledge the fluid policy setting has been the driver for not releasing evaluation findings.

It’s such a shame the information is there but it’s not being put to good use. I can’t understand why the Department is so vague, if we could only compare apples and apples we’d be able to improve what we’re doing.

PIR Manager
The climate of uncertainty surrounding the future of PIR – as discussed in section 3, the uncertainty surrounding the future of PIR is a challenge for PIR Organisations to manage. A number of PIR Managers stated that the lack of clarity and direction from the Department regarding the future of PIR had made it very difficult to plan ahead and indicated a desire for the Department to be more transparent regarding likely outcomes. However, PIR Organisations do understand the programme is subject to review, and that this review has driven much of the delay.

The engagement of the Expert Reference Group (ERG) – according to some of the ERG members, there have been few face-to-face meetings and meeting dates are often rescheduled. ERG members also reported receiving limited information on the impact of PIR, with most of the data they receive being primarily concerned with inputs, such as client numbers and activities.

Data management system – while all PIR Organisations have information and data systems in place (and many initially requested the flexibility for customised data management systems) a number reported difficulties with the systems developed and suggested a single data management would have added value and saved resources. For example, a small number of PIR Organisations are reportedly unable to extract reports necessary to meet the Department of Health’s reporting requirements and as a result are entering information into Excel spread sheets manually.

*Our biggest challenge by far has been our client information system…it doesn’t report properly. I have to pull the data out manually – it generally takes me between two full 12-14 hour days to get that out...the lesson is obviously when we roll these programmes out we should have a standardised system.*

PIR Manager

In general, most PIR Organisations recognise the challenges the Department of Health faces in delivering the programme in light of the significant changes and complexities in the sector. With some PIR Organisations providing specific positive feedback regarding the freedom the Department has provided in implementing the programme, and the support they receive from Grants Officers.

*The Department I think must be in a terrible spot at the moment and they really remain focused and passionate about PIR in my opinion whenever I see any of those guys speak and they are always open to questions.*

PIR Manager

5.7 PIR ORGANISATION GOVERNANCE

The PIR Annual Report 2013-14 noted that stable governance arrangements were in place in most PIR Organisations. The report identified that the role of the lead agency within PIR Organisation varied considerably with some lead agencies taking a more direct leadership role than others. Overall, at the time of the first round of consultations most PIR Organisations reported all partners were involved in planning and setting priorities for collaborative action and that participatory decision-making systems were in place that were accountable, responsive and inclusive.

The second round of consultations re-emphasised the importance of having a cohesive consortium, with good governance structures in place that promote collaboration, transparency and accountability. High performing PIR Organisations tend to be led by highly skilled and experienced leaders, supported by clear and effective governance structures.

Given the wide variety of service models across the PIR network nationally, it is not possible to identify specific governance structures or arrangements that tend to predicate success. One feature of governance arrangements that does appear correlated with higher performing organisations is strong carer and consumer involvement in governance structures and processes.
5.7.1 CONSUMER AND CARER INVOLVEMENT IN GOVERNANCE

Consumer and carer input to the strategic decision-making processes within mental health and other relevant service delivery organisations is a key tenet of recovery oriented practice and is reflective of a broader national movement towards greater inclusion of consumer and carer representatives in decision making in the health sector.

PIR Organisations generally accept that maximising consumer and carer involvement in the decision-making of PIR and other relevant organisations has the opportunity to enhance both the recovery focus and person centred orientation of service delivery. At the time of the first round of consultations in 2013-14, less than half of all PIR Organisations had established consumer and carer reference or advisory groups. In 2014-2015, most PIR Organisations had begun at least the planning required to establish consumer and carer reference or advisory groups, although many cited this as a key focus area for the next six months.

I think clinical people need to be here and hear what the consumers and family members have got to say. They need to encounter it. You know when we're talking about how do you get that vertical and horizontal reform, well that's one of the ways.

PIR consortium member

Higher performing PIR Organisations tend to be those with a strong recovery focus in their practice. As a result of this focus they subsequently paid more attention compared to some of their peers to involving consumers and carers in formal governance structures. However, even these PIR Organisations often reported this as an area requiring increased attention and improvement which indicates the significant challenges associated with involving consumers and carers in an effective and meaningful way.

Consumer and carer engagement was one of the areas that the consortium identified as one of the things that they wanted to pursue for this 12 months, so as a starting point for that we actually did some work with a consultant to map the engagement opportunities that were available within our catchment and we tried to chunk that into three levels. We looked at our consortium agencies, what consumer and carer engagement opportunities did they have within their own agencies, more broadly the PIR networks and [what] was going on there and then outside of the box, outside of mental health, what do other people do in that space? So map all of those opportunities and talk to a whole range of people - what would help, if there is an opportunity but no one takes it up, why not and so forth. From that we got a suite of recommendations to enhance consumer and carer engagement and leadership across our catchment.

PIR Manager

I sit on a lot of stuff and don’t feel that sense of shared value, equal status, level playing field that I do here. I sort of laugh because I say [to PIR Manager] you've created a space where families and consumers can speak and you’re going to regret it because they're all talking. It’s very interesting, I think service providers have actually found it quite confronting. It’s almost like service providers are a bit intimidated to step into the space.

Consumer/carer representative

RANGE OF ACTIVITIES

Organisations reported involving carers and consumers in a range of ways:

- as a named member of the consortium, which involved a high level of engagement and involvement in some consortia, while others struggled to move beyond tokenistic involvement

- as a member of an advisory group to the consortium, again with varying degrees of engagement

- as a member of an advisory group designed to specifically inform the development of internal PIR projects, processes, communications and policies
as a member for review panels for tender processes such as reviewing innovation funding submissions

as a participant in PIR Organisation staff recruitment processes, including being present at interviews

leading or participating in the training of PIR Organisation staff.

CHALLENGES
A number of PIR Organisations reported that engaging consumers and carers can be a challenging process.

Firstly, engagement can be slow and resource intensive given it involves identifying, engaging and often providing support to build capacity among consumers and carers prior to involvement. For example, some PIR Organisations were actively trying to increase the capacity of consumers to take part in meetings by providing training and mentoring on the processes involved.

A lot of our possible carers have very limited understanding of a role they can actually play in a process like this. A lot of my previous work and I’m still doing it around capacity building, is being sure that I can give the information to the carers that I’ve identified to see whether they’d be interested in participating. They don’t know there’s national documents that say carers and consumers have a right to participate in determining what happens in a type of programme like this for instance.

PIR Manager

We need to make sure they’re really prepared, they have a clear understanding, they have the skills they need to contribute to the best that they can.

PIR consortium member

A small number of PIR Organisations also commented that attendance has been an issue, and that it has been difficult to get consumer and carer representatives to commit to the number of meetings required. These individuals are often involved in other consumer representative groups and time poor. To address this issue, most PIR Organisations are paying consumer and carer representatives to attend meetings, though some consumer and carer representatives have declined to receive payment for their time.

One of the issues where you get consumers who are able to be directly involved there’s a big impost on them, it’s everyone wants a piece of them and it’s very difficult for them to say no to things, it’s like with, up here you have some very strong indigenous people and they get called upon all the time, anything to do with indigenous people they get called upon, anything to do with mental health these particular consumers get called upon so you have to be careful to try and spread it around but at the same time get the competence that you do need.

PIR Manager

Finally, and most critically, PIR Organisations report struggling to ensure that consumer and carer involvement in governance arrangements is meaningful rather than tokenistic. Several PIR staff, even from higher performing PIR Organisations, reported they were unclear about how to make the involvement of consumers and carers a positive and meaningful experience for representatives, that delivers tangible positive change for clients and the wider service system.

I think that everyone involved in the meetings is getting a sense of a new way of working. I don’t know that that goes far enough. It’s been on my mind to suggest that we actually do a group session on what that means for PIR.

Consumer/carer representative
I think it’s caused service providers to question kind of the way they’ve operated previously and how they work with consumer and family representatives and yeah, it’s challenged a few to not expect them to have tokenistic participation but actually working with consumers and family members.

PIR Manager

While some PIR Organisations could point to specific examples of how consumer and/or carer involvement had improved outcomes with regard to communications design or recruitment decisions, in general it was felt to be too early to discuss evidence of impact to date.

5.8 SUMMARY OF NEW ISSUES IDENTIFIED IN THE 2014-15 ANNUAL EVALUATION REPORT

<table>
<thead>
<tr>
<th>NEW ISSUES IDENTIFIED IN THE 2014-15 ANNUAL REPORT</th>
<th>PLANNED ACTION IN 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable capacity among leadership of PIR Organisations, specifically lack of capacity at a senior level in some PIR Organisations.</td>
<td>Not discussed as part of the evaluation.</td>
</tr>
<tr>
<td>Maintaining partnerships can be difficult and result in partners feeling isolated and disengaged.</td>
<td>Some PIR Organisations have adjusted processes to better engage these partners, others have accepted some degree of disengagement.</td>
</tr>
<tr>
<td>Failure of some leadership to develop, agree and communicate shared vision.</td>
<td>Not discussed as part of the evaluation.</td>
</tr>
<tr>
<td>The climate of uncertainty surrounding the future of PIR.</td>
<td>Several PIR Organisations said they would value the Department making an announcement on the future of PIR as soon as possible, but at least within the next six months.</td>
</tr>
<tr>
<td>The lack of evaluation findings and information has been very frustrating for PIR Organisations.</td>
<td>At this stage there is no planned activity to address this issue.</td>
</tr>
<tr>
<td>The management and engagement of the ERG.</td>
<td>At this stage there is no planned activity to address this issue.</td>
</tr>
<tr>
<td>Several PIR Organisations reported the Department of Health had been inconsistent in its communication regarding the transition arrangements for PIR following 30 June 2016.</td>
<td>At this stage there is no planned activity to address this issue.</td>
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</tbody>
</table>
Client engagement and enrolment

The process of finding, engaging and enrolling the correct client group in PIR is one of the most challenging and most critical elements to success for the programme. In the Annual Report 2013-14 most PIR Organisations were yet to begin working with clients, so many of the issues regarding engagement and enrolment were based on establishing processes and potential referral pathways, rather than actual experience with clients. In 2014-15 the discussion of client engagement and enrolment is closely based on real experience with clients.

6.1 SUMMARY OF ISSUES IDENTIFIED IN THE 2013-14 ANNUAL EVALUATION REPORT

<table>
<thead>
<tr>
<th>ISSUES IDENTIFIED IN THE 2013-14 ANNUAL REPORT</th>
<th>PROGRESS IN 2014-15</th>
</tr>
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<tbody>
<tr>
<td>The need to develop referral pathways with services who do not have time, resources or organisational support to take a recovery approach in dealing with consumers.</td>
<td>Awareness and relationship building activities, including recovery training in many cases, has been successful in establishing referral pathways. There is still room to further develop referral pathways, and most PIR Organisations feel it is too early to observe evidence of a systemic shift to recovery oriented practice.</td>
</tr>
<tr>
<td>Eligibility criteria focused on exclusion could replicate service gaps, rather than addressing them.</td>
<td>This tension around exclusionary eligibility criteria was not an ongoing issue in 2014-15.</td>
</tr>
<tr>
<td>Engagement and assessment process is very time consuming, particularly the pre-engagement stage which is often not accurately reflected in the client activity reporting.</td>
<td>This continues to be an ongoing issue. PIR Organisations would like clearer direction and/or adjustments to the MDS so the client activity reporting more accurately reflects activity.</td>
</tr>
<tr>
<td>Detailed consent process can be off-putting for clients.</td>
<td>This was not an ongoing issue in 2014-15.</td>
</tr>
<tr>
<td>Poor alignment between CANSAS as an assessment tool and the principles of recovery oriented practice.</td>
<td>This continues to be an ongoing issue, in part addressed by the use of additional recovery oriented measurement tools, although remains a frustration.</td>
</tr>
<tr>
<td>Home visits a source of concern among some with regard to personal security for staff.</td>
<td>Home visits were not raised as a consistent concern in 2014-15 – as the model has been rolled out, staff have become increasingly comfortable with the various operating guidelines of lead agencies and host agencies.</td>
</tr>
<tr>
<td>The need for culturally sensitive Support Facilitators to work with Indigenous clients.</td>
<td>This is an ongoing issue. Some PIR Organisations have invested resources into identifying and employing suitable candidates in these roles, often with strong success. Other PIR Organisations are not yet addressing the issue of providing access for equity groups via specific Support Facilitator choices.</td>
</tr>
</tbody>
</table>

6.2 IS PIR WORKING WITH THE TARGET CLIENT GROUP?

Ensuring PIR Organisations are working with the correct client group was a strong and ongoing focus across all PIR Organisations, with almost all PIR Organisations reporting they believe they are successfully targeting clients with severe and persistent mental illness with complex needs. However, the range and type of measures in place to ensure PIR is engaging and enrolling clients who not only fit the eligibility criteria, but represent the ‘hard to reach’ client group, was significant.

It is also important to note that engagement and enrolment strategies are not fixed. These strategies have and will continue to evolve over the life of the programme according to:
- the nature of the client group at any point in time
- available capacity to engage and service new clients
- the capacity and experience of staff in undertaking assertive outreach
- perceived return on investment of assertive outreach
- the strength of existing and new relationships across the PIR Organisation and wider service system to support client identification and engagement.

Several high performing PIR Organisations reported operating from day one with a very narrow focus on working only with the most hard to reach clients, who clearly demonstrated a strong fit with the eligibility criteria. These PIR Organisations spoke of a continuum of need within the eligible client group, resulting in a requirement to prioritise even among eligible clients. They had designed engagement policies, procedures and strategies to reach and engage those in most critical need.

*We’re dealing with people with severe and persistent mental illness and complex needs as well and we have ensured that all of our staff are able to work with people who hold some level of risk in terms of mental health issues, aggression, risk to property, all those sorts of things, whereas sometime in the past there was an exclusion criteria for services to carry people who had that kind of risk. We want to include those people in our programme and be able to work with them but the safety of staff and that person is imperative so as I said we don’t want to lower the bar and have people fall through the gaps because that’s our whole aim to not have people falling through the gaps - so if we say we can’t take someone who’s really unwell or who is aggressive or has a forensic history or something like that, then we’re going to miss half of our people.*

PIR Manager

Some PIR Organisations, particularly those who experienced a longer establishment phase, reported that there was initially significant pressure to register clients. Consequently some PIR Organisations targeted clients already known to staff, or accepted referrals that did not represent the most hard to reach clients. Some also noted that working with easier to reach, and potentially easier to service, clients in the very early days of the programme supported staff to gain comfort and familiarity in the operationalisation of PIR. All PIR Organisations who initially worked with easier to reach, and/or easier to service clients, indicated they have now tightened their focus to ensure they are working with the target client group.

As PIR Organisations have begun to grow their client lists and waitlists for service increase, PIR Organisations have responded in a variety of ways. Some PIR Organisations report that growing waitlists drive an even greater focus on working only with those most in need and they have responded accordingly, developing processes and procedures to triage/prioritise clients. However, those clients most in need are often the most difficult to reach and engage and can represent a greater time and effort investment in the pre-engagement phase. This raises a question regarding the return on investment of attempting to engage these difficult to reach clients while a waitlist exists of clients who may be more willing to engage.

*Because we’re aiming for this high, high, high, high group, the registration can take a little bit longer just because you’re engaging, and we’ve had a wait listing in two areas and we’ve learnt that holding a wait list is not very effective because if you don’t jump when that person is there and we’re not making the most of that opportunity then we lose them and a few weeks down the track they’re harder to find and to engage with and we’ve been losing people that way, which has been unfortunate.*

Support Facilitator

A risk was acknowledged by some PIR Organisations that as the client numbers and waitlists grow, there may be a propensity among PIR Organisations to focus less on the hard to reach clients, given the extra effort and investment often required to engage these clients. Importantly, this was identified as a risk, although no PIR Organisations or stakeholders reported any instances of the risk materialising.
Some stakeholders expressed concern that PIR was not reaching the correct client group as evidenced by the number of referrals received from clinical mental health services (19% at 31 December 2014). These interactions with the clinical sector were cited as evidence clients were connected to the service system, and therefore not a strong fit with the programme’s eligibility criteria. However, the majority of PIR Organisations and stakeholders believe interaction with the clinical system is not evidence that a client is connected to the service system. They report that individuals with severe and persistent mental illness are very likely to have regular interaction with the clinical mental health system via cycling in and out of acute mental health services. However, they often have very little or no other service support, meaning a high level of referrals from the clinical mental health service system does not indicate PIR is missing the target group.

6.3 MEASURES IN PLACE TO ENSURE PIR ORGANISATIONS WORK WITH THE TARGET CLIENT GROUP

High performing PIR Organisations acknowledged a desire to not only work with the eligible client group, but prioritise within this client group to work with those most in need first.

Some PIR Organisations cite the eligibility criteria, the nature of their consortium and the promotion of the programme among their consortium and the wider service system network as evidence of targeting the client group. Arguably, these elements of the Operational Guidelines in terms of eligibility criteria, diverse organisational structure and promotional requirements should ensure PIR Organisations engage and enrol the correct target group.

However, there is significant evidence among the majority of PIR Organisations of additional measures in place to ensure the correct client group is identified, engaged and serviced, often including a mix of outreach and outplacement strategies.

The table below outlines the key measures in place (beyond the eligibility criteria, the existence of a consortium of partners and promotion of the programme) to ensure PIR is engaging and working with the correct client group, and the benefits of each.

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centralised intake and assessment process</td>
<td>Centralised intake and assessment consolidates the knowledge of and experience with potential clients – facilitating prioritisation of clients most in need</td>
</tr>
<tr>
<td>Diverse set of client facing consortium partners from across the service system</td>
<td>A large and/or diverse set of consortium partners from across the clinical and community support sectors increases the range of potential client contact points, making it easier to identify and engage the target group</td>
</tr>
<tr>
<td>Significant and ongoing promotion of PIR beyond the PIR Organisation, to include the wider community</td>
<td>Promotion of the programme beyond traditional clinical and community support partners increases the chances of identifying and engaging with clients who may have minimal contact with the service system Examples include State housing and homelessness services, real estate agents in lower socio-economic areas, GPs, local councils, police and corrections</td>
</tr>
<tr>
<td>Outplacement of Support Facilitators</td>
<td>Support Facilitators are co-located at regular intervals with partners who may come into contact with the target group Examples include the discharge facility of acute care facilities, homelessness services, remand centres, Aboriginal Medical Services and employment services</td>
</tr>
<tr>
<td>Outreach services</td>
<td>Bringing the PIR programme to clients via outreach reaches those who are disconnected from services and potential referral partners Examples include joint patrols with police and local councils, regular attendance at drop-in centres, patrols of homelessness hotspots</td>
</tr>
</tbody>
</table>
Many of these measures to ensure PIR Organisations were targeting the correct client group were implemented following the initial establishment phase.

_There has been a lot of discussion around what severe and complex mental health looks like to people. So when Support Facilitators are going out to meet people around eligibility they are coming back and we are having those discussions. As time has moved on, myself as a team member, I have more of a concrete understanding of the correct people for the programme. If I think about some of the clients that’d I signed on earlier in the programme, I’m not sure now looking back a year later whether I would have accepted them into the programme._

Support Facilitator

6.4 FINDING THE HARD TO REACH CLIENT GROUP

PIR Organisations often cite outreach services as a measure to find and engage with particularly hard to reach clients, however the definition of outreach or assertive outreach varied across the country.

For the purposes of this report we have distinguished between assertive outreach and outplacement strategies and defined them as follows:

- **Assertive outreach** – in recognition some potential clients will need alternative methods of engagement, assertive outreach involves services reaching into the community where potential clients are located, rather than having clients go to a service. Assertive outreach is often carried out in multidisciplinary teams, and can involve integrated clinical support.

- **Outplacement** – involves co-location of Support Facilitators in services and other locations where contact with the hard to reach potential client group is increased. Outplacement may occur in clinical or community support settings, and is usually a regular but not permanent co-location arrangement.

**ASSERTIVE OUTREACH**

Assertive outreach is often described as ‘patrol’ and involves engaging with people on the streets and other private locations including state housing facilities and drop-in centres to find potential clients, build a rapport, educate potential clients regarding PIR with the view to enrolling them in the programme if eligible. These assertive outreach services are mainly aimed at targeting the homeless and transient cohort of potential clients.

Outreach services are often a critical element in engaging the very hard to reach or disconnected client group, and consequently the more progressive, higher performing PIR Organisations, who are narrowly focused on working with client most in need, tend to engage in more assertive outreach.

_We’re very, very keen to pick up the most disenfranchised, most disconnected people that we can find and we’ve actually got Support Facilitators literally trudging the streets, homeless shelters and soup kitchens and at [Suburb] and places like that which is in the city, so a lot of those people have mental health issues. They might not have had any support or connection to service for quite a long time._

Intake officer

Patrols to undertake assertive outreach are usually well-planned to maximise the return on time invested. PIR Organisations report a significant amount of work is required to make assertive outreach effective, including uncovering and building relationships with existing outreach services to avoid duplication and maximise return on investment.

Some assertive outreach services may be focused on locating a specific individual known to the PIR Organisation as a potential client or alternatively be focused on engaging potential clients more generally.
Some examples of assertive outreach activities are listed below.

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint foot-patrols with local council officers / public space liaison officers</td>
<td>Homeless and transient cohort</td>
</tr>
<tr>
<td>Visits to soup kitchens and other food crisis centres</td>
<td>Homeless and transient cohort</td>
</tr>
<tr>
<td>Visits to community / social housing facilities</td>
<td>Potential clients with agoraphobia, hoarding and squalor issues</td>
</tr>
<tr>
<td>Joint patrols with police and other first responders</td>
<td>Homeless and transient cohort, Potential clients who have had interaction with the justice system</td>
</tr>
<tr>
<td>Visit or host community events likely to attract client group</td>
<td>All potential clients</td>
</tr>
<tr>
<td>Build relationships with boarding house owners, guardianship boards</td>
<td>Homeless and transient cohort, Potential clients with agoraphobia, hoarding and squalor issues</td>
</tr>
</tbody>
</table>

Assertive outreach services are more common in urban areas compared to regional, rural or remote areas. Urban areas often have higher concentrations of homeless and transient potential clients, have a higher turnover of people in their boundaries compared to less densely populated areas, making it difficult to identify potential clients and have more services available for joint-outreach such as soup kitchens, drop-in centres and local council patrols. In less densely populated areas PIR Organisations report they have better knowledge of the homeless and transient potential client group, meaning there is less need for outreach to identify and locate them.

There are a number of significant challenges associated with undertaking assertive outreach services:

- **Structural** - outreach often requires Support Facilitators to work outside of standard business hours in order to reach potential clients at soup kitchens, early morning drop-in centres and places where homeless people spend the night.

- **Capacity** - assertive outreach can require a different skillset among PIR Managers (to plan outreach) and Support Facilitators (to undertake outreach) that is more focused on community development as opposed to the existing skillsets.

- **Return on investment** – some PIR Organisations reported pressure to reach client target numbers, and show quick return on investment, which discourages investment in assertive outreach which can be time intensive and associated with long period of pre-engagement and rapport building.

Assertive outreach was an area identified by many PIR Organisations as requiring increased focus and attention, reflecting the confidence among staff that outreach is successful in identifying and engaging with hard to reach potential clients.

> The Support Facilitators will probably tell you how overworked they are, and that they don’t have time [for outreach]. So that’s been a significant point of resistance.

PIR Manager

> I think the sense is that people feel that it’s something they should do but the reality has been that it’s not an effective use of time, particularly as client numbers rise and it becomes more difficult and you get away from direct service.

Support Facilitator
OUTPLACEMENT

PIR Organisations report co-location of Support Facilitators in a wide range of host/partner agencies as a means to engage the PIR target group. Outplacement supports the development of new and varied referral pathways, thereby improving access to the client group.

Some examples of outplacement strategies are listed below.

TABLE 13 – EXAMPLES OF OUTPLACEMENT STRATEGIES

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centrelink</td>
<td>▪ Disconnected cohort, who still engage with Centrelink regarding their benefits</td>
</tr>
<tr>
<td>Local club-house, Men’s Shed</td>
<td>▪ Disconnected cohort, who do not engage with services</td>
</tr>
<tr>
<td>Discharge facility at mental health unit, acute, sub-acute mental health services</td>
<td>▪ All potential clients</td>
</tr>
<tr>
<td>Homelessness and crisis accommodation services</td>
<td>▪ Homeless and transient cohort</td>
</tr>
<tr>
<td>Aboriginal Medical Services / Aboriginal Community Controlled Health Organisations</td>
<td>▪ Aboriginal and Torres Strait Islander potential clients</td>
</tr>
<tr>
<td>Remand centres</td>
<td>▪ Cohort engaged with the justice and/or corrections system</td>
</tr>
</tbody>
</table>

6.5 ENSURING ACCESS FOR KEY EQUITY GROUPS

While there is evidence of good practice among some PIR Organisations, almost all organisations acknowledged they need to be doing more to facilitate access to PIR for key equity groups including CALD populations, Aboriginal and Torres Strait Islanders and those living in rural and remote locations.

The key measures currently in place to specifically target some of these equity groups included the following:

▪ designing and employing roles specifically dedicated to engaging with equity populations, such as dedicated Indigenous or CALD Support Facilitators and capacity building roles

▪ partnering with organisations dedicated to engaging with specific equity groups such as migrants or Aboriginal and Torres Strait Islander populations

▪ community education and relationship building activities with organisations dedicated to engaging with specific equity groups who are not members of the PIR consortium.

While there is evidence of engaging on an organisational level to establish and support referral pathways that facilitate access to PIR for key equity groups, it is important to note that assertive outreach among these marginalised communities operates in a quite a different manner to the mainstream population. While assertive outreach is possible between a PIR Organisation and an individual in many cases among the mainstream community (acknowledging this is still a difficult task given the client group), outreach with individuals is reportedly more difficult with several key equity groups.

Instead, specifically with CALD and Aboriginal and Torres Strait Islander communities, outreach does not happen one on one but instead outreach often involves the whole community. For example, one PIR Organisation employed a dedicated Indigenous Community Capacity Building role, designed to build capacity among the local Aboriginal community with regard to mental health generally, a necessary precursor to developing the trust required to receive referrals from this community.
I can go out and visit a family and say to them for instance you’ve got a nephew or son or a sister using our PIR programme, how best can I build your capacity to understand the needs of how you need to support that person and survive yourself. So I see my role as a very important educative role for particularly what I call kinship groups. And as kinships groups would generally have a participant in our PIR programme and that role is an educative role around supporting the family to understand that the mental illness, very different to a medical model.

Indigenous capacity builder

Given the long legacy of forced family separation, abuse and trauma among Aboriginal communities, it is no surprise there is a higher need for PIR among Aboriginal communities. Client activity reporting reinforces this picture, revealing that 12% (at 30 June 2014) of PIR clients identify as Aboriginal or Torres Strait Islander, representing a significantly higher penetration than the general population. This number is evidence of pockets of good practice in relation to identifying and engaging with Aboriginal and Torres Strait Islander clients across the country.

Some examples of good practice of engaging with marginalised communities are listed in the table below.

<table>
<thead>
<tr>
<th>PRACTICE</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment of dedicated Indigenous capacity builder role, to work closely with local Aboriginal families and build their comfort and capacity in dealing with mental health issues as a community.</td>
<td>Given family and community often form a critical element of Aboriginal and Torres Strait Islander clients’ support network, direct engagement with families can ensure better coordinated and more consistent support for clients.</td>
</tr>
<tr>
<td>Employment of dedicated CALD Support Facilitator, hosted at the local Multicultural Centre, who speaks multiple relevant languages and undertakes outreach work with local communities to build trust prior to clients engaging with PIR.</td>
<td>Provides improved access for CALD clients to the programme.</td>
</tr>
<tr>
<td>Consortium and host agency group includes a number of specialist Aboriginal and Torres Strait Islander NGOs.</td>
<td>Enables culturally appropriate delivery of PIR in communities of need.</td>
</tr>
<tr>
<td>Recruitment of staff especially skilled at connecting with relevant CALD communities, with particular focus on supporting these workers to liaise with formal and informal carers groups within CALD communities to build trust with these populations and establish referral pathways.</td>
<td>Provides improved access for CALD clients to the programme.</td>
</tr>
</tbody>
</table>

6.6 THE REFERRAL AND INTAKE PROCESS

REFERRAL PATHWAYS

All PIR Organisations report they have successfully established effective referral pathways. While in the early days of the programme inappropriate referrals were a problem for some PIR Organisations, with time and increased investment in education the level of suitable referrals has grown.

Most are coming from clinical services…and that’s been on the back of a lot of education with those clinical services about what we do and what kind of referrals are appropriate. Initially we were getting a lot of referrals that weren’t really appropriate but that’s starting to get a lot better so they’re referring people that are appropriate for us.

Team Leader

PIR Organisations attribute this success to a range of critical factors outlined in the diagram overleaf.
Some referrals pathways have been less common than expected. Many PIR Organisations expected to receive more referrals from GPs, housing services, police, employment and corrections facilities. All these pathways were acknowledged as important in identifying and engaging with hard to reach potential clients, although PIR Organisations report these relationships can often be the most intensive in terms of building knowledge and trust of the PIR programme.

In particular, many PIR Organisations talked about the need to invest more in establishing strong referral pathways with local GPs. GPs were seen as a critical contact point with some of the hardest to reach potential clients. Several PIR Organisations have developed system reform projects and/or used innovation funding to strengthen relationships with GPs (see section 9 for system reform).

*We’re starting to engage with GPs and have another position dedicated to going out and making sure that GPs thoroughly understand what the programme is about so I would suspect that the number of referrals would start to go up quite significantly in the not too distant future.*

PIR Manager

Self-referrals, a referral pathway identified in the client activity reporting, is a pathway that was defined differently according to PIR Organisations. Some self-referrals involve a potential client contacting PIR to nominate themselves as a potential recipient of the service based on having seen PIR material, attending an event, or speaking with a friend or family member who was aware of the service. In other cases, self-referrals were the second step in a two stage referral process that commenced with a service already engaged with the potential client directing them to PIR, followed by the potential client submitting a self-referral. This is an area that would benefit from more precise definition in the client activity reporting to ensure accurate reporting.
In some PIR Organisations, there was a strong desire to see consistent growth in self-referrals as an indicator of good awareness raising of the programme, as well as a reflection of the recovery principle of PIR being client focused and client led.

Self-referrals was running at 12%. Our aim is to get that up to 80 and 90% because we heartily believe in the concept of nothing about you without you and if a person really wants to be engaged in PIR then they have the ability to pick up the phone, go online, drop in, or be supported to do any of those three things so that their commitment starts with that initial referral and we believe if they start being self-managed and so forth at that point then there’s great chance that that will continue to grow throughout their recovery.

PIR Manager

CENTRALISED VS DIFFUSED MODEL OF INTAKE AND ASSESSMENT

PIR Organisations adopted one of two models of intake and assessment: centralised and diffused.

The more common centralised model involves a single point of contact coordinating the receipt of referrals, the intake and assessment process and the allocation of new clients to host agencies and/or Support Facilitators. In nearly all cases, this centralised intake and assessment role was undertaken by the lead agency, although there were a few cases of a team leader within a host agency managing this process where the lead agency had taken a contract management style leadership role.

The reported advantages of a centralised intake and assessment process include:

- supports a consistent approach to programme delivery via a consistent interpretation of eligibility criteria and needs assessment
- facilitates optimal allocation and management of client loads across Support Facilitators and host agencies
- enables prioritisation of clients most in need, with single view of all potential clients on the waitlist

Among higher performing PIR Organisations, there was a strong belief that some clinical experience among intake and assessment coordinators was an advantage in making accurate assessments and managing what can be a sensitive interaction with clients.

We’ve set up our intake quite differently to a lot of the other PIRs in regard to having an intake and assessment coordinator. A lot of PIRs have maybe an intake officer and what they do is look at the referrals and field them straight out to the Support Facilitators. Our process is a little bit more clinical than that even though we’re recovery orientated. There was some ability I suppose to include a little bit of a clinical process in terms of assessment because PIR here has deliberately decided not to lower the bar of the people we take on board...They might have immediate needs that need to be met in terms of their physical and mental health so in terms of the process I do, I do all of the initial psychosocial assessments, plus a risk assessment so when they come through to our programme we’re very well aware of exactly where they are in terms of all of those areas. It allows us to hold some risk in a safe way because there are some people that might take weeks and weeks to actually get into clinical services so we need to be aware if they need something.

Intake officer

It’s always been set up that PIR is not a clinical service and we know that, and our Support Facilitators don’t work in a clinical model but our intake we do feel that there needs to be some understanding of mental health in order to do a proper assessment.

PIR Manager
The referrals get sent to us via our website, they go to our Team Leader and he does the triage initially…if there’s any ambiguity or concerns they come to me and we sit and discuss it.

PIR Manager

The main disadvantage associated with the centralised intake and assessment process has been the creation of a bottleneck, leading to a larger waitlist for clients to access PIR. Several PIR Organisations reported concern regarding waitlists, which can mean PIR Organisations miss the window of opportunity during which a client is well enough, willing and able to engage. Given the issue of waitlists was a new issue in the second year of the evaluation, clear methods for effectively managing waitlists are yet to emerge.

The diffused model of intake and assessment involves individual host agencies sharing the intake and assessment role. There were twin approaches to this including a rotation system for processing new referrals across team leaders and/or Support Facilitators in host agencies and team leaders and/or Support Facilitators taking responsibility for processing new referrals based on location of the client.

Several PIR Organisations had adjusted their intake and assessment process to move from a diffused model to a centralised model – primarily driven by a need to maintain consistency in assessment, as well as to support easier management of client loads across host agencies and/or Support Facilitators. Based on initial experience of the diffused model, several report finding a centralised model better is more time efficient and consistent.

It’s far more consistent and streamlined if you have one person doing it.

PIR Consortium Member

In cases where PIR Organisations had maintained a diffused model of intake and assessment, it tended to be driven by a need to customise the programme delivery due to a very diverse target population in terms of CALD or Aboriginal and Torres Strait Islander status. A diffused model was occasionally seen as better supporting culturally appropriate programme delivery.

ONGOING CHALLENGES WITH INTAKE AND ASSESSMENT

A key challenge in relation to intake and assessment is the effort required to get a potential client to be ready to undertake an intake and assessment – the pre-engagement phase. All PIR Organisations agree that pre-engagement phase with clients can be very time and resource intensive – to build a rapport and relationship with a client can take months before the potential client might be ready to discuss becoming involved with PIR. It is a point of frustration among many PIR Organisations that this time and resource intensive work, which is critical to the success of the programme, is not easily and accurately reflected in the client activity reporting.

In the PIR Annual Report 2013-14, there was some anticipation that ambiguities in interpreting the eligibility criteria would be encountered once PIR Organisations began receiving clients. In particular, PIR Organisations were concerned with regard to the need for a formal diagnosis. Based on the consultation undertaken in 2014-15, this concern did not materialise. While there was some ongoing resistance to the requirement for a formal diagnosis, with some Support Facilitators in particular noting that the pushing for a formal diagnosis could undermine the relationship established between client and Support Facilitator, in general the policies and procedures of individuals PIR Organisations seemed sufficient to allow flexibility where required.

I think the focus on encouraging clients to receive formal diagnosis, I think it’s a little bit of an issue and you can shoot yourself in the foot. I think with this particular group of participants, when you start focussing on okay, initially I’m not going to force you to go and see a psychiatrist and get a diagnosis but eventually I’m going to encourage you to do that. I think that’s counterproductive to establish a relationship with someone who’s very mistrustful of services. So I think the focus on that is a mistake in PIR in particular because we are providing services for people that have fallen through the cracks, pretty much every day in the service system and I think the focus should be on the holistic relationship and that person’s care instead of getting a formal diagnosis.

Support Facilitator
Also raised in the PIR Annual Report 2013-14 was the concern among most PIR Organisations in relation to the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) tool. The CANSAS needs assessment tool was criticised in 2013-14 for several reasons including: not being strengths-based; poor alignment with a recovery approach; lack of validation for use in Australian settings; that existing validation studies were based on the CANSAS being administered in single 30 minute sessions, whereas many PIR Organisations need to have multiple contacts with PIR clients over several weeks to complete the assessment; and, that the CANSAS tool is not culturally appropriate for several key equity groups particularly Aboriginal and Torres Strait Islanders. These criticisms of CANSAS were echoed in 2014-15 although PIR Organisations have largely accepted the CANSAS tool as imperfect but necessary and most are supplementing their needs assessment and outcomes measurement with other recovery-oriented tools such as Recovery Star and RAS.

Another challenge associated with the intake and assessment process was the use of the recovery principle of a client leading their recovery journey as a rationale for PIR Organisations not engaging or disengaging from harder to reach potential clients. Some PIR Organisations strictly adhered to the idea that recovery must be client lead, meaning persistent pursuit and follow-up of potential clients was not supported. However, other PIR Organisations suggested this principle of recovery based practice may be used by some Support Facilitators to avoid engaging with the most difficult to engage potential clients, who are arguably the most in need.

### 6.7 SUMMARY OF NEW ISSUES IDENTIFIED IN THE 2014-15 ANNUAL EVALUATION REPORT

<table>
<thead>
<tr>
<th>NEW ISSUES IDENTIFIED IN THE 2014-15 ANNUAL REPORT</th>
<th>PLANNED ACTION IN 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many PIR Organisations who adopted a diffused model of intake and assessment found it to be unsatisfactory.</td>
<td>Most of these PIR Organisations have adjusted their model to a centralised intake and assessment process.</td>
</tr>
<tr>
<td>The return on investment for outreach activities is questioned by some PIR Organisations, particularly as Organisations are seeking to demonstrate success and/or reach target numbers.</td>
<td>It is unclear whether PIR Organisations will focus less on outreach activities due to this pressure.</td>
</tr>
<tr>
<td>The most common model of intake and assessment, the centralised approach, can cause bottlenecks and increase waitlists.</td>
<td>This issue is yet to be addressed by many PIR Organisations, although some have developed triage procedures.</td>
</tr>
<tr>
<td>A principle of recovery, the client leading their journey, may be used by PIR Organisations as a rationale for not engaging and disengaging with the most hard to reach clients.</td>
<td>Given the relative infancy of the programme, this is an issue PIR Organisations expect will be reflected on and improved with time.</td>
</tr>
<tr>
<td>Almost all PIR Organisations acknowledged they need to be doing more to facilitate access to PIR for key equity groups.</td>
<td>Some PIR Organisations have specific strategies to improve access for equity groups underway and/or planned including employment of specialist Support Facilitators and other staff, development of partnerships and system reform projects. The uncertainty surrounding the future of PIR is slowing down progress in this area.</td>
</tr>
</tbody>
</table>
7 Profile of PIR client activity

7.1 INTRODUCTION

The following section presents data collected and reported for all 48 PIR Organisations for the period 1 July 2013 to 31 March 2015.

The data has been collected as part of the ongoing monitoring and evaluation for the PIR initiative. PIR Organisations are required to collect and report on a range of programme activity data as part of the MDS. The MDS includes data for all individuals referred to PIR, and data is collected on clients’ needs and progress at various stages of the support initiative. This profile of client activity does not report on the full MDS, but a subset of items as requested by the Department.

Please note, where data is missing this has been recorded as ‘not reported’ data. When a client should have been asked to provide data, but sufficient information has not been reported or recorded, this has been recorded as ‘not stated’ data. There were less cases of missing data in 2014-15 compared to the previous year – it is anticipated this is due to greater familiarity with the reporting requirements for the PIR MDS.

7.2 DEMOGRAPHIC PROFILE

From 1 July 2013 to 31 March 2015 there were 12,628 clients registered to PIR Organisations. This represents an increase of +141% since June 2014 (or 7,393 more clients). Table 16 below provides summary data on the demographic and location profile of registered clients. This indicates that:

- more than half (53%) of all registered clients were female
- over one quarter (28%) were between the ages of 35-44 years, with a similar proportion (25%) aged between 45-54 years
- the majority (83%) of all registered clients spoke English
- a total of 1,353 clients (11%) were of Aboriginal and/or Torres Strait Islander origin
- one third (32%) of clients were registered to organisations in New South Wales, with more than a quarter (28%) registered in Queensland (this represents a greater proportion of clients in NSW compared to 2013-14)
<table>
<thead>
<tr>
<th>GENDER</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>5,864</td>
<td>46%</td>
</tr>
<tr>
<td>Female</td>
<td>6,718</td>
<td>53%</td>
</tr>
<tr>
<td>Other</td>
<td>20</td>
<td>≤ 0%</td>
</tr>
<tr>
<td>Not stated</td>
<td>26</td>
<td>≤ 0%</td>
</tr>
<tr>
<td>Total</td>
<td>12,628</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AGE</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25 years</td>
<td>929</td>
<td>7%</td>
</tr>
<tr>
<td>25–34 years</td>
<td>2,597</td>
<td>21%</td>
</tr>
<tr>
<td>35–44 years</td>
<td>3,494</td>
<td>28%</td>
</tr>
<tr>
<td>45–54 years</td>
<td>3,175</td>
<td>25%</td>
</tr>
<tr>
<td>55–64 years</td>
<td>1,762</td>
<td>14%</td>
</tr>
<tr>
<td>65+ years</td>
<td>454</td>
<td>4%</td>
</tr>
<tr>
<td>Not stated</td>
<td>217</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>12,628</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LANGUAGE</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>10,435</td>
<td>83%</td>
</tr>
<tr>
<td>Arabic</td>
<td>109</td>
<td>1%</td>
</tr>
<tr>
<td>Cantonese</td>
<td>24</td>
<td>≤ 0%</td>
</tr>
<tr>
<td>Greek</td>
<td>21</td>
<td>≤ 0%</td>
</tr>
<tr>
<td>Hindi</td>
<td>13</td>
<td>≤ 0%</td>
</tr>
<tr>
<td>Italian</td>
<td>13</td>
<td>≤ 0%</td>
</tr>
<tr>
<td>Mandarin</td>
<td>39</td>
<td>≤ 0%</td>
</tr>
<tr>
<td>Spanish</td>
<td>32</td>
<td>≤ 0%</td>
</tr>
<tr>
<td>Tagalog</td>
<td>2</td>
<td>≤ 0%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>34</td>
<td>≤ 0%</td>
</tr>
<tr>
<td>Other</td>
<td>521</td>
<td>4%</td>
</tr>
<tr>
<td>Not stated</td>
<td>1,356</td>
<td>11%</td>
</tr>
<tr>
<td>Not reported</td>
<td>29</td>
<td>≤ 0%</td>
</tr>
<tr>
<td>Total</td>
<td>12,628</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ABORIGINAL AND TORRES STRAIT ISLANDER STATUS</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal and/or Torres Strait Islander origin</td>
<td>1,353</td>
<td>11%</td>
</tr>
<tr>
<td>Neither Aboriginal nor Torres Strait Islander origin</td>
<td>9,645</td>
<td>76%</td>
</tr>
<tr>
<td>Not stated</td>
<td>1,630</td>
<td>13%</td>
</tr>
<tr>
<td>Total</td>
<td>12,628</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>4,025</td>
<td>32%</td>
</tr>
<tr>
<td>QLD</td>
<td>3,517</td>
<td>28%</td>
</tr>
<tr>
<td>VIC</td>
<td>2,208</td>
<td>17%</td>
</tr>
<tr>
<td>WA</td>
<td>1,189</td>
<td>9%</td>
</tr>
<tr>
<td>SA</td>
<td>775</td>
<td>6%</td>
</tr>
<tr>
<td>TAS</td>
<td>462</td>
<td>4%</td>
</tr>
<tr>
<td>ACT</td>
<td>257</td>
<td>2%</td>
</tr>
<tr>
<td>NT</td>
<td>195</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>12,628</td>
<td>100%</td>
</tr>
</tbody>
</table>
Three quarters of all clients in the Northern Territory (75% or 149 people) were of Aboriginal and/or Torres Strait Islander origin, which was a significantly greater proportion than in all other states. A total of 14% of clients (37 people) in the Australian Capital Territory were of Aboriginal and/or Torres Strait Islander origin, followed by 12% (503 people) in New South Wales. Since June 2014 there has been a proportional increase in ATSI clients in New South Wales, and a decrease in ATSI clients from Queensland and Western Australia.

Figure 9 presents a breakdown of client age by location. This indicates that the Northern Territory had the highest proportion of clients under the age of 34 years (42%), followed by South Australia (33%). Since June 2014 there has been a slight decrease in the amount of clients aged under 34 years across all states, with the exception of Tasmania, which saw a slight increase. Comparison is not possible for the Northern Territory as this state was not reported last year.

New South Wales had the highest proportion of clients aged 55 years or older (20%), followed by Queensland and Victoria (both 18%) and Western Australia (17%). Since June 2014 there has been a slight increase in the amount of clients aged under 34 years across all states, with the exception of Tasmania, which saw a decrease (-8%). Comparison is not possible for the Northern Territory as this state was not reported last year.

7.3 LIVING ARRANGEMENTS

As indicated in Figure 10, more than one third (37%) of clients were living in a lone person household, with one in six living in ‘other family’ household (16%) and one in ten living in a ‘one parent with child(ren)’ household (11%). Very few clients were living in a group household (8%) or as a couple, either with children (6%) or without children (5%).

This is a similar profile compared to 2013-14, with a slight increase in the proportion of lone person households (+5%) and ‘other family’ households (+4%).
As indicated in Figure 11 over three fifths (62%) of all clients lived in a private residence, which represents a +12% increase since 2013-14. A total of 14% did not state their current accommodation type, and 8% of clients lived in other accommodation types (not classified). Only 4% were living in a boarding house or hostel, with 3% in other supported accommodation and 3% homeless.
As indicated in Figure 12 one third (31%) of clients had lived in their current accommodation for less than one year. This represents a +7% increase since 2013-14. Just under a quarter (22%) had lived in their current accommodation for between 1 and 4 years, and a similar proportion (20%) for 5 or more years. Over a quarter (25%) did not state how long they had resided in their current accommodation, and accommodation tenure was not reported for 29 clients (≤ 0%).

**FIGURE 12 – CLIENT ACCOMMODATION TENURE**

<table>
<thead>
<tr>
<th>Tenure</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>3,877</td>
<td>31%</td>
</tr>
<tr>
<td>1-2 years</td>
<td>1,703</td>
<td>13%</td>
</tr>
<tr>
<td>3-4 years</td>
<td>1,117</td>
<td>9%</td>
</tr>
<tr>
<td>5 or more years</td>
<td>2,560</td>
<td>20%</td>
</tr>
<tr>
<td>Not stated</td>
<td>3,342</td>
<td>26%</td>
</tr>
<tr>
<td>Not reported</td>
<td>29</td>
<td>&lt;0%</td>
</tr>
</tbody>
</table>

**7.4 EMPLOYMENT AND INCOME**

Figure 13 indicates that only one in twenty (6%) clients were employed, while one third (33%) were unemployed and almost half (48%) were not in the labour force. One in eight (12%) respondents did not state their labour force status, and labour force status was not reported for 110 respondents (≤ 0%).

While the proportion of clients in employment has remained stable since June 2014, the proportion of unemployed clients and clients not in the labour force has increased (by +4% and +11% respectively). These figures suggest PIR Organisations are working with an increasingly disadvantaged client group.

**FIGURE 13 – CLIENT LABOUR FORCE STATUS**
Figure 14 indicates that the Australian Capital Territory (9%) and Western Australia (9%) had the highest rates of employment among registered clients. The Northern Territory had the highest rates of unemployment (65%).

**FIGURE 14 – CLIENT LABOUR FORCE STATUS BY LOCATION**

<table>
<thead>
<tr>
<th>Location</th>
<th>Employed</th>
<th>Unemployed</th>
<th>Not in the labour force</th>
<th>Not stated</th>
<th>Not reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (n=12,628)</td>
<td>6%</td>
<td>33%</td>
<td>48%</td>
<td>12%</td>
<td>1%</td>
</tr>
<tr>
<td>NSW (n=4,035)</td>
<td>6%</td>
<td>32%</td>
<td>48%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>VIC (n=2,208)</td>
<td>6%</td>
<td>24%</td>
<td>59%</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td>QLD (n=3,517)</td>
<td>6%</td>
<td>34%</td>
<td>52%</td>
<td>8%</td>
<td>1%</td>
</tr>
<tr>
<td>WA (n=1,189)</td>
<td>9%</td>
<td>46%</td>
<td>31%</td>
<td>12%</td>
<td>3%</td>
</tr>
<tr>
<td>SA (n=775)</td>
<td>7%</td>
<td>33%</td>
<td>38%</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>TAS (n=462)</td>
<td>7%</td>
<td>34%</td>
<td>31%</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>ACT (n=257)</td>
<td>9%</td>
<td>25%</td>
<td>43%</td>
<td>5%</td>
<td>18%</td>
</tr>
<tr>
<td>NT (n=195)</td>
<td>5%</td>
<td>65%</td>
<td>19%</td>
<td>10%</td>
<td></td>
</tr>
</tbody>
</table>

Figure 15 shows that of those clients who were in employment (n=813), the majority (77%) worked part-time, with only 188 clients (23%) working full-time. This represents a +10% increase in the proportion of clients working full-time since June 2014.

**FIGURE 15 – CLIENT EMPLOYMENT PARTICIPATION**
As indicated in Table 17, with regard to income, more than half (53%) of registered clients were receiving income through the Disability Support Pension and one quarter (25%) were receiving some other pension or benefit. This represents proportional increases of +6% and +5% respectively since June 2014. It is anticipated that these proportional increases are due, in part, to the -11% decrease in ‘not reported’ cases since June 2014.

<table>
<thead>
<tr>
<th>SOURCE OF INCOME</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Support Pension</td>
<td>6,688</td>
<td>53%</td>
</tr>
<tr>
<td>Other pension or benefit (not superannuation)</td>
<td>3,148</td>
<td>25%</td>
</tr>
<tr>
<td>Not stated</td>
<td>1,388</td>
<td>11%</td>
</tr>
<tr>
<td>Paid employment</td>
<td>397</td>
<td>3%</td>
</tr>
<tr>
<td>Not known</td>
<td>347</td>
<td>3%</td>
</tr>
<tr>
<td>Nil income</td>
<td>265</td>
<td>2%</td>
</tr>
<tr>
<td>Other (e.g. superannuation, investments etc.)</td>
<td>166</td>
<td>1%</td>
</tr>
<tr>
<td>Not reported</td>
<td>127</td>
<td>1%</td>
</tr>
<tr>
<td>Compensation payments</td>
<td>102</td>
<td>1%</td>
</tr>
<tr>
<td>Total</td>
<td>12,628</td>
<td>100%</td>
</tr>
</tbody>
</table>

7.5 CURRENT EDUCATION

As indicated in Figure 16 the majority (70%) of clients were not currently enrolled in any form of education. One in twenty (5%) of clients were enrolled in a course with TAFE or another equivalent training organisation.

FIGURE 16 – CLIENT CURRENT EDUCATION ENROLMENT
7.6 MENTAL HEALTH STATUS AND SUPPORT

As indicated in Figure 17 over one third of registered clients (38%) had been diagnosed with a mood affective disorder, with a quarter (25%) diagnosed with schizophrenia, schizotypal and delusional disorders, and over one in ten (11%) with an unspecified mental disorder.

This was a similar profile to 2013-14, with a slight increase in mood affective disorder diagnoses (+6%).

FIGURE 17 – REPORTED PRINCIPAL MENTAL ILLNESS DIAGNOSES

- Mood [affective] disorders: 4,830 (38%)
- Schizophrenia, schizotypal and delusional disorders: 3,220 (25%)
- Unspecified mental disorder: 1,327 (11%)
- Neurotic, stress-related and somatoform disorders: 873 (7%)
- Disorders of adult personality and behaviour: 710 (6%)
- Organic, including symptomatic, mental disorders: 388 (3%)
- Mental and behavioural disorders due to psychoactive substance use: 298 (2%)
- Behavioural and emotional disorders with onset usually occurring in childhood or adolescence: 250 (2%)
- Behavioural syndromes associated with physiological disturbances: 151 (1%)
- Disorders of psychological development: 39 (<0%)
- Mental retardation: 38 (<0%)
- Not reported: 504 (4%)

By jurisdiction, Figure 18 indicates that:

- the Northern Territory (64%) had the highest proportion of clients with schizophrenia, schizotypal and delusional disorders, followed by Western Australia (28%)
- Tasmania (48%) had the highest proportion of clients with unspecified mental disorders, followed by South Australia (22%)
- the Australian Capital Territory (46%) has the highest proportion of clients with mood affective disorders, followed by Queensland and Victoria (both 42%) and Western Australia (41%).
FIGURE 18 – REPORTED PRINCIPAL MENTAL ILLNESS DIAGNOSES BY LOCATION

<table>
<thead>
<tr>
<th>Location</th>
<th>Mood [affective] disorders</th>
<th>Schizophrenia, schizotypal and delusional disorders</th>
<th>Unspecified mental disorder</th>
<th>Neurotic, stress-related and somatoform disorders</th>
<th>Disorders of adult personality and behaviour</th>
<th>Organic, including symptomatic, mental disorders</th>
<th>Mental and behavioural disorders due to psychoactive substance use</th>
<th>Behavioural and emotional disorders with onset usually occurring in childhood or adolescence</th>
<th>Behavioural syndromes associated with physiological disturbances</th>
<th>Disorders of psychological development</th>
<th>Mental retardation</th>
<th>Not reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>38%</td>
<td>25%</td>
<td>11%</td>
<td>6%</td>
<td>5%</td>
<td>3%</td>
<td>4%</td>
<td>10%</td>
<td>7%</td>
<td>7%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>NSW</td>
<td>36%</td>
<td>30%</td>
<td>7%</td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QLD</td>
<td>42%</td>
<td>23%</td>
<td>10%</td>
<td>7%</td>
<td>7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VIC</td>
<td>42%</td>
<td>25%</td>
<td>6%</td>
<td>6%</td>
<td>7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td>41%</td>
<td>28%</td>
<td>11%</td>
<td>5%</td>
<td>3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td>33%</td>
<td>10%</td>
<td>22%</td>
<td>11%</td>
<td>5%</td>
<td>3%</td>
<td>7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3%</td>
</tr>
<tr>
<td>TAS</td>
<td>23%</td>
<td>14%</td>
<td>48%</td>
<td></td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>46%</td>
<td>21%</td>
<td>6%</td>
<td>3%</td>
<td>3%</td>
<td>14%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td>13%</td>
<td>64%</td>
<td>15%</td>
<td></td>
<td>3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
As indicated in Figure 19, one in ten clients (11%) had been involuntarily treated under the relevant state mental health legislation, while over half (59%) of all clients had been treated voluntarily. This was a similar profile to 2013-14.

FIGURE 19 – CLIENT MENTAL HEALTH LEGAL STATUS

As indicated in Figure 20, the Northern Territory (14%) had the highest proportion of clients who had been treated involuntarily, followed by Queensland and New South Wales (both 12%).

FIGURE 20 – CLIENT MENTAL HEALTH LEGAL STATUS BY LOCATION
As indicated in Figure 21 one third (35%) of registered clients were being supported by public sector mental health services, 28% by a General Practitioner, and one in ten (9%) were accessing a private psychiatrist as their principal clinical service provider. This was a similar profile to 2013-14.

**FIGURE 21 – MENTAL HEALTH SERVICE PROVIDER**

![Bar chart showing mental health service providers with data](image)

Figure 22 indicates that three fifths (60%) of all registered clients had no carer, one in six (17%) had an informal carer and only 7% had a formal carer. This is a similar profile to 2013-14. There has been an increase in the proportion of clients with no carer (+10%), however it is anticipated that this is due to a decrease in ‘not reported cases’ (-12%), as all other carer arrangement categories have remained stable.

**FIGURE 22 – CLIENT CARER ARRANGEMENT**

![Pie chart showing client carer arrangements with data](image)
Figure 23 indicates that Queensland (69%) and New South Wales (60%) had the highest proportion of clients with no carer. The Northern Territory had the highest proportion of clients with a formal carer (14%).

**FIGURE 23 – CLIENT CARER ARRANGEMENTS BY LOCATION**

<table>
<thead>
<tr>
<th>Location</th>
<th>No carer</th>
<th>Informal carer</th>
<th>Formal carer</th>
<th>Not stated</th>
<th>Not reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>17%</td>
<td>60%</td>
<td>15%</td>
<td>&lt;0%</td>
<td></td>
</tr>
<tr>
<td>NSW</td>
<td>19%</td>
<td>60%</td>
<td>12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QLD</td>
<td>13%</td>
<td>69%</td>
<td>11%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VIC</td>
<td>21%</td>
<td>56%</td>
<td>15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td>20%</td>
<td>55%</td>
<td>16%</td>
<td></td>
<td>2%</td>
</tr>
<tr>
<td>SA</td>
<td>16%</td>
<td>55%</td>
<td>22%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TAS</td>
<td>11%</td>
<td>38%</td>
<td>45%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>11%</td>
<td>54%</td>
<td>30%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td>15%</td>
<td>46%</td>
<td>25%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**7.7 REFERRALS**

Between 2013 and March 2015, PIR Organisations received 19,994 referrals\(^{13}\). This represented a +152% increase from 7,913 referrals as at June 2014.

As indicated in Figure 24, one fifth (19%) of the 19,994 referrals were made by public sector mental health service clinics, with a further 15% provided by other community or health care services and 12% provided by non-government community support. Just over one in ten (12%) were self-referrals to PIR. This was a similar profile to 2013-14.

In terms of the outcome of referrals made to PIR, over three quarters (78%) were accepted, equivalent to 15,619 referrals. Over one in eight (14%) were refused, 6% were withdrawn prior to assessment and 2% had an unknown outcome. This was a similar profile to 2013-14.

Figure 24 provides analysis of referral outcomes for each type of referral. Overall, referrals were most likely to be accepted when referred by a cultural service (89%) or when self-referred (83%). Referrals were less likely to be accepted when referred by a family service (52%, although 20% of these referrals had an unknown outcome) or by police (51%).

Figure 25 provides a profile of referrals by location. PIR Organisations in New South Wales (37% of all referrals) received the most referrals followed by Victoria (28% of all referrals). In terms of the outcome of referrals made to PIR by location, Figure 25 shows that referrals in the Northern Territory were more likely to be accepted (81%), followed by South Australia and Queensland (both 80%). Referrals were less likely to be accepted in Tasmania (71%).

---

\(^{13}\) It is anticipated that the high number of referrals (n=19,994) compared to the number of clients (n=12,628) is due to a lag in the formal registration of clients.
FIGURE 24 – SOURCE AND OUTCOME OF REFERRAL

- Accepted
- Not accepted
- Referral withdrawn prior to assessment
- Unknown/not stated

<table>
<thead>
<tr>
<th>Source and Outcome of Referral</th>
<th>Accepted</th>
<th>Not accepted</th>
<th>Referral withdrawn</th>
<th>Unknown/not stated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public sector community mental health service - clinical</td>
<td>3,805</td>
<td>19%</td>
<td>78%</td>
<td>13%</td>
</tr>
<tr>
<td>Other community or health care service</td>
<td>3,075</td>
<td>15%</td>
<td>78%</td>
<td>14%</td>
</tr>
<tr>
<td>Public sector community mental health service - non clinical</td>
<td>2,410</td>
<td>12%</td>
<td>82%</td>
<td>13%</td>
</tr>
<tr>
<td>Self</td>
<td>2,410</td>
<td>12%</td>
<td>83%</td>
<td>11%</td>
</tr>
<tr>
<td>Housing/homelessness support service</td>
<td>1,467</td>
<td>7%</td>
<td>75%</td>
<td>17%</td>
</tr>
<tr>
<td>Hospital</td>
<td>1,282</td>
<td>6%</td>
<td>77%</td>
<td>13%</td>
</tr>
<tr>
<td>Family member/friend/carer</td>
<td>979</td>
<td>5%</td>
<td>75%</td>
<td>17%</td>
</tr>
<tr>
<td>Other</td>
<td>841</td>
<td>4%</td>
<td>78%</td>
<td>12%</td>
</tr>
<tr>
<td>Private medical practitioner - GP</td>
<td>676</td>
<td>3%</td>
<td>75%</td>
<td>18%</td>
</tr>
<tr>
<td>Other private medical practitioner (including specialists)</td>
<td>428</td>
<td>2%</td>
<td>80%</td>
<td>15%</td>
</tr>
<tr>
<td>Employment or Education service</td>
<td>417</td>
<td>2%</td>
<td>76%</td>
<td>15%</td>
</tr>
<tr>
<td>Correctional service</td>
<td>333</td>
<td>2%</td>
<td>72%</td>
<td>19%</td>
</tr>
<tr>
<td>Disability support service (other than Public sector community mental health)</td>
<td>322</td>
<td>2%</td>
<td>75%</td>
<td>19%</td>
</tr>
<tr>
<td>Family service (including family violence, other than Housing/homelessness)</td>
<td>292</td>
<td>1%</td>
<td>52%</td>
<td>24%</td>
</tr>
<tr>
<td>Alcohol and other drug treatment service</td>
<td>284</td>
<td>1%</td>
<td>80%</td>
<td>10%</td>
</tr>
<tr>
<td>Family service (including family violence, other than Housing/homelessness)</td>
<td>219</td>
<td>1%</td>
<td>82%</td>
<td>11%</td>
</tr>
<tr>
<td>Private medical practitioner - Psychiatrist</td>
<td>134</td>
<td>1%</td>
<td>75%</td>
<td>15%</td>
</tr>
<tr>
<td>Justice health service</td>
<td>113</td>
<td>1%</td>
<td>74%</td>
<td>19%</td>
</tr>
<tr>
<td>Emergency welfare service (other than Housing/homelessness)</td>
<td>105</td>
<td>1%</td>
<td>78%</td>
<td>10%</td>
</tr>
<tr>
<td>Police</td>
<td>93</td>
<td>&lt;0%</td>
<td>51%</td>
<td>32%</td>
</tr>
<tr>
<td>Cultural Service</td>
<td>85</td>
<td>&lt;0%</td>
<td>89%</td>
<td>6%</td>
</tr>
<tr>
<td>Court</td>
<td>56</td>
<td>&lt;0%</td>
<td>79%</td>
<td>9%</td>
</tr>
</tbody>
</table>
FIGURE 25 – OUTCOME OF REFERRAL BY LOCATION

<table>
<thead>
<tr>
<th>State</th>
<th>Total</th>
<th>% Active</th>
<th>% Not accepted</th>
<th>% Referral withdrawn prior to assessment</th>
<th>% Unknown/not stated</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>7,353</td>
<td>78%</td>
<td>15%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>QLD</td>
<td>5,568</td>
<td>80%</td>
<td>11%</td>
<td>7%</td>
<td>1%</td>
</tr>
<tr>
<td>VIC</td>
<td>3,039</td>
<td>77%</td>
<td>19%</td>
<td>4%</td>
<td>9%</td>
</tr>
<tr>
<td>WA</td>
<td>1,613</td>
<td>77%</td>
<td>10%</td>
<td>9%</td>
<td>3%</td>
</tr>
<tr>
<td>SA</td>
<td>1,041</td>
<td>80%</td>
<td>11%</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>TAS</td>
<td>655</td>
<td>71%</td>
<td>21%</td>
<td>7%</td>
<td>&lt;0%</td>
</tr>
<tr>
<td>ACT</td>
<td>446</td>
<td>75%</td>
<td>7%</td>
<td>4%</td>
<td>13%</td>
</tr>
<tr>
<td>NT</td>
<td>279</td>
<td>82%</td>
<td>15%</td>
<td>12%</td>
<td>0%</td>
</tr>
</tbody>
</table>

7.8 CLIENT STATUS

Figure 26 indicates that the majority of clients are active clients (59% or 7,440 people) and just under a third (30%) have exited the program.

FIGURE 26 – CLIENT STATUS

- Active
- Active – monitoring only
- Exited
- Not stated/unknown
- Not reported
Figure 27 shows that Victoria (75% or 1,665 people) had the highest proportion of active clients, followed by the Northern Territory (73% or 143 people). Tasmania had the highest proportion of exited clients (54% or 248 people).

FIGURE 27 – CLIENT STATUS BY LOCATION

With regard to reason for exit, over one third (38%) of clients had exited the PIR service as they no longer needed assistance. One fifth (19%) could no longer be contacted and a further 8% had left the area. One in ten clients (9%) had terminated the service themselves. This was a similar profile to June 2014.

FIGURE 28 – CLIENT REASONS FOR EXIT
7.9 NEEDS ASSESSMENT

When compared to those clients who had already undertaken an intake needs assessment, Table 18 indicates that 10% of clients (equivalent to 1,399 people) were still awaiting a needs assessment. Tasmania had the highest proportion of clients awaiting a needs assessment (48%), followed by the Northern Territory (20%).

**Table 18 – Clients awaiting a needs assessment vs clients who have completed an intake needs assessment**

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>awaiting a needs assessment</th>
<th>completed an intake needs assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>NSW</td>
<td>718</td>
<td>15%</td>
</tr>
<tr>
<td>QLD</td>
<td>121</td>
<td>3%</td>
</tr>
<tr>
<td>VIC</td>
<td>57</td>
<td>3%</td>
</tr>
<tr>
<td>WA</td>
<td>126</td>
<td>11%</td>
</tr>
<tr>
<td>SA</td>
<td>111</td>
<td>15%</td>
</tr>
<tr>
<td>TAS</td>
<td>221</td>
<td>48%</td>
</tr>
<tr>
<td>ACT</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>NT</td>
<td>45</td>
<td>20%</td>
</tr>
<tr>
<td>total</td>
<td>1,399</td>
<td>10%</td>
</tr>
</tbody>
</table>

Table 19 indicates that of all needs assessments undertaken over half (57%) were intake needs assessments. Just under a quarter (23%) were review needs assessments and a further 14% were exit needs assessments. The Northern Territory had the highest proportion of intake needs assessments (98%), followed by Tasmania (76%).

**Table 19 – Types of needs assessment**

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>clients with an intake needs assessment</th>
<th>clients with a review needs assessment</th>
<th>clients with an exit needs assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>NSW</td>
<td>4,146</td>
<td>61%</td>
<td>1,928</td>
</tr>
<tr>
<td>QLD</td>
<td>3,446</td>
<td>60%</td>
<td>1,190</td>
</tr>
<tr>
<td>VIC</td>
<td>2,088</td>
<td>61%</td>
<td>983</td>
</tr>
<tr>
<td>WA</td>
<td>1,043</td>
<td>59%</td>
<td>379</td>
</tr>
<tr>
<td>SA</td>
<td>645</td>
<td>53%</td>
<td>366</td>
</tr>
<tr>
<td>TAS</td>
<td>241</td>
<td>76%</td>
<td>31</td>
</tr>
<tr>
<td>ACT</td>
<td>169</td>
<td>65%</td>
<td>33</td>
</tr>
<tr>
<td>NT</td>
<td>182</td>
<td>98%</td>
<td>2</td>
</tr>
<tr>
<td>total</td>
<td>11,960</td>
<td>57%</td>
<td>4,921</td>
</tr>
</tbody>
</table>
Many clients identified multiple unmet needs. Over half (54%) of clients had unmet needs for daytime activities, with a similar proportion (53%) having unmet needs for psychological distress and social life (50%). Two fifths of clients also had unmet needs for physical health (42%), and employment (42%). This data is presented in detail in Figure 29 below.

**FIGURE 29 – TYPE OF NEEDS IDENTIFIED**

<table>
<thead>
<tr>
<th>Category</th>
<th>Unmet Need</th>
<th>Met Need</th>
<th>No problem</th>
<th>Not Known</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daytime activities</td>
<td>54%</td>
<td>21%</td>
<td>14%</td>
<td>11%</td>
</tr>
<tr>
<td>Psychological distress</td>
<td>53%</td>
<td>23%</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td>Company (social life)</td>
<td>50%</td>
<td>18%</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>Physical health</td>
<td>42%</td>
<td>28%</td>
<td>17%</td>
<td>13%</td>
</tr>
<tr>
<td>Employment and volunteering</td>
<td>42%</td>
<td>13%</td>
<td>30%</td>
<td>16%</td>
</tr>
<tr>
<td>Budgeting</td>
<td>34%</td>
<td>26%</td>
<td>26%</td>
<td>14%</td>
</tr>
<tr>
<td>Accommodation</td>
<td>33%</td>
<td>34%</td>
<td>26%</td>
<td>7%</td>
</tr>
<tr>
<td>Intimate relationships</td>
<td>27%</td>
<td>12%</td>
<td>33%</td>
<td>28%</td>
</tr>
<tr>
<td>Information about condition and treatment</td>
<td>22%</td>
<td>37%</td>
<td>27%</td>
<td>15%</td>
</tr>
<tr>
<td>Looking after the home</td>
<td>26%</td>
<td>28%</td>
<td>34%</td>
<td>13%</td>
</tr>
<tr>
<td>Psychotic symptoms</td>
<td>23%</td>
<td>24%</td>
<td>37%</td>
<td>16%</td>
</tr>
<tr>
<td>Food</td>
<td>22%</td>
<td>34%</td>
<td>34%</td>
<td>11%</td>
</tr>
<tr>
<td>Transport</td>
<td>21%</td>
<td>23%</td>
<td>44%</td>
<td>11%</td>
</tr>
<tr>
<td>Safety to self</td>
<td>20%</td>
<td>21%</td>
<td>42%</td>
<td>18%</td>
</tr>
<tr>
<td>Self care</td>
<td>19%</td>
<td>27%</td>
<td>43%</td>
<td>11%</td>
</tr>
<tr>
<td>Use of unprescribed drugs</td>
<td>15%</td>
<td>11%</td>
<td>55%</td>
<td>19%</td>
</tr>
<tr>
<td>Child care</td>
<td>15%</td>
<td>11%</td>
<td>62%</td>
<td>12%</td>
</tr>
<tr>
<td>Benefits</td>
<td>16%</td>
<td>32%</td>
<td>38%</td>
<td>15%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>14%</td>
<td>11%</td>
<td>56%</td>
<td>19%</td>
</tr>
<tr>
<td>Sexual expression</td>
<td>14%</td>
<td>7%</td>
<td>33%</td>
<td>46%</td>
</tr>
<tr>
<td>Basic education</td>
<td>13%</td>
<td>18%</td>
<td>55%</td>
<td>14%</td>
</tr>
<tr>
<td>Safety to others</td>
<td>7%</td>
<td>13%</td>
<td>63%</td>
<td>17%</td>
</tr>
<tr>
<td>Cultural service</td>
<td>11%</td>
<td>15%</td>
<td>46%</td>
<td>28%</td>
</tr>
<tr>
<td>Telephone</td>
<td>6%</td>
<td>20%</td>
<td>64%</td>
<td>10%</td>
</tr>
<tr>
<td>Other</td>
<td>32%</td>
<td>22%</td>
<td>26%</td>
<td>19%</td>
</tr>
</tbody>
</table>
7.10 PIR CLIENT ACQUISITION

In total the PIR initiative aims to identify and support approximately 20,000 clients within the first three years of operation, or one third of the estimated national target population. Each PIR Organisation had specific target client numbers based on estimated total potential client population in their regions.

From programme inception to March 2015, PIR Organisations had 12,628 registered clients, which is equivalent to 65% of the total programme target. Given PIR Organisations only began accepting clients in late 2014 at the earliest, this indicates client acquisition is on or ahead of target. Table 20 provides data on the number of registered clients in each state/territory.

**TABLE 20 – PIR CLIENT TARGETS BY LOCATION**

<table>
<thead>
<tr>
<th>JURISTICTION</th>
<th>TOTAL REGISTERED CLIENTS AT 31 MARCH 2015</th>
<th>TOTAL PROGRAMME TARGET</th>
<th>% OF TOTAL PROGRAMME TARGET ACHIEVED AT 31 MARCH 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>4,025</td>
<td>6,979</td>
<td>58%</td>
</tr>
<tr>
<td>QLD</td>
<td>3,517</td>
<td>4,267</td>
<td>82%</td>
</tr>
<tr>
<td>VIC</td>
<td>2,208</td>
<td>3,714</td>
<td>59%</td>
</tr>
<tr>
<td>WA</td>
<td>1,189</td>
<td>1,962</td>
<td>61%</td>
</tr>
<tr>
<td>SA</td>
<td>775</td>
<td>1,374</td>
<td>56%</td>
</tr>
<tr>
<td>TAS</td>
<td>462</td>
<td>532</td>
<td>87%</td>
</tr>
<tr>
<td>ACT</td>
<td>257</td>
<td>436</td>
<td>58%</td>
</tr>
<tr>
<td>NT</td>
<td>195</td>
<td>258</td>
<td>76%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12,628</strong></td>
<td><strong>19,522</strong></td>
<td><strong>65%</strong></td>
</tr>
</tbody>
</table>
8 Client and carer experience of PIR

Overwhelmingly, the experience of PIR clients and carers has been positive. Participating clients were reasonably satisfied with their experience, and carers have been glowing in their appreciation of the support provided by PIR. Benefits to clients were evident at the personal, social, and health and well-being levels.

Criticisms were made at times regarding the interaction of particular Support Facilitators, or following poor communication from PIR or across services. This highlights the importance of the role of the Support Facilitator as the public face of PIR for a client and their family or carer. One of the most important components of the PIR programme appears to be the initial period of active engagement, in which the Support Facilitator develops a relationship with the client at the client's own pace. It appears that the quality of the interaction between the Support Facilitator and the client during this time influences the overall quality of the client experience of the service. In particular, the ability to take time to develop a relationship was noted by many as a novel attribute for a mental health service.

For clients who have been wary and suspicious of services based on previous experiences, the willingness of Support Facilitators to take time to engage at the pace chosen by the client has empowered the client to determine how and when to engage with the service. Many clients reported that this helped them to trust in the Support Facilitator and, as a result, to begin to trust other services and service workers. Conversely, those criticisms that have been received during the evaluation resulted when clients felt that the Support Facilitator was not consistent or congruent in their availability or communication.

Carers have stressed, without fail, the importance of PIR in assisting them to care for their family member. For parents caring for adult children living with mental illness, this support has been profound in helping parents to regain the ability to attend to other aspects of their lives, including their own health and other family members.

8.1 INTRODUCTION

Fieldwork for the second year of the evaluation included, for the first time, interviews with PIR clients and their carers. Approval to conduct research with PIR clients and carers was received from the Commonwealth Department of Health’s Human Research Ethics Committee.

Clients and carers were invited to participate through an information sheet provided to sites along with consent forms. PIR lead agencies were asked to distribute these through their Support Facilitators to clients. Clients were thus introduced to the evaluation through their Support Facilitator although clients were able to return their consent forms directly to Urbis, so their choice to participate did not need to involve the Support Facilitator. Even so, most if not all consent forms were returned to the PIR Organisation and in most cases interviews were arranged by the PIR lead agency, to take place during the evaluation site visit. Telephone interviews were arranged directly by an Urbis researcher and conducted at a time chosen by the client.

Sixty-four interviews were undertaken either in person or over the telephone, with a total of 57 clients and 12 carers, as outlined in the table below.

<table>
<thead>
<tr>
<th>TABLE 21 – CLIENT AND CARER INTERVIEW SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTERVIEW PARTICIPANTS</td>
</tr>
<tr>
<td>Clients</td>
</tr>
<tr>
<td>Carers</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>
Five interviews were undertaken jointly with both a client and a carer together. All interviews were recorded unless the client requested otherwise, in which case handwritten notes were taken. Audio recordings were transcribed. Transcripts were coded and analysed using NVivo.

Urbis also developed an online survey for clients and carers that is available on the PIR initiative website (www.surveymonkey.com/s/PIR_Client_Carer_Feedback). This link was provided to all PIR Organisations as well as to a number of consumer and mental health peak bodies for wide distribution through client and carer networks. At the time of writing, 63 people had opened the survey although only 21 completed it.

TABLE 22 – CLIENT AND CARER SURVEY SAMPLE

<table>
<thead>
<tr>
<th>SURVEY PARTICIPANTS</th>
<th>MALE</th>
<th>FEMALE</th>
<th>DECLINED TO STATE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients</td>
<td>3</td>
<td>13</td>
<td>-</td>
<td>16</td>
</tr>
<tr>
<td>Carers</td>
<td>-</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3</td>
<td>17</td>
<td>1</td>
<td>21</td>
</tr>
</tbody>
</table>

More survey respondents were critical of PIR than those participating in interviews. Whereas all of the PIR interview respondents were broadly satisfied, or extremely satisfied, with their experience of PIR, seven of the 16 clients, and one of the five carers responding to the survey, described themselves as dissatisfied or extremely dissatisfied. This is not surprising as the nature of the survey allows respondents to provide anonymous feedback without any personal engagement with the researcher or PIR. This advantage is countered by the disadvantage of not being able to gain the depth of experience provided in an interview discussion. For this reason, the discussion in this chapter is based primarily on the data from the 64 qualitative interviews described above.

Clients and carers identified a wide range of activities and interactions undertaken by Support Facilitators. These can be gathered into four broad domains:

- presence
- needs assessment and response
- advocacy
- funding.

Overwhelmingly, the client and carer experience of PIR is mediated through the relationship with the Support Facilitator. The quality of this relationship determined whether or not the client perceived PIR to be a useful and effective service. Most of the negative comments provided through the online survey concerned the nature of the relationship with the Support Facilitator in some way, either through feeling misunderstood or not respected, or through not getting their needs met as they expected the programme to do.

Not surprisingly, clients’ perceptions of PIR were only minimally influenced by the structure and organisation of the local PIR Organisation, and this was generally in relation to the continuity of the relationship with the Support Facilitator. Clients and carers did not usually demonstrate a comprehensive understanding of the larger programme itself.

Many clients had been moving through the service system for many years and therefore could distinguish PIR from other mental health and social services. The key differentiating characteristic as described by clients and carers was the responsiveness of PIR workers: they ‘listen, and they care’.

For other clients, PIR was a novelty as they had not been able to access the service system before, either because of a lack of knowledge of available services, because they had not met service criteria, or because they were unwilling to engage. For this group, PIR often constituted a ‘lifeline’ in addressing significant unmet needs.
8.2 PIR ACTIVITY DOMAINS

The activity domains identified by clients are presented in the diagram below along a continuum describing the relationship with PIR, from engagement to empowerment. The four domains of activity (presence, needs assessment, advocacy, and funding) are discussed further below. Sections 8.3 through 8.6 discuss the impact and outcomes identified by clients and carers as a result of these activities. It is important to note that progression through engaging, enabling and empowering, as well as undertaking each of the four domains of activity, is not necessarily a linear process. Progression through this journey is highly dependent on clients’ wellness and preparedness to embark on various stages of their recovery journey.

Recovery? Recovery means to me to be able to see light at the end of a very dark tunnel.

Client K

The recovery approach is an essential component of PIR and is recognised by clients and carers as a factor that differentiates PIR from other health and social services. Clients and carers repeatedly noted that the experience of having a service worker ask them what was important was a novelty, and made them feel as though the Support Facilitator was actually interested in the client’s personal recovery. Over time, this experience helped clients to trust the PIR Support Facilitator enough to be able to articulate their needs more clearly.

Support Facilitators worked in various ways according to their own training and personal characteristics (more or less formal, more or less clinically focused). Even so, all PIR clients described their experiences in terms of four broad domains of activity undertaken by Support Facilitators. These are explored below.

8.2.1 PRESENCE

Overwhelmingly, the primary characteristic of PIR Support Facilitators was described as their willingness to be fully present with the client and carer before them. This experience of being accepted as an individual worthy of attention had a profound effect on many clients. Almost every client referred to this sense of being accepted with a kind of wonder that someone would take them seriously and listen to their needs. In a very real sense, this experience of being taken seriously was in itself part of the healing process for many clients. Support Facilitators approached clients with the expectation that individuals and situations can improve. The experience of a caring and consistent presence is new for many clients.

I feel like, I feel safe, you know, I’ve got someone I can turn back and say can you please help me do this or ask for help, how to cope with things. Like I can ring [my SF] and say this is what, I’m very scared, is there any advice and he can give me the best advice.

Client A
So they’ve been really good and when I’ve been upset they’ve taken me outside and [my SF’s] hugged me and said everything is going to be alright now. So supportive. I’ve never got that from anyone before.

Client B

Conversely, online respondents who were disappointed by the programme also emphasised the importance of the relationship with the Support Facilitator, from the perspective of having been let down.

I was not at all happy with the programme - it seemed to rely heavily on the Support Facilitators skill and ability to work with individual's needs. There was no substance to the programme at all. It was more like a carer role rather than a facilitator role. Opportunities that were offered to me- were not realised and acted on. It was empty promises from the programme. Any opportunity I was given, I acted on to the best of my ability, yet there was no follow-up or feedback from the facilitator. Very disappointed with the programme.

Survey client 6

In describing the positive experience of PIR, many clients described previous instances of engaging with other health services only to feel let down, rejected or misunderstood by service providers. The majority of clients described a lack of trust that services would be able to assist them, borne out of previous experiences with a variety of health and social service providers.

As described by clients and carers, the first activity of their Support Facilitator was to develop a relationship of trust and confidence. For some, this took quite a long time. For others, the very first meeting with the Support Facilitator was so surprisingly positive and affirming that they were more immediately drawn into a process of action and change.

The consistency of presence is a key component for PIR clients. One might say that this is the foundation on which the PIR programme is built. PIR clients regularly described their Support Facilitator as available and accepting of them in every circumstance. Over time, this consistent affirmation of the individual allowed the client to begin to see their own lives in a different and more positive light.

PIR never judged me… Like it didn’t matter if I wasn’t working or if I was having a bad day they were always still there. So whereas other services I’ve known you had to meet this criteria by this time and if we’ve set these goals out you have to have this done by that time and that kind of pressure and stress would have been too much whereas I’ve never felt like having, I’ve never felt stressed or expectations put on me by them. Things got done. So when it comes to being how I am now, I mean I’m in a far better place than I was a year ago.

Client C

Many clients had never experienced this kind of individual affirmation either by family or by service providers, and only began to see themselves as worthwhile because of this consistent available presence of their Support Facilitator. Once this relationship of trust had been established, it was possible for the Support Facilitator to work with the client, and sometimes the extended family, to assist the client to move to a position of self-efficacy.

If I had any issues about anything she’d listen and we’d make decisions, she involves you in the decision making processes and she’ll only involve herself to the extent that you can do the rest yourself, you know what I mean, which means you’re not abusing the system.

Client D

The importance of this relationship was highlighted by survey respondents who did not experience the level of engagement and consistency of presence described above.

Consistency of SF is desirable… it has all fallen apart since my SF left; services ceased, no communication about what was going on, and no meetings with new SF, and not able to get hold of new SF. I want the other SF back.

Survey client 1
The focus of PIR on ‘extended engagement’, in which the PIR Support Facilitator takes time to develop a relationship with the client, is a significant component of the programme. Clients and carers noted, with some wonder, the ability of the PIR Support Facilitator to spend time with them. For those with previous negative experiences of being let down by a service because the individual did not conform to the demands of the service, being able to progress at one’s own pace was an important step in engaging further with PIR and eventually with other services.

8.2.2 NEEDS ASSESSMENT AND RESPONSE

Clients described the process of needs assessment as iterative. Many clients recognised an initial period of form filling and assessment; for others, this did not appear obvious and these clients described a process of the Support Facilitator simply listening and getting to know them. For some clients, the process of needs assessment was experienced solely as the meeting of immediate needs.

She helped me a lot, she helped me get a birth certificate for one thing and she was helping me with shopping and everything like that when I had to get things to move in, yeah just practical things like that she was helping with.

Client D

For others, there was a recognised period of discussion (usually over several visits) leading to the development of a plan, including an agreed set of goals for the individual.

You know, I can talk to them and then they look out for my needs and they've set a [series] of goals for me to achieve and they keep assessing how I'm going. Yeah yeah, so. They've put me back on the right track, you know? ...They don't shut the door on ya, you know what I mean? Their door's always open for you so I speak very highly of them.

Client E

There appears to be a spectrum in the initial phase of the PIR engagement, from an explicit needs assessment process to a softer less visible approach in which the Support Facilitator, over the course of a number of conversations, assists the client to identify their own needs. This period of assessment could take a number of weeks, or it could happen quite quickly, depending on the level of engagement of the client.

In many instances it appears as though the Support Facilitator addressed the most immediate and pressing needs, for instance finding accommodation, before sitting down to talk about goals and longer-term needs, in this way building a relationship of trust before moving to more personal goals such as developing positive self-care routines, social engagement, or occupational activities.

Importantly, Support Facilitator’s are not able to meet all of a clients’ expectations in all cases due the limitations on the availability of services or access to some services in regions – that is, in some cases client expectation is above or outside of what can be provided within the constraints of the programme.

When immediate and pressing needs were not met, a few survey respondents indicated that the experience contributed to a deterioration of their wellbeing and circumstances, demonstrating the importance of clear and realistic expectations being set and met in early stages of the relationship.

I have become more desperate and suicidal because I feel that in spite of my best efforts I have been unable to fit into the system enough to access desperately needed support… When I hear stories about people who have been helped by PIR it breaks my heart because I know I deserve the same treatment. I am a good, proactive, community-minded person who has reasonable needs and deserves respect and access to a meaningful life. The fact that PIR has chosen to not provide me with the services they have promised, and have not acknowledged their failings make me feel worthless even when the evidence about my worth says otherwise. I feel I have no control because I cannot manage my afflictions without supports and I cannot manage the system and the organisation put in place to help me do this, does not want to or is unable to assist me...I believe PIR's goals and mission is excellent, but my actual experiences of PIR as a service has dashed all of my hopes that the ideas can be put into concrete meaningful actions.

Survey client 4
The majority of clients recognised that once immediate physical needs were met, such as accommodation, access to food, and health care, it was easier to focus on mental health, emotional and social needs. Clients could usually articulate the impact of their mental health on the stability of their personal environment; conversely, once their personal environment had stabilised they were able to turn their attention to improving and learning to maintain their mental health.

*Getting the place, getting the flat was the main thing, now I’ve got a stable roof over me head I can get into things, I start planning things and get them done.*  
Client F

Other clients were not aware of a formal needs assessment process, nor were they able to articulate any particular goals for which PIR was assisting them. At the same time, clients could recognise that through the Support Facilitator they were getting some of their priority needs met, such as housing or engagement in social activities. It seems that for many clients the process of needs assessment was not a formal period of identifying needs and creating action plans; rather, the period of engagement was a lived experience of having a supportive person walk alongside them and help them to address emerging needs.

8.2.3 ADVOCACY

For the majority of clients, accommodation was a primary issue and in many instances the PIR Support Facilitator was critical in assisting them to secure stable accommodation. Other primary needs identified by clients were health care (physical and mental), employment, social engagement, and support with financial matters. Almost all clients described an advocacy role undertaken by their Support Facilitator to assist them with one or more of these needs.

*He’s an advocate see, he gets you in contact with people so he got me in contact with mental health and got me glasses and got me me place and stuff like that.*  
Client F

Many clients had either had negative experiences of health and other social services, or had never been able to access appropriate services before. For these clients, having assistance to navigate service access was critical in enabling them to create enough stability in their lives to be able to take greater control in meeting their own needs. Most clients did have an idea of how they wanted their lives to be and recognised what they needed in order to get there, but they were not always sure of how to get started.

*It’s not a case that they pick up the telephone and make everything go away or just change things, you have to first - when I say you, the customer or client or whatever - has to be able to do something to get the picture right and then also I think contribute to their own success as well. Nobody is just going to get there and do it all and everything just goes away. So I can remember talking, I can’t remember who it was with now, but if you’re willing to work on your own recovery, then they will assist with everything and provide everything you need to facilitate that recovery, which suited me because that’s what I wanted, I wanted to do my own really, I just needed that guiding hand.*  
Client G

For other clients, it had been much more difficult to establish control in maintaining a stable life. For people in this group, an active and directive Support Facilitator was a critical catalyst to address pressing needs. For those with severe mental disequilibrium, there could be a significant backlog of physical, social, and emotional needs requiring attention. In these instances, the Support Facilitator was helpful in identifying and prioritising practical needs and assisting clients to navigate the myriad number of services required.
My life’s changed, she’s done absolutely everything that I could never do and there was a lot of things that needed doing…I had holes in my teeth and she paid all my dentist bills so I could get them all fixed. She’s rang everybody, every time I’ve got to make a move during the week she has already rang somebody and she’s telling me what I need to do and where I need to go, she makes all the calls for me it’s absolutely, like it’s incredible, yeah… If I ring her and ask her for something she’ll do it; I’ve never had anything like that in my life and someone to tell me you’ve got an appointment and organise out care to take me – I’m going to rehab on Saturday at [name of clinic] so yeah I’m staying there for three months.

Client H

Advocacy is experienced by clients as the practical outworking of presence. That is, clients first experience an unconditional acceptance of themselves as human beings, and out of this acceptance comes practical assistance to create stability in their lives and strengthen their capacity to develop and maintain a life that is meaningful for them.

At the same time, some clients still found it difficult to access services, even with the efforts of the Support Facilitator, suggesting that there are other service access and availability challenges which remain to be addressed.

I think PIR is a great programme. It would be better if there was someone within PIR that was trained in the physical and mental health needs of eating disorders, as EDS are much more complex than other mental illnesses. My Support Facilitator did his best and really tried to help me access services, but it is hard if there are no services to connect into. I don’t think he understood how physically unwell I was at one point in time. I am very satisfied that I did get connected into a psychologist and that PIR assisted with payment of the psychologist at the end of 2014. Without that support of someone that actually understood eating disorders I may well have died, and I was pretty close to death and unable to eat at all for a period of time. I am very satisfied of where I have ended up at my current point in time. There was a period of time I just wasn’t getting anywhere, but eventually it all came together, even without being able to access specialised intensive eating disorder treatment programs. It has made a difference having PIR there. I now have a new Support Facilitator that I haven’t seen much, but my previous one really did try to help and do what he could.

Survey client 7

8.2.4 FUNDING

Funding is another practical activity and serves several purposes. First and foremost, funding allowed Support Facilitators to meet clients’ most immediate needs, such as securing stable accommodation and accessing needed health and social services.

Secondly, the ability to offer small amounts of funding, for instance to purchase sunglasses or white goods, provided tangible evidence to clients that PIR was responsive to their needs. It seems that this funding is often used by Support Facilitators as a way of demonstrating their commitment to clients and is similarly taken by clients as a demonstration that they are a worthwhile investment. Facilitators reported the immense power of flexible funding as a catalyst for building rapport with clients. Some Support Facilitators noted that granting a request or meeting an identified need with flexible funding may be the first instance clients have not been blocked by the system in a very long time.

Finally, providing funding is a way of encouraging clients to achieve their goals, for instance through providing funding to join a weight loss programme or through purchasing a musical instrument so that the client can develop their musical aptitude. A number of clients considered that this practical vote of confidence strengthened their resolve to meet their goals.

The use of funding differs across PIR Organisations, and is discussed in other chapters of this report. From the clients’ perspective, the ability to provide small amounts of funding or receive a co-contribution from PIR was often a surprise. In most instances, clients did not initiate the request for funding but Support Facilitators offered funding for the needs that clients identified in conversation.
She knew I was troubled about the weight because I hadn’t moved the body and I was eating so much, eating vegemite sandwiches and milk all the time I just put on 20 kilos and my eating habits were all over the place from not eating to eating … I was actually malnourished but yeah my belly was all blown up and everything and it was causing havoc and I said to her I’m going to see how much Weight Watchers cost and join Weight Watchers and in their programme they are putting in so much, I put in 100 and they pay the 50 a week for 3 months so she hears [what I need], I had no idea, I don’t ask her, she goes we can help there and she just comes straight out with it and it’s just been great.

Client S

Across the PIR Organisations, the visibility of funding to clients differed. Some clients discerned the ‘rules’ or guidelines within which Support Facilitators were operating to make funds available for their needs. In other instances, the client’s perspective was that funding was available for whatever they needed. This was regarded as something of a small miracle.

It is difficult to know to what extent clients sought funding, or sought inappropriate access to flexible funds. The very flexibility of the funding model leaves the determination of what is appropriate to the Support Facilitator or the PIR Manager, and the question of what is appropriate may be answered differently in different places. It is possible, therefore, that what may have been provided by one PIR Organisation would not be provided by a neighbouring PIR Organisation.

Many clients seemed to be aware that there was discretion in decision-making regarding funding, and a few survey respondents expressed dissatisfaction as a result of being told their expectations regarding funding support would not be met.

I feel more frustrated and annoyed that I have been made to tread water and gone round in circles with trying to get anything sorted out. Despite having less than a month to have my house tidy and acceptable and having a termination date already set because everything has taken so long to organise I am so annoyed and frustrated in the constraints placed on my PIR worker by her manager which takes all her autonomy out of the role and she has no ability to make any decision regarding allocating funds for what is clearly needed and necessary and should’ve been able to be funded by PIR with relative ease and without this huge drama.

Survey client 9

For the most part, small amounts of funding were used to pay for a wide range of goods and services, including:

- assistance to move house or cleaning services
- a new oven to replace a broken one, so that the client could cook rather than rely on takeaway
- groceries
- eyeglasses and optometry services
- dentistry
- a ukelele
- coffee or meals in a café
- transport, such as buses or taxis
- assistance with getting a driver’s licence
- registering for a training course
- obtaining a birth certificate
For the most part, clients understood that funding was allocated to assist with pressing needs that would help to improve their mental health and living conditions. Some clients noted that having a service responsive to their personal needs – such as losing weight or being able to cook at home – encouraged them to follow through on their commitment to take better care of themselves.

### 8.3 IMPACT AND OUTCOMES FOR CLIENTS

*[My Support Facilitator] became my partner in recovery.*

Client K

For many clients, the impact of PIR has been profound. Clients spoke of the relationship with their Support Facilitator with gratitude for their support and unwavering encouragement. A common image used by a number of clients to describe the impact of PIR is ‘light at the end of the tunnel’: *I can see light at the end of the tunnel now.*

Clients identified a range of outcomes as a result of PIR. These can be gathered into three broad categories:

- **Personal outcomes** – reflecting improvements internal to the individual, e.g. the ability to increase one’s own sense of resilience, improve one’s control of emotions and thoughts, and have confidence in oneself and one’s sense of agency

- **Social outcomes** – relating to external improvements, e.g. finding stable accommodation, locating volunteer or paid employment, joining a social group, and improving family or other relationships

- **Health and well-being outcomes** – including physical and mental health, e.g. accessing health care services, losing weight, increasing exercise, reducing drinking or other harmful behaviours.

These outcomes are not entirely discrete and the boundaries overlap as depicted in the diagram below.

![Figure 31 - Categories of Client Outcomes](image)

Each of these categories is described below.
8.3.1 PERSONAL

I think if they hadn’t come into my life, I don’t think I’d be here. I think that’s how much they’ve helped me. The programme is a really good programme and I didn’t even know it existed. It’s just given me lots of different things to look at and I feel a little bit more alive inside and I know I can do it. I know I can keep going and I can fight for my life.

Client A

Most, if not all, PIR clients articulated a struggle with a sense of their own self-worth and their ability to create a life that is meaningful for them. Many clients identified the primary need to improve their own internal locus of control in order to take control and to manage their own lives in more constructive ways.

That’s what drove me to go into like different mental health facilities, just breaking down and just like the biggest thing was I had no voice… I just grew up thinking my life doesn’t matter. Eventually it does come down to how much money or what you were or what kind of drug if you have no voice. It doesn’t matter. I learnt with this process like to have your own voice is the best power you can have.

Client L

So sort of like a lifeline, it was just like having a lifeline thrown out to me, that was my responsibility to grab hold of that lifeline and use it.

Client M

Possibly the first and most important impact of the domain of presence discussed above is the impact on a client’s self-esteem and sense of self-worth. The immediate impact of being heard and of having a consistent, accepting presence was, for many clients, the beginning of seeing themselves as someone worthy of care and attention.

I got back my manners and I got back self-respect and pride in trying to portray yourself as someone likeable, to someone you’d like you know, establishing friendships and things like that, yeah.

Client D

The outcome of this improved internal sense of self was described by many clients as a motivation to care for oneself and also to care for others. Several clients spoke of their desire to do something useful for others. For instance, one man spoke of wanting to work with young people who were homeless because of his own experiences of being homeless as a young person. Another was intending to train as a mental health worker for the same reason. One woman described her sense of feeling that her life has a purpose as an outcome of working with PIR after a suicidal crisis.

The thing is I don't feel like I've got any [strength] but I found out I've got a lot and I'm starting to acknowledge that now. And see this is the thing that I beat myself up so bad because of all the incorrect information that was fed to me as a child of being useless and dumb and stupid and all these words I had to turn them all around, I had to change them because if I didn't they were going to destroy me. But you know, it's not easy, it's not an easy one at all. But I'm so glad I made it because now I know that I'm supposed to be here in [this town] because I know I'm here to help people. I don't know what part in the area but whatever it is I will be there, but most importantly I need to learn to help myself first.

Client M

Developing a sense of hope or resilience that one will be able to address challenges in the future is another outcome described by clients. Recognising that everyone faces challenges in life and that they can be overcome was acknowledged by several as one indication of their growing sense of wellbeing.
I feel more self-confident in myself and much more able to realise my dream. I feel that I can accomplish the things I have set out to do even although I may have a setback, it won’t matter as everyone does.

Survey client 15

8.3.2 SOCIAL

Social outcomes were described by clients in terms of engagement with the wider world. This could include improving relationships within one's family, increasing social engagement through clubs or community centres, undertaking education or employment, or accessing stable accommodation and being able to maintain daily domestic routines such as cooking, cleaning, washing.

I feel better, more confident, to the point, like I said before, I can finally see the light at the end of the tunnel. I can see finally reaching my goals which is what everyone else has every day. A car, a job, that’s what I wanted the TAFE course for, for more qualifications. All that sort of stuff you know. People my age have that and I’ve struggled even though I’ve never given up and I’ve always tried, I’ve never been able to get there. Yeah, I want to feel like an adult, not just be one because I’ll finally be there, where everyone else is when you’re 17, and they’re lucky enough to have their parents support them, you know?

Client N

Clients often had very clear ideas about what constituted a positive and meaningful life for them. Their aims were largely the same as others in the general population, such as being able to hold down a job and maintain an income, having a safe and comfortable home, maintaining positive and affirming relationships, feeling healthy and strong.

We go out more, I can walk the kids to school, I’m exercising more than what I used to do. Now we go out, we go shopping and everything now. I couldn’t do that before….I feel like, I actually, I feel really happy going out or doing the stuff now. I used to stay at the other house and if I couldn’t go anywhere I’d have to get someone else to do it for me, like my best mate to go and do it for me and she’d bring it home or I’d sleep for the rest of the day until the night time or the kids came home from school…. I’m now going outside and hanging out my washing, not having, thinking that I’m getting spied on all the time when they used to be watched all the time. That happened to me no more or anything. I’m loving life a lot more than what I used to.

Client B

For this woman, reclaiming her Aboriginal heritage was an important part of her healing process.

Yes we were learning about the dancing, Aboriginal dancing, smoking ceremony, the Aboriginal artworks on the rocks. We were learning everything that we’ve never had experience with before….It felt good. I’ve never like, some of the things that they were saying about the Aboriginals what they do and everything and learning about our culture and what we did many years ago, it was fantastic than I ever knew before…I was quite proud of being an Aboriginal and it taught my kids to be proud of who they are…

Client B

Others were not able to articulate a specific focus or desire for the future, and simply identified the needs which arose on the given day. Some clients appreciated the fact that as their needs became acute they could call their Support Facilitator for support.

Safety and security were key aims for a majority of clients and stable and safe housing was an immediate priority for many. A number of PIR clients were homeless or in temporary or insecure accommodation when they first encountered PIR. In these instances, the ability of the Facilitator to advocate for them in obtaining secure accommodation was a key factor in engaging the client with the programme and, ultimately, with health and other services.
Getting better because I've got stability now. Like I've got a place of security. I'm safe where I am. So yeah, just being stable you know, it's a start, you know and then everything else falls into place after that. … Like when you've been out there on the street, there's no sense of direction, you know, like, now I've got direction, I know I can get up of the morning, I can clean the house, you know, I've got a plan for the day, you know.

Client E

Once the physical and other external needs were addressed, clients were able to focus on their own mental and physical health needs. As with Maslow's hierarchy of needs, meeting the basic living needs of a person allowed them to direct their attention towards higher level needs, such as relationships and further professional and social development.  

Because of PIR I guess all these doors have opened up so, especially when I went to budgeting and then to the church, and the budgeting helped me financially and then PIR helped me go to counsellors and sort of get all the other stuff sorted and sort of led, eased off them and eased off now, it's been an inspiration and I guess heading towards a future where I'll get back to work. It has been good. I'm really thankful that I did have PIR.

Client H

8.3.3 HEALTH AND WELLBEING

For many PIR clients, health and well-being needs were less of a priority than those described above, such as housing and social engagement. Many clients recognised that mental illness was a condition with which they would always live; for them the goal was to live as well as possible while managing a chronic condition.

Well I've still got my mental illness… but I'm improving, I'm getting better, and better and better and I'm improving so much it's opening my whole world and it's a feeling that I am getting well.

Client J

For one woman living with bipolar disorder, the outcome of PIR was improved management of her condition. With the assistance of her PIR Support Facilitator, the client and her partner were able to develop a plan so that they could recognise warning signs and respond accordingly before any crisis occurred. As part of the plan, the client identified the factors in her life that strengthened wellbeing, such as painting and spending time in nature. This client recognised that when she was well she didn't require assistance from mental health services, so that she 'fell off the radar'; when she was unwell she needed to be able to access services quickly.

I think it is about recovery from a crisis. You know, you come to, when you do become unwell it's generally because there's stuff and it's like having someone to help you sort out that stuff. That's what I see the Partners in Recovery as doing really, you know just when you're not well, you need help. You know it's like, yeah when you've kind of, I don't know, broken your leg you can't go outside to water the garden. You need someone else to come in and do it.

Client P

Many clients understood the notion of recovery as living along a spectrum of wellness. Those for whom PIR had been helpful could recognise that they were now better equipped to meet their own needs and maintain a level of well-being.

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I can fill my own forms in and I don’t need [Support Facilitator] so much. I mean before I got my house in [suburb] I was probably phoning [Support Facilitator] every week. Now I can go weeks without phoning her up or her phoning me up….Well I can do things for myself. I’ve got a dog that I can take for walks. I’m doing more exercise, I’m losing weight. I was a couch potato before and I exercise now, I have healthy meals. It probably doesn’t sound much but for me it is. I’ve lost 10 kilos since I left [the hostel]. Just through walking the dog twice a day for half an hour each time and from eating healthily.

Client K

This understanding of recovery as the ability to live with an illness rather than to be cured of an illness was expressed differently by different clients, as no doubt it is experienced differently by different clients. According to many clients, one of the critical benefits that PIR has provided has been to strengthen one’s ability to manage well and to be able to find support when it is needed. For some clients, PIR has been able to assist them to learn to live well within the constraints of a chronic condition and to accept that there will be times when this is difficult.

It’s hard when you’re in a black mood to give yourself the courage to say, I think they taught me to have courage, just courage and to breathe. And that’s a very important thing you know people often say that’s a funny thing – breathe - but when you can’t breathe for that long it’s horrible, it’s trapping. Because you’re always, your adrenalin is going at a thousand to one, your head’s going a million to one and you try to function as a person and I think if a lot of the normal people got what we got, oh my god they’d strain…. I say they’re very excellent, I’m not just saying that but this is the first time in 23 years that I’ve had air to breathe or yeah. And for a 53 year old lady to learn to cry.

Client R

8.4 IMPACT AND OUTCOMES FOR CARERS

The majority of carers interviewed for this report were caring for adult children living with mental illness. Many carers had been in a caring role for decades and for these carers the impact of PIR has been immense.

Carers also experienced outcomes in the three domains described above by clients, although the impact on carers was somewhat different relevant to their caring role, and generally focused on the ability to regain a sense of their own independent lives, activities and relationships.

8.4.1 PERSONAL

The primary impact on carers was being provided with additional support and some hope that their loved one would be able to access the services he or she needed.

We have been advised of a variety of services that can help our family member receive extra help and support. This has made a difference. He is not so isolated now…there is help and assistance out there in the community that we were not aware of. We do not feel so alone and isolated in our need to help our brother.

Survey carer 4

As the above respondent indicates, many carers experienced isolation and a sense of being solely responsible for caring for their family member. For those who had been in this role for many years, the relief of having someone else take over the advocacy role and navigate the service system was palpable. Some carers recognised that their caring role had reduced their ability to care for and be available to other members of the family, with negative consequences for family relationships.
Relief. I feel that I, well I don't know whether I should be but I have been taking more time out for myself. When I say for myself, I have other children and they have babies and children and I have demands on me from that angle, caring for babies and grandchildren and so forth. So this is my focus now because my other daughter has just returned to work having had her first baby and I feel that she needs support now. And it's hard when you have like my son who is so ill and then you've got the other children needing help as well, you get torn.

Carer S

A number of carers expressed great gratitude for a Support Facilitator who was able to provide care and respite for the carer as well as for the client.

And it was the Support Facilitator...she is fantastic. I talk about her as my Support Facilitator because that's what she's been, she's been my support. I think the world of her. I don't know whether other Support Facilitators are as good as she is but she just stepped straight in and said give me a brief outline of what's happening and what the needs are, now what do you need. She just took over, it was amazing. She is just utterly fantastic and for me, and I do, she is the greatest support that I have had through the last 13 years because she's allowed me to step back and I don't have to be [my son's] gaoler and the person who keeps telling him what he has got to do and how to go about it. I don't have to do that anymore.

Carer T

Carers identified a number of outcomes as a result of this personal support from a Support Facilitator, either direct support to the carer or indirect support through working with the client. These outcomes ranged from sleeping better and having time to attend to their own health needs to improved family relationships. A critical component of the personal outcomes experienced by carers is the reclaiming of their sense of their own personal life separate to that of their loved one.

8.4.2 SOCIAL

For many carers, their own social engagement, employment, and other relationships had gradually diminished due to their role as a primary carer. For some the consequences were loss of friendships or intimate partnerships, employment and even accommodation.

Carers recognised that, just as living with someone with a severe mental illness had impacted on their lives, receiving additional support from PIR had also had a positive impact on their lives and lives of those around them.

For the first time in 13 years I can say I feel happy and I feel as if life is going really well with me and it wouldn't be if it wasn’t for Partners in Recovery and it's not just me it's my two older boys and their wives and their children … if I think of how many people Partners in Recovery has affected I’m going to have to spread it out to the other two boys, their wives, the four granddaughters, my [separated] husband and i guess even friends to a certain extent and you know my brother and sister in law in [city] who have been very supportive of [my son], it’s been a huge effect.

Carer T

8.4.3 HEALTH AND WELLBEING

Carers often neglected their own needs for the sake of their loved one, and sometimes found themselves suffering from depression or other mental health issues as a result. As an example, one client interviewed for this report had come to the attention of PIR because he was a carer of an adult child with mental illness. It was rare that a carer became a client themselves, as with this parent. In many cases, however, PIR Support Facilitators assisted carers to access services for themselves, or had organised respite care so that carers could have a break.
For many carers, PIR has been able to provide support and encouragement and to relieve some of the pressure of being the sole person who knew the client’s history and needs.

I do feel a lot more relaxed, knowing there is somebody in the wings if I need and that does happen. So in the beginning I would attend the meetings with my daughter and I would have phone calls with [the Support Facilitator], they weren’t actually meetings but something would happen and she would talk to me for an hour if she had the time so I can leave her a message on her mobile or a message on her land line and she gets back to me and you know that just doesn’t always happen, I leave so many messages in places looking for help and often you get off the phone more confused because they’re talking about their boundaries or it’s the funding, it’s just so much overwhelming when I’m already dealing with a very stressful situation. So having [the Support Facilitator] I don’t hang up [from] those phone calls feeling overwhelmed. I hang up those phone calls thinking here is somebody who is going to help me and then she does come back with solutions.

Carer U

I want to see this continue. For a client and carer to know support is there for the long term, if need be, is of paramount importance, from the lessening of stress and anxiety in both carer and client to the lessening "revolving door syndrome".

Survey carer 5

As noted above, some carers had been in the caring role for many years and had dedicated themselves to ensuring that their adult child was safe and able to function within the constraints of their illness. Being the only carer of an adult child with mental illness led to concerns for the future of the adult child.

[My son’s] situation is that he lives in a government flat by himself and has been from the age of 16 and he’s now 35, and he’s just not coping at all. He hasn’t been coping at all throughout all of those years and I’m his only support. His father died 10 years ago and nobody else with family or friends has taken any interest whatsoever in his situation. And I’m now 66 and have diabetes and my health is declining quickly and… so I have major health problems of my own which I’m facing. So I don’t think the chances are that I’m going to be around for too much longer at all. But anyway, I was quite desperate to find something that might be able to help him if I should die.

Carer S

8.5 IMPACT ON THE SERVICE SYSTEM

Clients and carers were not generally able to speak about the impact of PIR on the wider service system. However, carers were generally able to identify the impact of having a Support Facilitator to advocate for the client with other services. As many carers had been engaged with this advocacy role for many years, they were able to recognise the value of the Support Facilitator’s ability to navigate the system and negotiate entry for the client. Often the Support Facilitator was able to gain access where the carer had not been able to do so.

Carers who had been involved with the mental health system from many years believed that PIR offers a unique service because of the ability of the Support Facilitator role to access and coordinate a wide range of services across the social and health service system. One carer described her perspective of the impact of PIR in minimising duplication of service activity through the streamlining service access.
I think what is really valuable about it is the way it coordinates the services because I can see that there is a lot of waste of people’s time, as well as the funding that each of the different NGOs receive because there is easily a doubling up of services. What I find, when I go looking for services is I might ring a service and find they’ve got a boundary and so they can’t help or they’ve got a service and a programme but there is a waiting period so what I would tend to do is put my daughter’s name down on any services that she was in the boundary of so some of those services would be duplicate services but I had to put her name down on them because maybe it would come up in six months or maybe it would come in eight months and that’s what would often happen strangely, one service would ring me up one week and say her name has come to the top of the list and I’d say fantastic and so we’d start activating that service and then the next week another service whose name would ring me and so I’ve kind of wasted their time in a way by duplicating, also earlier I could see that one service they would go through the whole housing thing so they would put her name down on you know community housing and housing trust and they’d actually go through the same thing she’s been through with another worker six months previously and each time she moved region because she was homeless a lot and moving around to different people’s houses she would be changing boundaries so that would mean changing services. So I think PIR doing this coordination thing and having a handle on all of these boundaries that might stop that duplication.

Carer U

For others, having a Support Facilitator able to give time and energy to understanding and addressing the needs of the client was paramount. This included bringing together a range of service providers to discuss the client’s complex needs and ways in which services could work together to meet needs without duplication. Carers were able to provide a number of instances in which discrete services communicated with each other to ensure that each was informed about what the other was providing to the client.

The advantage of networking across sectors became apparent to carers as different services began to communicate with each other in new ways. This was a visible and tangible outcome for carers and a point of difference between PIR and other services.

In what ways is it different, there’s two in particular, actually there’s three that are emailing [each other] and I think it’s really useful for them to know what’s going on with each other so in some ways it might keep my daughter accountable. She will have to not keep secrets from one worker or another, she might not be talking about perhaps one of her workers is a drug and alcohol worker so she might not be completely honest with some of her other workers but also sometimes she will say things, even today she was telling me, she was with her GP and was requesting a change in her medication and I was wondering why but it turns out that her drug and alcohol worker has suggested this to her and given a reason why and so you know sometimes we might not always understand what she’s saying but it’s because a worker has suggested something and if that worker is then communicating with other workers it fills everybody in on what’s going on behind the scenes which perhaps she can’t verbalise…. that has been very, very helpful, just simply having someone to talk to who wants to get to know [my daughter] and wants to get the big picture, not just dealing about one topic say accommodation or say drug and alcohol because it is complex and no one person knows what’s going on that the PIR has a picture now and just being able to talk to her about things has been amazing.

Carer U

8.6 SERVICE EXPERIENCE

Both clients and carers were able to articulate the benefits of working with PIR. Almost all PIR clients, and all carers, interviewed for this report considered that their experience of PIR had been positive. Eight of the 21 online survey responses from clients and carers were critical of the PIR service.
8.6.1 CLIENTS

As noted above, the experience of PIR was coloured by the relationship with the Support Facilitator. One of the most significant aspects of PIR for clients was the flexible nature of the programme and the fact that the programme was tailored to their own needs. This was coupled with the ability of the Support Facilitator to take the time required to engage with the client and build a relationship with the individual.

It’s hard because emotionally and mentally where I was, was a really dark place, so and I did [get knocked] back over and over again because like if you need five criteria to qualify for something I’d have four or things like that and so I had absolutely no faith that was I gonna qualify and so I was just going along with the first couple of meetings to see, because it doesn’t hurt and so when I got the email saying yes you qualify for our services I was quite shocked actually because I had so many knock backs and it was just all a bit of sunshine amidst all the darkness I guess. It was actually going to happen, I was actually going to get help, this is actually a good thing.

Client C

After many years of trying to help myself, ‘Partners in recovery’ have supported me fully in a professional and practical way that fits in with my obstacles.

Survey client 11

Where a respondent expressed dissatisfaction it was generally because the service had not responded as the client wanted. A few survey respondents were highly critical of their PIR service, as in the response below. At the same time, without further details it is not possible to know whether the client’s expectations were reasonable, whether the service performed badly, or whether the issue was one of communication.

Unfortunately the only effect PIR had on my life was a negative one. I was referred to PIR because I am mentally struggling to cope with an unsafe living situation. After promising me an appointment within a couple of weeks, PIR then constantly shifted it, until I had waited 7 weeks. After the meeting I initially agreed to participate in their programme, but on reflection had too many concerns about their unethical conduct, and discriminatory attitude towards me and people with a mental illness generally, so cancelled my participation. I wrote them an email detailing the reasons, but they did not even bother to respond. Hence, the only effects on my life, were to cause delays in me being able to access assistance to enable me to be safe, and to ensure that I will never consider approaching any mental health organisation again.

Survey client 12

Clients who had been with PIR for a while could also see that there would be a time when they didn’t need the same level of support. For some, this was experienced as a loss of someone who had been very helpful to them. For others, it was affirmation that they were ready to continue their lives on their own. This was couple with the belief that PIR would not discharge them until the individual was ready to be discharged, and that a level of step down support would be available until the point of discharge.

Obviously at the start there was a lot of support and I guess as I sort of got on my feet I guess they adjusted it and sort of made it more, in a way backed off so it’s sort of, yeah, I sort of understood what they were doing so yeah nah it was good because especially initially when I was sort of, my headspace wasn’t quite right it was good that they were there supporting and involved quite a bit and then as I sort of got on my feet they yeah, reduced that and it became more independent for me which is good.

Client O
8.6.2 CARERS

Carers were generally very articulate about their experience of the service system, particularly those who had been negotiating the system for a long time on behalf of their loved one. They were therefore able to identify the aspects that worked well and those which could be improved.

After 16 years of care PIR is the second time I’ve encountered a group of professionals who get the importance of the person and the evidence of the loved [one’s] experience. The other was a living skills centre (health closed it down in 08).

Survey carer 2

For one carer, the aspect of advertising the programme and making information available to potential clients was an area for improvement.

I looked on websites, couldn’t find – I knew about Partners in Recovery but found this process really, really difficult and this is something I brought up with Medicare Local afterwards and said I couldn’t find my way through this system. You have to rearrange this website, you have to make it clear how to make contact. Carers are allowed to make contact and I couldn’t do it and I’m experienced so other people will be finding that. So they have fixed that and there’s a 24 hour number.

Carer T

Most carers identified the importance of having a dedicated Support Facilitator who could take the time to listen and understand their particular situation. This was an experience which was considered unique within the service system, of having a neutral professional who could liaise with all service sectors without being aligned to one or the other.

What was important to me was having somebody walk the journey with me that has some experiences in services that are available. And every service seems to have different parameters, it’s so confusing, they’ve all got boundaries, they’ve all got regions, they’ve all got different buckets of money that they keep talking about and say yes we can fund it under this bucket. As a carer, I don’t know how they work it or get their head around it. So that was one benefit. The other thing was I was unable to get any other services to work with my daughter like we couldn’t get a care worker because borderline is often considered to be not as serious in the mental health industry as schizophrenia or bipolar, borderline’s do have a reputation of being difficult to work with so I could never get any workers so I was really hoping that the PIR worker would kind of fill that role really.

Carer U

8.7 SUMMARY

TABLE 23 – 2014-15 SUMMARY OF CLIENT AND CARER ISSUES

<table>
<thead>
<tr>
<th>ISSUES IDENTIFIED IN THE 2014-15 ANNUAL REPORT</th>
<th>PLANNED ACTION IN 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small number of clients dissatisfied with service delivered by Support Facilitators</td>
<td>Individual PIR Organisations feedback mechanisms should be equipped to deal with client complaints</td>
</tr>
</tbody>
</table>
9 PIR as a system reforming programme

In 2013-14 the evaluation found most PIR Organisations were in the planning stages of system reform. In 2014-15, almost all PIR Organisations have a considerable number of system reform projects with some Organisations having in excess of 30 projects underway. System reform activities are being resourced via significant investment by PIR staff, as well as via innovation funds to support specific projects and initiatives.

System reform is consistently acknowledged as a process that will take time to deliver tangible results across the service system and for clients individually, with the majority of PIR Organisations reporting it is too early to detect impacts of system reform. However, while too early to measure impacts of these activities, there are strong signs of the creation of sustainable change within consortia and regional service systems. These early signs suggest there is strong potential for the PIR model, with time, to positively reform the system it operates within.

The system reforming impact of PIR Organisations via their everyday operations should not be underestimated. The evaluation uncovered significant evidence that relationships developed within PIR consortia have established new referral pathways to better access and service the target group, and that shared training, development of agreements, policies and procedures within consortia are positively impacting local and regional service systems.

9.1 SUMMARY OF ISSUES IDENTIFIED IN THE 2013-14 ANNUAL EVALUATION REPORT

TABLE 24 – 2013-14 SUMMARY OF SYSTEM REFORM ISSUES

<table>
<thead>
<tr>
<th>ISSUES IDENTIFIED IN THE 2013-14 ANNUAL REPORT</th>
<th>PROGRESS IN 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>A lack of consensus across the PIR Organisations about what system reform activities should look like and be focused on.</td>
<td>As PIR has progressed, most PIR Organisations appear to have gained comfort that system reform activities necessitate customisation according to region and existing partnerships. Some PIR Organisations are still struggling to conceptualise, plan and implement activities.</td>
</tr>
<tr>
<td>The extent to which system reform is regarded as being part of the Support Facilitator role.</td>
<td>Ongoing issue, despite many PIR Organisations having dedicated resourcing for system reform activities.</td>
</tr>
</tbody>
</table>

9.2 APPROACHES TO SYSTEM REFORM

For the purposes of this report, system reform has been defined as activities that are:

- **Multilateral** – involving more than two partners
- **Sustainable** – activities that aim to create ongoing and permanent change
- **Share a common agenda** – stakeholders working collaboratively together towards an agreed desired outcome
- **Complementary** – activities that complement rather than replicate existing systems
- **Recovery oriented** – activities that are focused on improving recovery oriented practice and person-centred supports across the services sector and the wider community.

Almost all PIR Organisations are now engaged in system reform activities, although there are considerable differences with regard to progress. Some PIR Organisations have more than 30 system reform projects, partnerships or activities underway, whereas a small number of PIR Organisations have only a handful of projects underway or in planning. In these cases of slower progress it is often due to the lack of existing relationships across the sector with whom to collaborate on system reform projects.
The system reform activities reported by PIR Organisations vary in terms of size, scope, objective, cost, number of partners and sectoral focus. While PIR Organisations have learned much from each other’s activities, all Organisations acknowledge the importance of customising their own projects and activities to suit each region. For example, some regions have extensive existing collaboration frameworks, while others are starting from scratch.

A small number of the high performing PIR Organisations commenced system reform planning and activities very quickly upon programme commencement. However, most PIR Organisations did not commence system reform activities until July 2014, with a small number commencing in the last few months of 2014, or early 2015.

We undertook the process of identifying what the system issues were in the region so we had our annual forum which we first did in October [2013] and the focus of that was to identify the system reform issues and possible solutions to that. After several months of seeing consumers there were patterns emerging from the types of issues that consumers were presenting to PIR with so we could use that sort of information. Obviously we had pre-existing data and research talking about the needs of people with severe and persistent mental illness and then also we developed the issues register so any Support Facilitator could identify a system reform issue and log that with us…From that we’ve identified 13 system issue themes for want of a better term that we would be working on.

PIR Manager

System reform is conceptualised in a variety of ways by PIR Organisations, with two predominant approaches adopted which are outlined below.

FIGURE 32 – APPROACHES TO SYSTEM REFORM

The parallel approach conceptualises system reform as embedded in nearly all or almost all roles across the PIR Organisation. This approach expects, that while system reform objectives and projects are still conceived of and driven from a senior level, all staff have a role to play in system reform by identifying opportunities to work on the system and working on specific projects. Importantly, this parallel approach sees the opportunity for system reform as not being constrained by dedicated activities, projects and roles, but believes there is potential for all roles within PIR Organisations to work with their peers in the service system on change via the day to day operationalisation of their role. For example, this may be as subtle as the language a Support Facilitator uses while in conversation at case coordination meetings or revisions to referral forms to better reflect recovery principles.
Figure 33 further demonstrates the parallel approach to system reform, where PIR roles engage in system reform with their peers in the wider service system.

**FIGURE 33 – PARALLEL APPROACH TO SYSTEM REFORM**

These PIR Organisations also tend to conceptualise system reform at both a systemic level and an individual level. System reform on an individual level can mean that when a barrier is encountered in the system, staff are encouraged to approach resolving the barrier in a way removes that barrier for other service users.

*The Support Facilitators do system reform work…there’s a whole bunch of things that happen at the lower level just between a couple of agencies locally or about the local situation and that’s in our view the best result. Support Facilitators are best placed to resolve local issues but they can also name issues that are of higher significance or need a higher level of resolving.*

PIR Manager

The isolated model of system reform draws a closer link between funding and system reform – seeing system reform as activity based, via the employment of dedicated system reform roles or the use of innovation funding to support system reform projects such as capacity building for consumers and carers involved with governance and recovery training for staff.

While it is too early to observe the impacts of system reform activities, those PIR Organisations following the parallel model of system reform seem to be more progressed in terms of planning and implementing activities and are more likely to feel confident in the potential outcomes of their activities.

Importantly, the parallel model tends to correspond with strong leadership of the PIR Organisation. Strong leaders tend to view PIR as a programme that is about not only service coordination and system reform activities, but also see the critical importance of a wider cross-sectoral cultural change that better supports recovery oriented practice. Given this view regarding the need for cross-sectoral cultural change, it is not surprising strong leaders tend to drive an organisation-wise parallel model versus an isolated model of system reform.
Regardless of the approach taken to system reform, sustainability is a strong focus nationally. Potential system reform activities are assessed based on the capacity for the activity and consequent systemic change to endure beyond the committed PIR funding period – that is, will the activity and desired change still be supported and effective if the PIR Organisations cease to exist following the transition of PIR into the NDIS.

With this requirement for sustainability in mind, some PIR Organisations require that the PIR Organisation itself cannot lead system reform activities and projects, to ensure responsibility for the ongoing reform lies with partners elsewhere across the system.

9.3 THE SUPPORT FACILITATOR’S ROLE IN SYSTEM REFORM

The PIR Operational Guidelines state the types of tasks Support Facilitators should undertake to support systems reform, such as the ‘development of system-level partnerships’. Training provided by the Capacity Building Project suggests Support Facilitators should consider how servicing of individuals may lead to sustainable system change in their region.

I think we’re very much involved in doing the system reform. I know that a lot of the work that my team has done has informed other people on issues that we see quite consistently in the client group we work with and also from previous roles and we do feed stuff up to [PIR Manager].

Support Facilitator

It’s very much a community development type role, the system reform projects anyway, and I think it’s been beneficial if you’re the sort of person that can wear that hat and wear the client hat as well.

Support Facilitator

The Support Facilitators’ participation in networks and inter-agencies is a system reform activity in itself because they’re there putting the issues around people with severe and persistent mental illness into those networks and advocating for the PIR client group, hearing what other issues are happening in the sector or other systems and drawing those connections together. So we count, not literally but figuratively, participation in networks, active participation in networks and inter-agencies as a system reform activity because you’re there to progress the systemic and individual client objectives.

PIR Manager

The Support Facilitators have been able to broker some relationships between large agencies that had fractured, so there have been some very good pathways created for clients. To get better housing for example through a very large housing provider...that relationship had fractured to the extent that they weren’t accepting referrals from the hospital and one of our Support Facilitation teams were able to get a local partnership agreement and identify what is needed for really good discharge and transition plan, so then clients have access to housing again. I think that was really significant.

PIR Manager

Despite this, there is still a wide range of acceptance and comfort with Support Facilitators undertaking system reform in addition to their service coordination tasks. This may be due to a lack of training or clarity regarding elements of the role upon commencement of employment.

Support Facilitators employed by PIR Organisations following both the parallel and the isolated approach to system reform tend to vary in terms of satisfaction with the expectation of their involvement. Levels of dissatisfaction tend to be based on two key factors: capacity in terms of their workload and the perception that system reform is not in the job description for Support Facilitators and should be accounted for at a higher level in the organisation.
When you start talking about systems improvement we’re talking community development, we’re talking about two separate roles here – you can’t have both, you can’t. My priority is the client, always, it will always be the client and yeah I can set up cooking programs, nutritional programs, is that my job – nuh I don’t really think it is. I know that people will question that but I think to do justice, to work I think that part of my job is not so much to initiate that on my own but to work in partnership with say another service like a PHaMs to do that.

Support Facilitator

How do you work effectively in an ineffective system? You do that by changing the system and that’s where I guess the capacity building stuff comes into it but again, it’s another workload and it comes back to how do you balance. That’s where I come back to that thing of the programme itself may have a few flaws in terms of the allocated positions in it.

Support Facilitator

It is really hard to do where you’ve got the clients in crisis. A systems change thing is not usually at the forefront of anybody’s mind.

Support Facilitator

Among those Support Facilitators that are enthusiastic about involvement with system reform activities, there is again a range of attitudes in terms of what this element of the role should look like. Some Support Facilitators are most enthusiastic about undertaking system reform at a very local level, through interaction with their counterparts and peers across the system, while others have sought the opportunity to be involved at a higher systemic level on dedicated projects. In addition, while some Support Facilitators enjoy the freedom associated with combining service coordination and system reform in their role on a flexible basis, others would like more guidance regarding the ideal percentage of their role that should be dedicated to service coordination and system reform.

Critical to the effectiveness of Support Facilitators with regard to undertaking system reform is that they feel authorised and empowered to identify and address barriers in the system. Most Support Facilitators have some background in service delivery with individuals, so working with their peers across the system on hurdles encountered in the service coordination process can at times feel less comfortable, meaning empowerment by their managers is very important.

There is early evidence of the effectiveness of Support Facilitators both in identifying and ‘reporting up’ systemic barriers as well as their success in directly addressing system barriers until the hurdle is removed for their client.

9.4 MAPPING SYSTEM REFORM

In the PIR Annual Report 2013-14 a conceptual framework was developed by Urbis based on the activity to date and informed by other related conceptual frameworks. In 2014-15, this conceptual framework has been updated to reflect the views of all PIR Organisations who reviewed the framework at the Regional Evaluation Workshops in late 2014, and the system reform activities underway nationally (see Figure 34 below).

There was strong support among PIR Organisations for this framework as a tool to assist in describing the range and complexity of system reform activity, and to inform future planning. Many PIR Organisations had either developed their own similar system reform frameworks or adapted the Urbis framework to assist with monitoring and planning.
FIGURE 34 – SYSTEM REFORM ACTIVITY ACROSS THE PIR NETWORK NATIONALLY
9.4.1 WHAT THE FRAMEWORK TELLS US ABOUT SYSTEM REFORM

THE LEVEL AT WHICH SYSTEM REFORM IS UNDERWAY

In 2013-14 the bulk of the system reform activity across the PIR programme nationally was described as occurring at the PIR Organisation or regional service system level and focused on organisational development and the development of information and tools.

As the horizontal rows on Figure 34 show, the evidence from 2014-15 shows system reform activities are still primarily focused at the PIR Organisation and regional service system level, with some focus at a whole-of community level. Given the mandate of PIR to undertake collaborative system reform within the local and regional service landscape, it is not expected there would be significant activity at a national level.

System reform work involving the wider community tended to focus on capacity building activities with individuals and organisations to provide education regarding the target group and attempt to break down stigma.

THE TYPE OF SYSTEM REFORM UNDERWAY

For the purposes of analysis of the framework, system reform activities have been grouped into three categories (as indicated in the purple boxes at Figure 34).15

- **Activities focused on communication and coordination to better understand the sector and tailor services appropriately** – including organisational engagement and development, and workforce development including training and other capacity building. These activities tended to carry the least risk and investment, and offer a lower return in terms of potential system change compared to some of the other types of activities.

- **Activities focused on collaboration to address service gaps** – including interagency agreements and partnerships and development and/or refinement of tools and resources. This work involved a higher level of investment in terms of time and effort, although promised greater potential returns in systemic change.

- **The creation of new opportunities for recovery aligned change across sectors** – specifically the development and/or refinement of new policies and procedures to deliver person-centred recovery oriented services. This style of system reform activity requires the greatest investment and risk on behalf of the parties, although potentially has the greatest impact on the system given policies and procedures – when implemented effectively – tend to deeply embed change within organisations.

The differentiation of activities as focused on either: communication and coordination to better understand and tailor services appropriately, collaboration to address service gaps and creation of opportunities for recovery aligned change across sectors again draws on the work of White and Winkworth’s Rubric for Collaboration.16

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THE VOLUME OF SYSTEM REFORM UNDERWAY

The orange colour coding on Figure 34 indicates the volume of activity underway by activity type and location.

In 2013-14 most activities were focused on organisational engagement and workforce development, or activities focused on communication and coordination. In 2014-15 a significant amount of additional activity focused on collaboration and opportunity creation, which has greater potential to embed lasting systemic change, was identified within PIR Organisations and in regional service systems.

The wide variety of activities being undertaken is described in Table 25.

TABLE 25 – SYSTEM REFORM ACTIVITIES AND EXAMPLES

<table>
<thead>
<tr>
<th>SYSTEM REFORM ACTIVITY TYPE</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational engagement and development</td>
<td>- Sharing of recovery based tools and resources, among consortia and the wider service system</td>
</tr>
<tr>
<td></td>
<td>- Cross-sectoral meetings and forums, including police, corrections, GPs, emergency services and a wide range of other parties, to bed down referral pathways, learn from others’ experience and knowledge</td>
</tr>
<tr>
<td></td>
<td>- Case coordination meetings with consortia and wider service system partners</td>
</tr>
<tr>
<td></td>
<td>- Outplacement of Support Facilitators in consortia and other service system partners</td>
</tr>
<tr>
<td>Workforce development including training and other capacity building</td>
<td>- Shared recovery training with consortia members and in many cases service partners from the wider service system</td>
</tr>
<tr>
<td></td>
<td>- Shared mental health first aid training with consortia members and in many cases services partners from the wider service system</td>
</tr>
<tr>
<td></td>
<td>- Hoarding and squalor specific capacity building with housing services, real estate agents and other relevant members of the service system</td>
</tr>
<tr>
<td>Interagency agreements and partnerships</td>
<td>- Issues based working groups, including domestic violence, hoarding and squalor, specific diagnoses</td>
</tr>
<tr>
<td></td>
<td>- Partnership with Department of Health, Department of Justice and Corrective Services to engage potential clients three months prior to release to plan service coordination</td>
</tr>
<tr>
<td></td>
<td>- Joint care coordination with GPs and other relevant services</td>
</tr>
<tr>
<td>Tools and resources development/refinement</td>
<td>- Shared data systems to better track and coordinate services for clients</td>
</tr>
<tr>
<td></td>
<td>- Amendments to consortia and other service system partners’ materials including referral forms, programme information and other materials</td>
</tr>
</tbody>
</table>

As outlined in Figure 34 and Table 25, there is a significant amount of system reform activity underway within PIR Organisations (which given the size and diversity of most consortia can represent a large volume of the service system in a single region) and beyond consortia into the regional service system. While PIR Organisations agree it is too early to comment on outcomes, these activities appear to have delivered two key impacts to date.

Firstly, this work has established and/or developed partnerships across the sector resulting in improved communication and coordination of services, as well as potential collaboration to address service gaps. An example of this collaboration that has created sustainable change in the sector is the partnership in Western NSW formed with the Department of Health, Department of Justice and local corrections facility to engage potential clients before their release, as mentioned above.

The second impact of this work at a PIR Organisation and regional service system level is the development of new referral pathways which better support the targeted engagement of the client group.

One of the strategies is that numbers of Support Facilitators regularly go to clinical team meetings, and do discharge transition groups and I think also helping in terms of getting the right referrals.

PIR Manager
As discussed, there is a strong focus among PIR Organisations on the critical importance of creating sustainable change within the system. If this focus is realised across the system, increasing evidence of the development and refinement of policies and procedures should be noted in the framework at a regional and wider community level at the time of the final evaluation report in 2015-16.

9.5 SYSTEM REFORM IMPACTS

There is a general feeling across the PIR network nationally that it is too early to observe the impacts of system reform activities. However, in some areas there are early signs of the potential of system reform activities to shift the service system towards a strong recovery oriented practice and a greater focus on the delivery of person-centred supports for the target group. High performing PIR Organisations consider the potential for an effective programme of system reform to mean that the PIR Organisation becomes the regional planning mechanism for mental health.

*For various reasons the Commonwealth and states sometimes don't work well together and PIR is an opportunity to actually problem solve to say well here’s an individual, here’s a real person, who hasn't got what the needed despite all your investments, you know, how do we make sure that it doesn't happen again. And if we could do that as a kind of, thinking pie in the sky here, but you know as a no blame kind of discussion, then you might land in a space where people could say oh yeah if [I] modified this or if I just modified that, then it wouldn't happen again.*

External stakeholder/Peak body representative

*PIR is a bit of the glue that makes us all talk.*

PIR Consortium member from clinical mental health service

*One example, one particular client, forensic mental health were involved, PIR involved, [service] was involved. Now previously PIR wouldn't have been involved because there was no communication between forensic and [service]. [The Service] are the ones who are out there delivering the psychosocial supports, quite often in the absence of any information with regard to the risk or anything like this. I mean I was appalled but there had been no communication whatsoever between those two agencies. Because PIR got involved it started off that forensic would communicate with us and [service] would communicate with us now everyone is communicating with everyone and there is that project which is looking at improved connections with other PIR’s.*

PIR Manager

As discussed above, a key focus for most PIR Organisations in considering the impacts of system reform is that these activities must achieve sustainable and lasting change in the sector. Many PIR Organisations have planned for sustainability by working on projects with other services such as state housing or corrections services, where new practices, policies or programs are developed in consultation with PIR under the guise of system reform, however the changes are designed to endure a range of future scenarios for the PIR programme.

*They got the mental health service to actually deliver mental health training to housing providers… they’ve negotiated to fund that and pay for that, so that supports the MOU or the local partnership agreement they have in place. So you’ve got housing providers who now have some skills in terms of supporting the consumers.*

PIR Manager

The measurement of the efficacy of system reform activities is acknowledged as a challenge for PIR Organisations. A number of factors mean accurate measurement is difficult, including the long time frames involved, the difficulty of developing accurate indicators to measure improved coordination and integration, and the importance of ensuring the lasting nature of change in an ever-changing and complex system.
Only some PIR Organisations have begun to consider the integration of system reform measurement into their local evaluations and this was often mentioned as an area requiring attention and action.

*Indicators for me [of system reform] would be a diverse PIR [Organisation], policy changes across the sector that actually create equity...Being able to or seeing evidence of more professional networks. So you can see that child protection [is] working with mental health, working with drug and alcohol, working with nutrition, primary health. Seeing those networks create policies, service user friendly policies. Another indicator would be some peer workers in mental health services. I think that that's a real opportunity like for PIR [Organisation] and operationally.*

PIR Consortium member

9.6 CHALLENGES IN IMPLEMENTING SYSTEM REFORM

There are four key challenges associated with planning and implementing successful system reform projects, identified by evaluation participants.

Firstly, system reform takes time. Many PIR Organisations feel that the full three year period of committed funding to the PIR programme is insufficient to begin to see real impacts associated with the system reform activities. This was particularly the case where PIR Organisations were beginning their programme of system reform from a relatively fresh start, compared to others where the region may already have in place existing collaboration frameworks and agreements.

*I just wanted to say about systems change that, and I'm sure I won't be the only one that says it, it takes time and you know, it always involves some level of analysis and planning because you actually can do anything and given it's only been really a year, I think we've gotten as far as we could. Our way is take time to see what bubbles up, what the evidence is telling us, know what to focus on...So it does worry me that we've only got 18 months to go and what are we going to show for it? When some high level change would have to go beyond that. It will have to go beyond that to have the real impact. We'll try and do as much as we can obviously.*

PIR Manager

*I think something we've definitely learnt is the duration and determination it takes to build a relationship with an organisation like [state/territory clinical mental health provider]. To get them to attend a meeting and they're now happening fortnightly it was about a year of work to get them in the door and onside but that's been probably one of our biggest achievements and it's going to continue to grow and get better and better but it took a long time.*

PIR Manager

The second major challenge to effective system reform is the uncertain policy landscape around PIR specifically and mental health generally in Australia. Many PIR Organisations reported it is difficult to both motivate staff and gain traction with partners on system reform projects given the uncertain future of the programme. The term ‘legacy’ is used consistently to refer to system reform projects, in anticipation that these activities are a measure of what PIR will leave behind following its transition into the NDIS in 2016.

Thirdly, measuring system reform impacts is a significant challenge, and consequently potentially demotivating for PIR Organisations.

Finally, the contractor based model of some PIR Organisations appeared to pose barriers to effective system reform. While this purchaser-provider style model may be suitable for the service delivery element of PIR, the model was correlated with PIR Organisations who find system reform particularly difficult and are yet to make significant progress.
### 9.7 SUMMARY OF NEW ISSUES IDENTIFIED IN THE 2014-15 ANNUAL EVALUATION REPORT

**TABLE 26 – 2014-15 SUMMARY OF SYSTEM REFORM ISSUES**

<table>
<thead>
<tr>
<th>NEW ISSUES IDENTIFIED IN THE 2014-15 ANNUAL REPORT</th>
<th>PLANNED ACTION IN 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three year funded period for PIR felt by some too short a period to see results of system reform activities.</td>
<td>Most PIR Organisations accept that their system reform activities may only deliver impacts following the committed 2013-16 funding period, and consider these projects to be no less important or necessary.</td>
</tr>
<tr>
<td>Uncertain policy landscape driving lack of dedicated focus on system reform activities among some PIR Organisations.</td>
<td>Ongoing issue.</td>
</tr>
<tr>
<td>Measuring system reform is a challenge for PIR Organisations in their local evaluations.</td>
<td>Ongoing issue.</td>
</tr>
</tbody>
</table>
10 Delivering PIR in various localities

10.1 OVERVIEW

The PIR programme faces many of the same challenges as other health and social services in Australia due to the difficulties associated with delivering services in regional, rural and remote settings, housing and workforce shortages and issues that occur when attempting to deliver services across boundaries, including programme boundaries, state/territory boundaries and service provider boundaries.

On the other hand, the PIR model’s inherent flexibility (due to the consortium structure customised to local conditions) supports the tailored implementation of the programme dependent upon local conditions, better enabling effective roll-out across a wide range of localities.

The following case study outlines a number of workforce issues common to the delivery of health and social services, and highlights the ways in which the flexibility of the PIR model has aided addressing these issues.

CASE STUDY 1 – WORKFORCE RECRUITMENT ISSUES

WORKFORCE RECRUITMENT ISSUES

Recruitment and staff retention is an issue for PIR Organisations across all regions (urban, regional and rural/remote), but is a particular issue for PIR Organisations operating in rural and remote areas where there is often not a pool of suitably qualified people to recruit from.

*It’s a very different recruitment environment out here for anything at any time, especially a professional skill based role, added to that is it’s a particular skill base we need for a Support Facilitator so that diminishes the pool even further.*

PIR Manager

One PIR Organisation has come up with a unique way to solve the problem of recruiting people in rural and remote areas.

After advertising for a Support Facilitator in a remote regional area and not receiving any applicants, the PIR Organisation is trialling a sub-contract model, which involves funding a person employed by a private provider to deliver Support Facilitation work at an hourly rate on a part-time basis. The person is employed for approximately five hours a week with the expectation that each participant will require approximately 50 – 60 hours of Support Facilitation over the course of their involvement with PIR.

*We’ve recently engaged as a pilot a private psychological provider and they’ve nominated a person within their service and we’ve trained them as a Support Facilitator and that will allow us a little more latitude around servicing areas where we haven’t got a Support Facilitator.*

PIR Manager

Depending on how the trial goes the PIR Organisation is also considering putting out an Expression of Interest for a private provider to deliver Support Facilitation services to a larger cohort of participants on an ongoing basis. However, the PIR Organisation recognises that if the number of hours of Support Facilitation for each participant ends up being higher than the expected 50-60 hours then it could become unsustainable.

The following sections outline the particular challenges associated with delivering the PIR programme in various settings. Some metropolitan PIR Organisations operate in a solely urban area, but it is important to remember that most PIR Organisations operate across several geographical contexts and some, given their size and breadth are potentially delivering the programme across all geographic settings simultaneously.
10.2 PIR IN URBAN AREAS

PIR Organisations operating in urban areas acknowledge that, on the surface, their operating context may appear to more easily facilitate programme implementation due to the availability of services and shorter distances to cover.

However, nearly all urban PIR Organisations reported that operating in an urban context presents a unique set of challenges that may influence the quality of programme outcomes. The table below outlines the key challenges highlighted by PIR Organisations with regard to urban delivery.

TABLE 27 – CHALLENGES FACED IN URBAN AREAS

<table>
<thead>
<tr>
<th>CHALLENGES</th>
<th>EXAMPLES OF SOLUTIONS TO ADDRESS THIS CHALLENGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>In terms of both the volume of clients and services available, urban areas encompass the majority of system. This sheer volume presents a range of challenges:</td>
<td>PIR Organisations report an effective response has been to bring services together for joint meetings/forums, which assist PIR staff to better understand the services landscape, and simultaneously communicate about the programme to the wider service system, is an effective tool in urban areas.</td>
</tr>
<tr>
<td>• The larger the system, the more there is for Support Facilitators to navigate in their service coordination role. Navigating the range and choice of services can be time-consuming.</td>
<td>This can also assist to build buy-in from a range of partners, given the service system has the opportunity to discuss early evidence of outcomes with each other at these sessions.</td>
</tr>
<tr>
<td>• Urban areas are often a crowded landscape in terms of mental health and other human services programs. Given the volume of programmes and services available, PIR Organisations have found it can be difficult to engage and convince the wider service system of the value of yet another new programme.</td>
<td></td>
</tr>
<tr>
<td>• Competitive tensions often arise in a crowded services environment, which can make it difficult to gain buy-in for service coordination and system reform activities.</td>
<td>In PIR Organisations where existing relationships/networks were in place prior to the development of PIR (at all levels from PIR Managers to Support Facilitators), the process of getting to know the range of services available and convincing the system of the value of PIR is often shorter and more effective given the existing knowledge base of staff. With regard to competitive tensions, there were no substantive solutions offered. Instead, PIR Organisations seem to accept that given the PHN transition, funding cuts and ongoing uncertainty around the future of the programme are the current status quo.</td>
</tr>
<tr>
<td>Almost all urban areas have comparatively more services in existence to support clients. However, these services are often not available, due to long waitlists.</td>
<td>There is evidence in urban areas of PIR Organisations using flexible funding to purchase services, such as support worker, cleaning or other basic services, to circumvent long waitlists.</td>
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<tr>
<td>The comparatively wide selection of services in urban areas also reportedly raises unrealistic expectations of clients, carers and wrap-around services – which can create additional work for PIR Organisations to manage these expectations.</td>
<td>PIR Organisations also reported creating their own ‘services’ such as social groups consisting of several clients, to get around waitlists for support worker or other social inclusion type services.</td>
</tr>
<tr>
<td>Urban areas, while not exclusively, often have higher concentrations of equity groups including CALD and Aboriginal and Torres Strait Islander clients that can present challenges in terms of delivering quality, accessible services. These clients can often be more time-consuming and represent a greater cost to service for PIR Organisations where interpreters or translation services may be required.</td>
<td>There is evidence in urban areas of PIR Organisations adapting to suit local populations in need, including employing specialist staff and using flexible funding to purchase services such as interpreters and translation.</td>
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### Challenges

<table>
<thead>
<tr>
<th>CHALLENGES</th>
<th>EXAMPLES OF SOLUTIONS TO ADDRESS THIS CHALLENGE</th>
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<tbody>
<tr>
<td>Housing affordability, housing shortages and homelessness were reported by nearly all PIR Organisations as a key challenge in terms of delivering the programme – although this challenge is often pronounced in urban areas, particularly with regard to homelessness.</td>
<td>Flexible funding was often used to address housing issues, mainly centred on the purchase of crisis accommodation including motels, caravan park occupancies and tents. Many PIR Organisations had system reform projects underway or in planning, to specifically target housing shortages and homelessness, including hoarding and squalor specific capacity building with housing services, real estate agents and other relevant members of the service system.</td>
</tr>
<tr>
<td>In urban areas, clients often move between PIR Organisational boundaries, making transition to a new PIR Organisation necessary. Given the consortium model of PIR and the range of organisational cultures in any sector, this transition can often result in tension due to different styles and cultures around programme delivery.</td>
<td>There were no specific solutions to this issue presented by PIR Organisations, although close collaboration between PIR Organisations that share boundaries was considered an advantage for many reasons.</td>
</tr>
<tr>
<td>A key challenge in delivering PIR is turnover of staff. For a range of reasons staff turnover was reportedly more significant in urban areas, making consistent programme delivery more difficult.</td>
<td>There were no solutions to this issue beyond the desire for greater policy certainty about the future policy landscape to provide a greater sense of stability and security for both current and potential staff.</td>
</tr>
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CASE STUDY 2 – SERVICING CALD POPULATIONS

SERVICING CALD POPULATIONS

Engaging with CALD populations is frequently identified as a challenge by PIR Organisations, with key barriers reported to include differing cultural conceptions of mental illness, mistrust of authority (especially for refugees), and language. These factors add an additional layer of complexity to working with these groups.

"Particularly when people have come through as asylum seekers [there is] …a great mistrust, not only about authority and institutions and organisations but a sense that you probably won't return even though you've said you're going to return. So that work is multilayered and complex and slow."

PIR Manager

"The whole concept of mental health and mental illness… within CALD community groups is described differently and named differently…"

PIR Manager

In urban areas, the presence of a defined cultural community was beneficial to PIR Organisations seeking to engage with individuals from CALD backgrounds; conversely, in some rural areas, the challenges for individual clients were exacerbated by the absence of a supportive community.

"You might have 10 people from Poland and you might have four people from Vietnam… which makes people really isolated because they don't have a CALD community to call upon, they're really in an isolated situation."

PIR Manager

PIR Organisations which reported some success in connecting to CALD clients employed a range of strategies including specific workers with the right skills and focus to engage CALD communities (commonly a project officer or a 'specialised' Support Facilitator), working closely and respectfully with the communities, engaging with services that already have an established relationship of trust with the CALD community, and offering in-service training for the PIR Organisations’ frontline teams.

"It wasn't an identified position, so it wasn't a CALD position, so what's our skill, so in that particular team and in [area] the new Support Facilitator there has an amazing history in CALD mental health work and so you know just the expertise networks and connections that that brings from someone who has a 30 year history in [area] is quite remarkable."

PIR Manager

"We've been working very, very closely with the migrant resource service… so we've already tapped into the services which are working with those individuals… we're constantly connecting with the [CALD] services we're not going in with any preconceived ideas of how it should work … [They] need to tell us how we should be looking at [their] areas and how we should be running and I think that's the beauty of PIR."

PIR Manager

Access to printed material in different languages and access to interpreting capabilities were enablers of engagement. In some cases, PIR Organisations are deploying flexible funding to secure these services, while others have engaged multi-lingual workers. However, the ongoing costs associated with interpreting services over the course of a client's engagement with PIR were potentially significant.

"Brochures made in different languages is a positive thing for people of CALD background. Just having a brochure in your own language to read will encourage you to want to access a service."

PIR Manager

"We're not able to access the national translational services in the way that GPs can – so you can use flexible funds to purchase an interpreter at 100 bucks an hour [but] you quite quickly get through that fund allocation…"

PIR Manager
10.2.1 PIR IN PERI-URBAN AREAS

A number of PIR Organisations highlighted the importance of considering the challenges associated with delivering the programme in peri-urban or urban fringe areas. The specific hurdles related to these areas are outlined below.

<table>
<thead>
<tr>
<th>CHALLENGES</th>
<th>EXAMPLES OF SOLUTIONS TO ADDRESS THIS CHALLENGE</th>
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<tbody>
<tr>
<td>While many urban areas are well serviced by public transport, creating vital pathways to services for PIR clients, PIR Organisations reported transport options in peri-urban areas are often more akin to regional or rural areas than their urban neighbours.</td>
<td>Flexible funding often utilised to address transport shortages, including the purchase of transport services and bicycles.</td>
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<tr>
<td>Some PIR Organisations servicing urban fringe areas reported that populations often migrate from the city to the fringe areas in search of more affordable housing, exacerbating the existing shortage of affordable housing in these areas.</td>
<td>No tailored solutions for addressing housing shortages in peri-urban areas were identified. Like urban areas, flexible funding was often used to address crises.</td>
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</table>

10.3 PIR IN REGIONAL, RURAL AND REMOTE AREAS

PIR Organisations operating outside urban areas face challenges with regard to a reduced range of services to support clients, as well as challenges relating to the distance required to service regional, rural and remote areas.

It was also observed that some PIR Organisations in regional areas gained advantage from their geographical location. In less crowded service landscapes in regional areas, existing long and deep relationships across the service sector often enabled PIR Organisations to more effectively collaborate and gain traction on relationship building and system reform projects compared to some of their counterparts in urban and rural/remote areas. Of course, the advantage that existing relationships offered to PIR Organisations was not confined to regionally based PIRs. This was evident in a number of urban PIR Organisations also, although the effect was often pronounced in areas where the regional network was smaller.

*Probably because I chair the Alliance of Social Services and we try and do work on a state and national level, not just do local work so I tend to get calls or contacts from other people who are wanting to come into this area. And if someone new comes to town, a new CEO or something like that the first thing I do is ring them and say if you want to know who’s who in the zoo let’s catch up for coffee. So we sort of spread ourselves around as much as possible and that community connection is one of our key strategic goals.*

Regional Lead Agency CEO

The table below outlines the key challenges faced by PIR Organisations that are common to delivery of PIR in regional, rural and remote settings.
### Table 29 – Challenges Faced in Regional, Rural and Remote Areas

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Examples of Solutions to Address This Challenge</th>
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</table>
| The large distances to cover in order to service regional, rural and remote areas – both to visit clients and for clients to access services – are a huge challenge for PIR Organisations. These distances impact efficiency of Support Facilitators who may be travelling several hours in each direction to visit a client, and have negative effects on the engagement and retention of Support Facilitators. | There are several strategies adopted by PIR Organisations to address the distance challenge:  
- The host agency model allows Support Facilitators to be spread out across the region, which helps curtail travel distances although it presents additional barriers in terms of staff engagement.  
- Most PIR Organisations in vast geographic regions recognise it is impossible to reach all clients so they make use of existing regional networks to provide referrals and inform the PIR Organisation of relevant information/events.  
- Many PIR Organisations are making use of technology including using video conferences, Skype and GoToMeeting to engage with staff and occasionally clients across their region. |
| PIR Organisations report it can be very difficult to support and maintain engagement with staff who are required to travel very long distances and/or be hosted at a large distance from the PIR Organisation/their colleagues. | PIR Managers and/or Team Leaders report that is it critically important to provide opportunities for Support Facilitators in regional, rural and remote areas to engage regularly with their peers and other colleagues in order to maintain staff morale. Most PIR Organisations convene regular Support Facilitator meetings and Support Facilitator and Team Leader (either from host agency or PIR Organisation) meetings to provide a forum to discuss practice and other issues, in lieu of being in each other’s physical company. These meetings can occur face to face or via video conference. |
| Following on from the challenges in supporting and engaging staff, some PIR Organisations spoke of the tendency for Support Facilitators to embody their host agency culture and model of practice, rather than the PIR culture and practice principles, due to their relative isolation. This challenge is not unique to regional, rural and remote areas, and does occur in urban settings also. | Similarly to above, for staff operating relatively autonomously due to their regional, rural or remote location, PIR Managers and/or Team Leaders also emphasised the importance of high quality induction and ongoing training, close supervision and close monitoring of workloads. |
| A significant lack of transport, both public transport and community transport services in regional, rural and remote settings makes it difficult for clients to access services, including PIR and other supporting services. | Flexible funding is often utilised to address transport shortages, although the larger the distance the more costly and difficult meeting the transport shortage becomes. |
| Several PIR Organisations reported significant workforce shortages make it very difficult to attract and retain quality staff required to deliver PIR. | Flexible working practices, including location, and higher pay scales were the only potential solutions being used to address this ongoing issue. |
CASE STUDY 3 – TRANSPORT IN REGIONAL AREAS

TRANSPORT IN REGIONAL AREAS

Many PIR Organisations describe the ongoing transport challenges associated with operating in relatively large geographical areas, where populations may be highly dispersed and activity centres isolated from each other. Others in outer urban and regional/rural areas focused on the absence or inadequacy of public transport options and the constraints placed on individuals accessing services and supports.

Distance and travel is always the problem. It’s difficult… even if you transport people once or twice a month to their psychiatrist appointment or that sort of thing you’re not really addressing their physical isolation or the lack of resources or facilities in the places that they live.

PIR Manager

In some cases, PIR Organisations are simply unable to service all remote areas within their catchment primarily because of the logistical challenges.

[It’s] such a big area and being able to kind of cover all those areas really difficult and I’m not sure how that’s going to happen. But at the moment we’re just focussing on town and one specific remote community... there are so many remote communities that it’s just impossible to get to all of them.

PIR Manager

Transporting clients to services or services to clients also added a layer of complexity and additional effort that impacts on the capacity of PIR Organisations to organise the services people need.

If you’re [arranging] the transport because there is no public transport, you have at least 20 [clients] to do this with… it’s very problematic because it’s very time consuming.

PIR Support Facilitator

Some PIR Organisations reported some positive steps in terms of working with local stakeholders to look for solutions to transport issues at the community level or linking them into existing transport systems, while Support Facilitators doing outreach or using flexible funds to support individual transports needs is common.

We don’t take people in the car at all… the focus is really around how come that person can’t get transport? There’s transport programs, you can help them sign up to community transport so they can pay a little bit and get picked up if it’s a mobility issue.

PIR Support Facilitator

We’ve recently fixed a guy’s car that was… his dad’s car and he didn’t want to get a new one because he had some sentimental value, so we flexible funded it and got it up and going and that’s given him so much more independence now in terms of being regional, where there is limited transport.

PIR Support Facilitator

A frequent response to large geographies is an outplacement approach where Support Facilitators are located around a catchment, often based within partner or host organisations. While this enabled greater connection to community, the isolation this creates for Support Facilitators is often cited as a problem.

There is probably an idea that local is best within that consortium but… it’s an interesting one, it’s a really challenging one. I think it probably challenges rural and remote areas regularly, this kind of balancing the local versus the hub and spoke type model.

PIR Project Officer

The challenges of working alone are not just limited to engaging with challenging clients, but also extend to the system reform aspects of Support Facilitators’ role.

We’re asking them to work in systems change and they’re confronted by a number of people from agencies and they’re working in sort of isolation so as much support as we’ve been able to give them from afar…their day to day work they’re doing in isolation and I think that’s been one of the big challenges… if we were to do it again we’d probably base them all in the one location and outreach.

PIR Project Officer
CASE STUDY 4 – LACK OF SERVICES IN REGIONAL/RURAL/REMOTE AREAS

**LACK OF SERVICES IN REGIONAL/RURAL/REMOTE AREAS**

The lack of services in regional, rural and remote areas was an issue identified by many PIR Organisations. A number of innovative approaches have been taken by PIR Organisations to address these service gaps. These include:

1. **sub-contracting Support Facilitators from private providers** - one PIR Organisation has employed a private provider to deliver support facilitation work on a part-time basis

2. **developing new service offerings with existing players in the region** – a member of a consortium has been supported to become accredited to deliver a new line of services lacking in the region

3. **using flexible funding to purchase services or to create services** - PIR Organisations are also using flexible funding to develop new service offerings – either with existing players in the region or independently. Some PIR Organisations are pooling individual flexible funding to develop new services, for example, support groups for particular types of clients where there are few existing services, such as people with borderline personality disorder.

   …pooling individual funds for the purpose of providing a service, short term gap filled service where that service is not always available or access to it is significantly problematic.

   **PIR Manager**

4. **using peer support workers to fill the support service/social inclusion gap** - several PIR Organisations are using peer support workers to provide social support to PIR clients and in a few cases peer support workers are helping Support Facilitators circumvent having to provide case management.

One PIR Organisation has used flexible funding to train and recruit a group of peer workers to provide transport and personal care to clients. The peer workers also accompany clients to medical appointments and help them link into community organisations such as the local neighbourhood centre. The peer support workers are paid for their time and the PIR Manager commented on how useful they were in helping clients establish community connections.

   …they can get involved in a craft group and the kind of connections it can be very difficult to do on your own but with someone who can give you that bit of extra confidence and support in communicating with that person in the first instance.

   **PIR Manager**
Issues unique that are to rural and remote settings are explored below.

### TABLE 30 – CHALLENGES SPECIFIC TO RURAL AND REMOTE AREAS

<table>
<thead>
<tr>
<th>CHALLENGES</th>
<th>EXAMPLES OF SOLUTIONS TO ADDRESS THIS CHALLENGE</th>
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<tbody>
<tr>
<td><strong>Staff safety when travelling large distances on their own can be an issue.</strong></td>
<td>Safety issues include going to remote places alone, being in areas with no phone reception and the dangers associated with driving long distances.</td>
</tr>
<tr>
<td>It is impossible for Support Facilitators in rural and remote regions to avoid travelling on their own, so PIR Organisations attempt to regularly check-in with staff to ensure they are safe and several used the lone worker ‘Stay Safe’ mobile app which tracks the location of lone workers in real-time and allows them to check-in safely after meetings, travelling and solo working sessions.</td>
<td></td>
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<tr>
<td><strong>Given the lack of available services in rural and remote regions, particularly acute mental health and primary health services, it is often necessary for clients to leave their communities for a time to access services.</strong></td>
<td>This creates huge challenges in terms of social isolation, which can negatively impact the recovery journey. While this is an issue for all populations, it is particularly pronounced among Aboriginal and Torres Strait Islander communities where connection to country, culture and family is often a critical piece of the recovery journey.</td>
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<tr>
<td>PIR Organisations spoke of the importance of attempting to support clients to maintain contact with family and friends while out of their communities, which might involve use of flexible funds for phone and internet access. For Aboriginal and Torres Strait Islander people, PIR Organisations also reportedly use traditional healing services in the service location and attempt to connect clients with the local community for support where possible.</td>
<td></td>
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<tr>
<td><strong>Many PIR Organisations operating in remote areas engage with remote Aboriginal and Torres Strait Islander communities, which present challenges in recruiting appropriate and culturally competent staff and in terms of the time necessary to build trust and relationships with communities as a necessary precursor to engaging clients.</strong></td>
<td>PIR Managers, dedicated Aboriginal and Torres Strait Islander staff and Support Facilitators who work with these communities all report that ideally, the Support Facilitator role with remote indigenous communities involves a significant amount of community capacity building with regard to mental health in addition to the service coordination role. This community capacity building can be hugely beneficial in engaging communities and clients, but very time consuming for Support Facilitators. Actively engaging elders is also a successful means of building relationships with Indigenous communities.</td>
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<tr>
<td>Small, tight-knit rural and remote communities that are visited by PIR often reportedly have ‘gatekeepers’ whose trust must be won before engaging local people. These gatekeepers are often resistant to visiting programmes, and might be GPs, the Aboriginal Community Controlled Health Organisation, the Aboriginal Medical Service, the Closing the Gap programme staff and/or other rural mental health workers.</td>
<td>Gatekeepers need to be won over which takes time to get to know the needs and challenges of each community. There is no shortcut to building this trust. Support Facilitators also emphasised the importance of good coordination and communication when visiting communities to maintain efficiency and pay respect to communities, including not duplicating existing services. Some PIR Organisations reported strong success in engaging with the Closing the Gap programme staff as a means to gain social license to operate in Indigenous communities.</td>
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CASE STUDY 5 – USE OF TELE-HEALTH TO ADDRESS DISTANCE BARRIERS

USE OF TELE-HEALTH TO ADDRESS DISTANCE BARRIERS

A small number of the PIR Organisations who span significant areas of rural and remote Australia (South West WA, New England in NSW and others) report using tele-health to overcome the significant barriers associated with delivering PIR in rural and remote locations. Tele-health is the delivery of health related services and information via telecommunications technologies. Specific technologies might include but are not limited to video-conference facilities, Skype, Facetime and GoToMeeting.

While tele-health is traditionally associated with facilitating interactions between service providers and clients, and there is some use of tele-health to do this by PIR Organisations, most report using technology to enable more frequent interaction among staff as a means to better support and engage them.

Maintaining engagement among staff that may be located a five hour drive or more from their peers and managers is cited as a key barrier to delivering PIR in these rural and remote locations. Physical isolation and the psychological impacts of isolation among staff has reportedly has had three main impacts:

- Long driving distances to meetings, either with clients or colleagues, can significantly add to Support Facilitators’ caseloads, risking burnout
- Support Facilitators and/or Team Leaders located far from the lead agency can lose morale and motivation, often leading to a high turnover of staff
- Support Facilitators and/or Team Leaders are at risk of adopting their host agency model of practice which may not be consistent with the PIR model of practice.

Consequently, staff meetings such as Support Facilitators’ regular catch-ups, and supervision sessions between Support Facilitators and Team Leaders, or Team Leaders and PIR Managers, regularly happen in PIR Organisations situated in rural and remote areas via the use of tele-health rather than face to face.

While tele-health does go some way to bridging the impacts of great distances, it is by no means a perfect solution. PIR Managers tended to report the importance of face to face time to share practice learnings with colleagues, and undertake the necessary personal engagement with clients. Several noted they deliberately try to share the travel burden across roles, rather than always expecting far-flung Support Facilitators to visit the lead agency. PIR Managers also spoke of the value of networks beyond the PIR Organisation, such as the Support Facilitators Mentors and Leadership Group and the Capacity Building Project’s dedicated Rural and Remote Working Group as valuable environments for isolated staff to share experiences and access support.
COLLABORATION WITH COMMUNITY CHANGE AGENTS TO ENGAGE WITH REMOTE INDIGENOUS COMMUNITIES

PIR is targeted at a cohort that has often developed a strong mistrust of services designed to assist them. Arguably, the widespread mistrust of services among Aboriginal and Torres Strait Islander Australians with a severe and persistent mental illness with complex needs is even greater, making this a challenging cohort to engage. This challenge is further compounded by remote locations that are difficult to access and provide consistent service delivery.

A key strategy for effectively delivering PIR in remote Indigenous communities has been to first build relationships with existing community change agents, to gain a social license to operate the PIR programme in the community, before attempting to engage clients directly. These community change agents may be individuals or organisations, and can include:

- community elders
- Aboriginal Community Controlled Health Services
- Aboriginal Medical Services
- the local Aboriginal Land Council
- the local Closing the Gap team.

In a few cases community change agents were members of the PIR consortium, although in most cases these relationships were built following commencement of the programme and may or may not be guided by an MOU or similar.

PIR Organisations note that effective outreach in remote communities requires a persistent ongoing presence, and while in some communities it has been possible to employ (often Indigenous) Support Facilitators dedicated to one or a small number of communities, in most cases Support Facilitators are required to cover a vast area and have found it effective to have community change agents provide an ongoing voice for PIR in their absence – providing information and making referrals to the programme.

The day to day operation of Support Facilitators servicing remote Aboriginal and Torres Strait Island communities can vary from that of a Support Facilitator in an urban or regional setting. While the role involves engagement and service coordination with individual clients, PIR Organisations report that these Support Facilitators also play a community development style role, engaging elders, families and organisational partners to provide information and education regarding mental illness generally as well as PIR specifically. This work can be time consuming, and many of these Support Facilitators carry smaller caseloads than their colleagues.

The idea of his role is he has a really small caseload and then he’s building up networks within those communities and services to hopefully make that happen but it’s a very, it’s a long term thing, it takes a while to do and it’s based around continuity again.

Team Leader

There’s a recognition for the work that the Aboriginal Support Facilitator has been doing but it’s far more intense and there’s a lot more protocols it has to follow. Pathways for them are linking up with people and families…so the level of case load for them is different.

PIR Manager

We don’t go in with any preconceived idea of how PIR is going to work, we’re really led by community…The first thing the remote area coordinator needs to do is start to engage with those services, start to engage with community. We’ll have a little community forum within that community to identify what their needs are, what’s working well, what’s not working well before we do anything. You need to tell us how we should be looking at your areas and how we should be running and I think that’s the beauty of PIR where a lot of programs come in with a set agenda this is how we have to work and this is what we have to do. We’re actually being driven by carers, people with a lived experience, community elders, the councils in those communities, everything guides us so we won’t do anything without their input. Everything we do gets fed back and it works really well.

Team Leader

We haven’t actively targeted the Aboriginal population other than we have strong connections with [Aboriginal Medical Services] AMS’s around the area and use that as kind of our strategy into the Aboriginal population. I’d say we’re probably sitting at around about 20% of our participants are of Aboriginal background, in the context of about 10 to 12% of the general population across the area I think that’s a pretty good job.

PIR Manager
11 PIR and the NDIS

In 2014-15, consultations were conducted with PIR Organisations in several NDIS trial sites including the Hunter region, Perth’s Hills region, the Northern Territory and the ACT. These site visits explored the interface between PIR and the NDIS with regard to collaboration at a strategic and operational level, as well as the PIR client experience of applying for the NDIS. Stakeholder consultations were also held with a number of NDIA staff including the Strategic Adviser on mental health, Local Area Coordination and community capacity building, and members of his team.

The evaluation uncovered considerable goodwill among both PIR and NDIA staff regarding the interface between PIR and the NDIS and found that both organisations are engaged in a process of shared learning and development. The NDIA is currently undertaking key pieces of work focused on mental health and access and eligibility for the NDIS for the PIR target group including:

- the operational access review for people with a psychosocial disability
- the mental health support design project, and
- scoping mental health supports to be offered under the ILC component of the NDIS.

This strong working relationship established between PIR and the NDIA will become increasingly important as the transition of PIR into the NDIS gets underway from 1 July 2016.

11.1 SUMMARY OF ISSUES IDENTIFIED IN THE 2013-14 ANNUAL EVALUATION REPORT

<table>
<thead>
<tr>
<th>ISSUES IDENTIFIED IN THE 2013-14 ANNUAL REPORT</th>
<th>PROGRESS IN 2014-15</th>
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<tbody>
<tr>
<td>Concerns regarding the degree of overlap in eligibility criteria between PIR and the NDIS.</td>
<td>Ongoing issue.</td>
</tr>
<tr>
<td>Concern regarding apparent contradiction between the recovery model and the requirement of permanence that guides the NDIS.</td>
<td>Ongoing issue.</td>
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11.2 A SHARED JOURNEY

PIR representatives felt there has been increasing attention over the past year from the NDIA regarding the issue of psychosocial disability. The NDIA has also reportedly focused on reinforcing the trial nature of the NDIS in its current state, which has helped to set realistic expectations among PIR staff and allay initial frustrations regarding NDIA systems and processes.

I think it’s functioning quite well now. We have a pretty good relationship and we just try and nip issues in the bud. It’s been very difficult for the Scheme in determining eligibility for people with psycho-social disability purely because the legislation wasn’t set up for mental illness and I don’t think there was an intention to bring mental illness into the Scheme. So whilst our mental health agencies and our state mental health services speak in recovery terms, the legislation and the agency [NDIA] speak from permanent terms. It’s been really challenging for our staff to make eligibility decisions, especially when they have no experience in mental health and the nature of certain conditions and certain medications that cause certain physical conditions and so that has been a huge piece of work that the agency has been doing and I think we’re getting better at it and I think PIR would agree. But that was basically the cause of a lot of frustration in the beginning.

NDIA representative
There’s lots of energy and commitment on both sides.

NDIA representative

There is evidence in NDIS trial sites of strong engagement and significant amounts of collaboration. This includes regular meetings on strategic and process issues, engagement at senior, as well as practitioner (Planners and Support Facilitators) level and establishment of working groups on specific elements of system or process integration. At a national level, NDIA has dedicated psychosocial working group/s and trial sites have also developed mental health special interest groups, comprising staff who have a background or specialist interest in mental health.

There is also significant staff overlap across PIR Organisations and the NDIA in terms of staff who have worked with each other before, which has supported the engagement and collaboration between the two organisations.

[The NDIA representative] comes from NGO space and mental health background, she’s managed PHaMS in the past, so she gets us, she’s comfortable with us and we can talk to each other, in the same language and she’s really committed for the relationship to build into work. So just that in and of itself has made a massive difference. And so we’re able to meet regularly, that’s the most significant benefit.

PIR Manager

11.3 SYSTEMS AND PROCESSES

There is evidence of successful integration of PIR and NDIA systems and processes beginning to emerge, including:

- **Referrals** – both PIR and NDIA report referral pathways are in place in both directions, that is PIR referring to the NDIS and the NDIA Planners referring clients to PIR.

- **Communication at a strategic and practitioner level** – there is very strong evidence of collaboration at a strategic level, and some evidence of Planners and Support Facilitators feeling informed of each other’s progress regarding shared clients, although this has been a point of frustration for some Planners and Support Facilitators.

- **Familiarity with eligibility requirements** – PIR and the NDIA both report levels of familiarity with each other’s eligibility requirements is increasing steadily with time.

- **Integration of PIR following NDIS acceptance** – there is evidence now of PIR Support Facilitation (where the PIR is an approved supplier) being included in NDIS action plans, to provide ongoing service coordination support to clients.

11.4 ELIGIBILITY AND OVERLAP

There is ongoing lack of clarity among both PIR and NDIA representatives regarding the degree of overlap between the NDIS and PIR. While some felt that the PIR eligibility criteria of severe and persistent mental illness with complex needs would meet the permanence requirements of the NDIS, the more consistent degree of overlap that PIR and NDIA staff referenced was that they expected the NDIS to cover approximately 70% of PIR clients.

*My understanding was that there would be 70% of PIR eligible for the NDIS.*

NDIA Planner

To date, this degree of overlap is not being borne out in trial sites. The reasons for this remain unclear and there is significant opportunity for both PIR and the NDIA to better understand each other’s eligibility criteria - to avoid frustration when referred clients are not accepted and avoid wasting resources.
PIR staff report there is evidence some conditions are more likely than others to be accepted into the NDIS. Clients with schizophrenia who are likely to have a long history of hospital admissions are likely to be accepted, while bipolar, post-traumatic stress disorder (PTSD) and dissociative identity disorder (DID) are reportedly less likely to be accepted.

PIR Organisations report their approach to NDIS applications has shifted with time, with a tendency to focus on the permanent functional impairment experienced by clients as a result of their mental illness (for example cognitive impairment or morbid obesity), rather than the permanence of their mental illness, which with episodic conditions can be more difficult to evidence.

11.5 RECONCILING RECOVERY AND PERMANENCE

There is a persistent tension among many PIR Organisations and other stakeholders about the philosophical underpinnings of PIR and the NDIS, and the potential to reconcile these differences.

_There has to be permanency, they will be with us for the rest of their life so it’s a really diligent decision and we really need to make sure it’s well researched, so a lot of the time we get referrals from PIR there’s no evidence attached and we can only make decisions on what we have. So we need to make sure the condition is permanent, that it’s related to a psychosocial disability, they meet the residency requirements, that all known treatments have been effective and that they have substantially reduced functional capacity in some area and that’s the main area we find difficulty in getting evidence for._

NDIA Planner

While the NDIS rests strongly upon the requirement for permanent or likelihood of permanent disability among clients, PIR is very strongly focused on a recovery based approach, which affords clients the opportunity to improve and remove their existing level of disability due to mental illness.

_Again when you look at the permanency stuff and the substantial reduction in function not everyone meets that. Just because you’ve got an intermittent mental health condition you can’t prove that there’s always a substantial reduction in function._

NDIA Planner

This opposition continues to be a strong concern for PIR Organisations and other stakeholders, although recognising the importance of collaboration to support outcomes for clients, PIR Organisations have tended to take a pragmatic approach to this issue and express hope that some elements of the recovery model may become embedded within the NDIS model.
11.6 OTHER CHALLENGES

The table below highlights some of the additional challenges that were raised by PIR Organisations and NDIA staff regarding their experience of working together to date.

TABLE 32 – CHALLENGES FACED BY PIR AND NDIA IN WORKING TOGETHER

<table>
<thead>
<tr>
<th>CHALLENGES FOR PIR IN WORKING WITH NDIA</th>
<th>CHALLENGES FOR NDIA IN WORKING WITH PIR</th>
</tr>
</thead>
</table>
| The amount of evidence required by the NDIA can be burdensome and some felt unrealistic.  
They want histories a mile long. | Some NDIS Planners expressed concern regarding the consistency of PIR service delivery – where some host agencies seem to deliver a very good service, while others lag behind. |
| The NDIS application process has been reported as cumbersome and often duplicating the assessment process undertaken by PIR – which goes against the objective of PIR to avoid clients telling their stories multiple times. | The relatively high staff turnover among Support Facilitators has been frustrating for some Planners in terms of ongoing collaboration. |
| The wait-time for notification of acceptance can be very long. | NDIS Planners reportedly have a very strong focus on their eligibility criteria and assessment processes, and felt some PIR Organisations could improve their attention to targeting the correct client group. |
| Support Facilitators, as referrers to the NDIS, often assist PIR clients prepare for their planning meeting with NDIA which can be very time consuming. | Some Planners report that PIR Support Facilitators tend to rely on the funded supports potentially available to NDIS accepted clients, as opposed to exploring the mainstream supports available. |
| ‘My Access Checker’ with its deficit model focus is felt to be opposed to the principles of recovery. | |

11.7 ROLLING PIR INTO THE NDIS

At the time of conducting the site visits and stakeholder consultations, it was widely speculated among PIR Organisations, external stakeholders and NDIA representatives that some, or all of, the PIR programme would be rolled into the NDIS as of 1 July 2016.

PIR Organisations,NDIA representatives and a range of other stakeholders expressed a strong desire to highlight the elements of the PIR programme are unique and should not be lost in this transition process, and that the NDIA could learn from in implementing the NDIS.

The figure below outlines these key learnings:
There's a lot of value in what PIR is doing, we wouldn't want that lost…We need to align the work of PIR with opportunities under the NDIS – specifically how the Scheme can build on PIR’s work in assessment and targeting as well as their approach to individual support coordination and the capacity building that’s happening and how that fits with the Information, Linkages and Capacity Building area.

NDIA representative

If someone was on a PIR programme within the NDIA or NDIS space, I would see it would value add, you know there would be more connection out with the community and other service providers. So it would probably round out their plan. So a participant plan looks at the person’s functional support needs but it also looks at their goals and aspirations and I think that's where, it's the goals and aspirations that I think fits really well with something like PIR.

External stakeholder
### SUMMARY OF NEW ISSUES IDENTIFIED IN THE 2014-15 ANNUAL EVALUATION REPORT

#### TABLE 33 – 2014-15 SUMMARY OF ISSUES RELATED TO THE PIR - NDIS INTERFACE

<table>
<thead>
<tr>
<th>NEW ISSUES IDENTIFIED IN THE 2014-15 ANNUAL REPORT</th>
<th>PLANNED ACTION IN 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some PIR staff report burdensome evidence requirements for PIR clients applying to the NDIS.</td>
<td>PIR and NDIA staff recognise this is an operational issue requiring attention.</td>
</tr>
<tr>
<td>There is opportunity to streamline or combine the needs assessment process for potential clients of both PIR/NDIS, to avoid duplication for clients.</td>
<td>PIR and NDIA staff recognise this is an operational issue requiring attention.</td>
</tr>
<tr>
<td>There is a strong desire to not lose the value created by PIR to date in rolling the programme into the NDIS. Specifically, representatives from PIR and the NDIA value the system reform activity underway, the skills of PIR in targeting hard to reach clients, the recovery and person centred approach modelled by PIR and the service coordination skills, both in preparing for and following on from an NDIS planning meeting.</td>
<td>Ongoing issue.</td>
</tr>
</tbody>
</table>
12 Conclusions

This section presents an overview of key findings, a description of key facilitators and barriers to success, and recommendations to enhance and inform the delivery of PIR.

12.1 EVIDENCE OF SUCCESS OF PIR

The PIR model is proving to be an innovative model that is delivering transformational change via a recovery based approach for clients. The PIR model has been increasingly effective in supporting the target group, who are traditionally very difficult to reach and engage. The evaluation has uncovered emerging evidence that the recovery based PIR model has created real change for individuals, based on reports of a range of improved personal, social and health and wellbeing outcomes.

PIR staff, consortia members and many external stakeholders have strong belief that the PIR model delivers real change. Operating in a changing and complex policy setting has been a challenge for PIR Organisations. There is an extraordinary commitment among most PIR staff to the programme, indicating the strong belief staff and others have in the potential for the model to deliver real change. Evidence suggests the programme architecture enables the programme to meet its objectives, underpinned by a shared vision and tight focus on improving client outcomes.

In evaluating PIR, it is important to distinguish between the value in the model and implementation of that model nationally. It is important to distinguish between the inherent value and potential of the PIR model and the implementation nationally, as there are examples where the implementation has fallen short of expectations. Most consortia are functioning well and partnerships have endured despite a climate of uncertainty. This is a measure of strong skill and commitment among PIR staff. In cases of poor or inconsistent delivery, this is often a reflection of inexperience and/or poor fit for the PIR roles, particularly PIR Managers and Support Facilitators.

12.2 PIR PROCESS AND OPERATIONS

The flexibility of the PIR programme design creates strong opportunities to achieve outcomes both for individuals and across the service system.

The consortia model provides the flexibility to design partnerships best suited to local conditions in order to achieve the objectives of PIR. This high degree of flexibility is delivering results with regard to establishing partnerships that are effective in collaborating for improved individual and systemic outcomes. In particular, this consortia model has been critical in establishing new and effective referral pathways to target clients most in need, and in building an organisational focus on recovery oriented and person centred service delivery via shared training and resources.

The flexibility afforded to Support Facilitators, with regard to engaging clients, coordinating services and providing funding, is vital to the success of PIR. This flexibility allows Support Facilitators to be present in a way clients have often never experienced before, while the funding can be catalytic in to establishing trust and rapport with clients, as well as in overcoming immediate barriers to their recovery.

The ability of PIR to deliver improved outcomes for individuals is conditional upon the strong relationship between clients and their Support Facilitator. If trust and rapport are not successfully established between clients and their Support Facilitator client progress can be undermined, with regard to developing and completing their personal action plans, and taking steps toward their recovery goals. While it is critical to recruit highly suitable Support Facilitators, it is equally important to acknowledge some individuals will not gel with even the most well qualified and experienced Support Facilitator, so the ability for clients to change Support Facilitators should be communicated to clients.

The consultations with PIR Organisations revealed a picture of the skillset and background of effective PIR Managers and Support Facilitators. Given the success of PIR is contingent upon the recruitment of effective Support Facilitators and PIR Managers, this picture of the interpersonal skills, skillset and experience required in these roles is powerful in planning for success.
12.3 PARTNERSHIPS, GOVERNANCE AND MANAGEMENT

Sophisticated leadership among PIR Managers is the strongest predictor of high performing PIR Organisations. The evaluation provides evidence of the skillset and experience of strong PIR Managers.

Structurally, there is some early evidence to suggest that diverse consortia and medium to large size consortia are achieving better results compared to their peers. However, it is too early to determine an ideal or most effective size or structure. The evaluation has revealed significant detail regarding the features of effective PIR consortia, clustered around having a shared vision, providing appropriate support and authority and high levels of capability.

PIR Organisations generally accept that maximising consumer and carer involvement in the decision-making and governance processes of organisations, a key feature of recovery oriented practice, has the opportunity to enhance service delivery and ultimately client outcomes. Most PIR Organisations identified this as an area for improvement, highlighting the challenges associated with involving consumers and carers in an effective and meaningful way.

12.4 CLIENT ENGAGEMENT AND ENROLMENT

Ensuring PIR Organisations are working with the correct client group was a strong and ongoing focus across all PIR Organisations, with almost all reporting they are successfully working with the correct client group. There is a large range of measures in place to support this including centralised intake and assessment processes to promote consistency and prioritisation of clients most in need, diverse client facing consortia members, promotion of the program to the wider service sector, outplacement of Support Facilitators in the wider service sector and assertive outreach to bring the PIR programme to clients.

While there is evidence of good practice among some PIR Organisations, almost all organisations acknowledge the need to be doing more to facilitate access to PIR key equity groups including CALD populations, Aboriginal and Torres Strait Islanders and those living in rural and remote locations.

12.5 SYSTEM REFORM

There is early evidence that PIR has the potential be a system reforming programme in the future. While most PIR Organisations agree it is too early to comment on the impacts of system reform, there are early signs that PIR can create sustainable change across the wider service system. There are high levels of activity and some evidence of change at a consortium level, and among high performing PIR Organisations, there are early signs of change in the regional service system.

The high degree of flexibility embedded within both PIR Organisation design (for example dedicated system reform roles compared to models where system reform is considered embedded within all roles), as well as the innovation funding available to resource system reform projects, has contributed to early evidence of sustainable change across the system.

12.6 CHALLENGES FOR PIR

Delivering the PIR programme to ensure a consistent experience for clients, across consortia and across regions, is perhaps the biggest challenge at present. Where operational issues with the programme emerge, the distinction between the strength of the model and the actual implementation is critical. However, this distinction is often overlooked by critics. In order to support a consistent implementation nationally, a highly developed approach to staff induction, staff and partner training and ongoing supervision of staff is required.

As outlined at section 3, there is significant change underway in the mental health, disability and wider health and social services sectors in Australia. This period of significant change with regard to the policy setting for PIR has created a number of challenges.

Staff engagement, recruitment and retention have been a challenge given the uncertainty surrounding the future of the programme. Many PIR Organisations reported losing staff and finding it difficult to recruit appropriate staff as candidates look for more secure options. While successful PHNs have been announced and the National Mental Health Commission Review has been released, the uncertainty
regarding the future of PIR is likely to persist for some time which represents a significant ongoing challenge to effective service delivery. PIR Organisations reported that staff retention will be a major risk in the final 12 months of the programme, and will potentially limit the number of people who can access PIR in 2015-16.

The enthusiasm and commitment to system reform projects has been undermined by a complex and changing sector among some PIR Organisations. While not a consistent response (many PIR Organisations acknowledge the ability to operate in an uncertain environment as part and parcel of working in a fluid policy setting), some PIR Organisations have found it difficult to commit to projects and motivate staff and partners across the sector to drive system reform.

PIR Organisations are eager to continuously improve their practice, thereby improving outcomes for individuals and across the wider service system. Specifically, PIR Organisations wish to learn from experiences of other PIR Organisations and benchmark their findings against the national picture through examination of the findings of the national evaluation. The lack of publicly available evaluation findings has been a significant challenge faced by Organisations in planning for continuous improvement, although some local evaluation findings are beginning to be received, and many PIR Organisations understood the changing policy environment was driving the lack of publicly available data.

12.7 SUGGESTIONS FOR STRENGTHENING PIR

These suggestions are intended to strengthen and enhance the ongoing rollout and delivery of the PIR Initiative.

TABLE 30 – SUGGESTIONS TO STRENGTHEN THE PIR INITIATIVE

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>SUGGESTIONS FOR STRENGTHENING</th>
</tr>
</thead>
<tbody>
<tr>
<td>PIR Organisations</td>
<td>1. Clearly articulate to staff and partners the ongoing commitment of the Department to PIR to 30 June 2016, in order to reduce fears among staff regarding job security and to maintain momentum and commitment to system reform projects.</td>
</tr>
<tr>
<td></td>
<td>2. Continue to develop partnerships, focusing on the importance of shared vision, support and authority, and capacity in operating highly effective partnerships.</td>
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<td></td>
<td>3. Ensure clients are aware they can change Support Facilitators if desired. It may be necessary to develop criteria and guidelines for these instances.</td>
</tr>
<tr>
<td></td>
<td>4. Utilise evaluation findings with regard to the skills and experience of effective Support Facilitators and PIR Managers in recruitment decisions.</td>
</tr>
<tr>
<td></td>
<td>5. Review and if necessary refine the staff and partner induction, engagement, training and supervision procedures to support consistent and high quality service delivery.</td>
</tr>
<tr>
<td></td>
<td>6. Continue to develop and strengthen policies and procedures for engaging clients and carers in governance arrangements, to ensure engagement is meaningful and drives improved outcomes.</td>
</tr>
<tr>
<td></td>
<td>7. Continue to develop and strengthen measures to target the correct client group, utilising assertive outreach and outplacement as appropriate.</td>
</tr>
<tr>
<td></td>
<td>8. Develop and share strategies/approaches for targeting and assisting PIR clients in key equity groups including Indigenous, culturally and linguistically diverse (CALD)/refugee clients.</td>
</tr>
<tr>
<td></td>
<td>9. Commence or continue investment into a strong collaborative relationship with the NDIA at both operational and strategic levels as the staged roll-out of the NDIS continues.</td>
</tr>
<tr>
<td>The Capacity Building</td>
<td>10. More emphasis should be placed on building capacity for partnership development and strengthening.</td>
</tr>
<tr>
<td>Project</td>
<td>11. Work with consortia to ensure the evaluation findings regarding the skillsets of effective PIR Managers and Support Facilitators are applied throughout recruitment processes.</td>
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</tbody>
</table>
12.8 PIR, THE NDIS AND THE FUTURE

The PIR programme will be in transition to the NDIS from 1 July 2016 and is subject to the roll-out arrangement for the NDIS on a state by state basis, with full NDIS roll-out expected by 2019-20. While this had not been announced at the time of data collection for the second year of the evaluation, there was strong speculation among PIR staff, consortia members and the sector more broadly this transition would occur.

Given this confirmed transition strategy, the interaction between PIR and the NDIA is increasingly important. A strong cooperative relationship currently exists between the NDIA and PIR in a number of trial sites, creating an opportunity to plan for a smooth transition with minimal negative impact on clients.

While there is strong evidence of collaboration between the NDIA and PIR both at a strategic and an operational level, critical questions remain in terms of programme design. These questions include the extent of programme overlap, reconciling the key underpinnings of PIR and the NDIS given the NDIA’s requirement for permanent disability which many see as counter to the recovery approach of PIR, and how the service experience will roll-out for clients of both programmes. The Department is currently working closely with the Department of Social Services and the NDIA to inform the roll out of the NDIS for psychosocial disability.
Disclaimer

This report is dated July 2015 and incorporates information and events up to that date only and excludes any information arising, or event occurring, after that date which may affect the validity of Urbis Pty Ltd’s (Urbis) opinion in this report. Urbis prepared this report on the instructions, and for the benefit only, of Department of Health (Instructing Party) for the purpose of PIR Evaluation (Purpose) and not for any other purpose or use. Urbis expressly disclaims any liability to the Instructing Party who relies or purports to rely on this report for any purpose other than the Purpose and to any party other than the Instructing Party who relies or purports to rely on this report for any purpose whatsoever (including the Purpose).

In preparing this report, Urbis was required to make judgements which may be affected by unforeseen future events including wars, civil unrest, economic disruption, financial market disruption, business cycles, industrial disputes, labour difficulties, political action and changes of government or law, the likelihood and effects of which are not capable of precise assessment.

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Urbis has made all reasonable inquiries that it believes is necessary in preparing this report but it cannot be certain that all information material to the preparation of this report has been provided to it as there may be information that is not publicly available at the time of its inquiry.

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This report has been prepared with due care and diligence by Urbis and the statements and opinions given by Urbis in this report are given in good faith and in the belief on reasonable grounds that such statements and opinions are correct and not misleading bearing in mind the necessary limitations noted in the previous paragraphs. Further, no responsibility is accepted by Urbis or any of its officers or employees for any errors, including errors in data which is either supplied by the Instructing Party, supplied by a third party to Urbis, or which Urbis is required to estimate, or omissions however arising in the preparation of this report, provided that this will not absolve Urbis from liability arising from an opinion expressed recklessly or in bad faith.
Appendix A  Research Instruments
Evaluation of Partners in Recovery (PIR)
Client and Carer Feedback

Have your say on Partners in Recovery

Urbis would like to hear from any clients and carers who would like to share their experiences with Partners in Recovery.

We are very keen to hear from clients and carers about your views of the service and whether or not it has made it easier to improve your quality of life. These questions are not a test, we want to hear about your thoughts and experiences regarding Partners in Recovery.

1. Have you been involved with Partners in Recovery as a:
   a. Client [GO TO Q2]
   b. Carer [SKIP TO Q6]

2. What if anything has changed since you’ve been involved with Partners in Recovery?

   For example, have you made changes or new connections in your life? Have you accessed new services? How has this made a difference to you?

3. What, if anything, has changed for you in terms of how you feel in yourself since you’ve been involved with Partners in Recovery?

   For example, has your hope for the future changed? Has your sense of control/responsibility for the direction of your life changed?

Urbis is an independent social research company contracted by the Commonwealth Department of Health to evaluate the Partners in Recovery programme. Over the period 2013-16, Urbis will be collecting a range of data from PIR Organisations, including staff, stakeholders, clients and carers to evaluate the implementation and coordination of the programme, and the impact for clients.

Anything you share with us will be reviewed carefully and then put together when Urbis writes a report for the government to let them know what people think of Partners in Recovery. Urbis may use what you say in the report but will not use your name or any details about you so no one will know what you personally said. All information you provide totally confidential. Your name is not used when Urbis write up their report and no one involved in the Partners in Recovery service is advised of what you have said.
4. Overall, how satisfied would you say you are with your experience of the Partners in Recovery programme? Why is that?

5. Is there anything else you would like to share about Partners in Recovery?

SKIP TO Q10

6. What if anything has changed since you've and/or your family member has been involved with Partners in Recovery?

For example, have you/your family member made changes or new connections in your life? Have you/your family member accessed new services? How has this made a difference to you and your family member?

7. What, if anything, has changed for you in terms of how you feel in yourself since involvement with Partners in Recovery?

For example, has your hope for the future changed? Has your sense of control/responsibility for the direction of your life changed?
8. Overall, how satisfied would you say you are with your experience of the Partners in Recovery programme? Why is that?

9. Is there anything else you would like to share about Partners in Recovery?

10. How long have you been involved with Partners in Recovery:
   a. Less than 3 months
   b. Between 3 and 6 months
   c. Between 6 and 12 months
   d. Longer than 12 months

11. I am:
   a. Male
   b. Female
   c. Transgender
   d. Prefer not to say

12. I am aged:
   a. Under 25
   b. 25-35
   c. 36-45
   d. 46-55
   e. 56+

13. Please select the State/Territory you are located in:
   a. NSW
   b. ACT
   c. VIC
   d. QLD
   e. WA
   f. SA
   g. NT
   h. TAS

Thank you very much for your time today.

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Anything you share with us will be reviewed carefully and then put together when Urbis writes a report for the government to let them know what people think of Partners in Recovery. Urbis may use what you say in the report but will not use your name or any details about you so no one will know what you personally said. All information you provide totally confidential. Your name is not used when Urbis write up their report and no one involved in the Partners in Recovery service is advised of what you have said.
Hello, my name is XXXX and I would like to talk to you today about some of your experiences with Partners in Recovery. I work for an independent research company called Urbis and we have been contracted by the Commonwealth Department of Health to talk to people who have been involved in the PIR programme. The Department is very keen to hear from clients about their views of the service, whether or not it has worked for them or made it easier to improve your quality of life. This is not an evaluation of you, we want to hear about your thoughts on PIR.

We will be talking to PIR clients and carers in different parts of the country as part of our project, and we will listen carefully to what everyone says and then put it all together and write a report for the government to let them know what people think of PIR. We would like to use what you say in the report but we will not use your name or any details about you so no one will know what you personally said.

The interview is totally confidential. We do not use your name when we write up our report and we do not tell anyone involved with the service about what you have said.

Taking part in this interview is entirely voluntary – you do not have to speak with me if you do not want to. Nor do you have to answer all the questions. If there is any question that you would rather not answer, you can just say you don’t want to answer it. You can also stop the interview at any time if you wish. If, later on, you decide you don’t want us to use your words, you can also let us know and we won’t include them in our report.

The interview will take about 30 minutes but it can be shorter if you wish. Are you still happy to go ahead with the interview? (confirm consent in writing if face to face – by signing the existing consent form - or verbally if by telephone) Would you mind if I recorded our conversation with a tape recorder? (confirm verbally and if yes, repeat confirm on tape). Do you have any questions for me before we begin?

1. May we start by talking a little about how you came to be involved in PIR? (probe for: pathway of initial referral, experience of first meetings and assessments, agreement to be registered as a client, determine whether client chose PIR or it was chosen for them).

2. What were the areas where you were hoping PIR could have an impact on your life? (eg: housing, health service access, employment, benefits, etc)

3. What if anything has changed since you’ve been involved with PIR?
   a. What changes or new connections are you making?
   b. What services have you been able to access?
   c. Are services working together or talking to each other differently than in the past?
   d. How has this made a difference in your life?

4. How important has PIR been in assisting you to achieve this? And what is it about PIR that has made this possible?

5. What was it like trying to make connections and access services before PIR? How does PIR compare to other services you’ve been involved with if any?
6. What, if anything, has changed for you in terms of how you feel in yourself?
   a. How has your hope for the future changed since your involvement with PIR?
   b. How has your sense of control/responsibility for your own life changed since your involvement with PIR?

7. What, if anything, has changed in your quality of life?
   a. How has your feeling of involvement with other people or activities changed since your involvement with PIR?

8. What, if anything, has changed in terms of the kinds of things you do each day?

9. What has your Support Facilitator been like? What has been best about how they have worked with you? What might they have done better?

10. Overall, how satisfied would you say you are with your experience of the PIR programme? Why is that?

11. Is there anything I haven’t asked you about that you would like to tell me about PIR?

Thank you very much for your time today.

Rephrased questions for carer-only interview:

1. May we start by talking a little about how you and your [family member] came to be involved in PIR? (probe for: pathway of initial referral, experience of first meetings and assessments, agreement to be registered as a client, determine whether client chose PIR or it was chosen for them by carer)

2. What were the areas where you were hoping that PIR could have an impact on [family member] life? (eg: housing, health service access, employment, benefits, etc)

3. What if anything has changed since you’ve / your family member been involved with PIR?
   a. What changes or new connections is [family member] making?
   b. What services have they been able to access?
   c. Are services working together or talking to each other differently than in the past?
   d. How has this made a difference in your and [family member’s] life?

12. How important has PIR been in assisting you /family member to achieve this? And what is it about PIR that has made this possible?

13. What was it like trying to make connections and access services before PIR? How does PIR compare to other services you/family member have been involved with if any?

14. What, if anything, has changed for you in terms of how you feel in yourself?
   a. How has your hope for the future changed since your involvement with PIR?
   b. How does [family member’s] sense of control/responsibility for their own life changed since their involvement with PIR?

15. What, if anything, has changed in your quality of life?
   a. How has [family member’s] feeling of involvement with other people or activities changed since your involvement with PIR?
16. What, if anything, has changed in terms of the kinds of things you and your family member do each day?

4. What has your Support Facilitator been like? What has been best about how they have worked with [your family member]? What might they have done better?

5. Overall, how satisfied would you say you are with your experience of the PIR programme? Why is that?

6. Is there anything I haven't asked you about that you would like to tell me about PIR?

Thank you very much for your time today.
**Evaluation of Partners in Recovery**  
**2014/15 Interview Guide**  
**PIR Consortium Members**

**Introduction**

My name is XXX and I work for social research consulting firm Urbis. As you are aware, Urbis has been commissioned by the Australian Government Department of Health to conduct an evaluation of PIR from 2013 to 2016. The primary focus in this second year of the evaluation is *early outcomes and achievements*, including any evidence of impact on the mental health system, clients and carers.

This visit is one of twelve site visits that we will be conducting this year. In selecting sites for visits, we have sought a variety in terms of Lead agency type (Medicare Local, NGO), geographic location (States/Territories and urban, regional and remote localities), size of target population, population demographics (including PIRs servicing high proportion of Aboriginal or CALD clients) and PIR service model.

Six of the twelve sites we visit this year are longitudinal sites and are being visited each year. This will enable us to track and report on issues, challenges and outcomes for these PIRs, their service systems, clients and carers over a three year period. Each year six additional sites are being chosen to enable us to visit as many PIRs as possible over the three years.

PIRs that do not receive a visit will be consulted by telephone over the next few months.

Consultations for the evaluation are confidential. No comments will be attributed to any individual or organisation in other discussions or in reports, except with express permission.

Have you any questions to ask before we start?

*I would like to confirm that you consent to this interview being recorded.*

**(A) PIR Organisation**

Please describe your PIR

1. [for Consortium members] As a consortium member, what is the nature of your involvement in the PIR Organisation? What involvement, if any, does your organisation have in PIR beyond regular meetings with the consortium? [for longitudinal sites: What, if anything, has changed from a year ago?]

2. How is your PIR operational model structured, eg types and number of staff? Where are staff hosted? How well is this model working at this point?

3. To what extent is the PIR model enabling your organisation to meet the needs of clients?

**(B) Clients and carers**

How have clients engaged with PIR and what has been the impact on clients and carers?

4. What is the size and nature of your target population? What, if anything, is different or unexpected about the number and type of clients who are participating in PIR from your original expectations?

5. What measures are in place to ensure your PIR Organisation is targeting the correct client group? How are you attempting to reach the hard to reach client group? And what success are you having? (people with severe and persistent mental illness with complex needs, individuals who are reported to often fall through the system gaps)
6. What are the predominant referral pathways for clients entering PIR? How does this compare to the expected channels through which clients would be identified and engaged? What things have progressed well? What factors have assisted with this?
   a. Based on the first 12 months of PIR, the most common referral pathway at 20%, is referrals from public sector mental health service clinics. How does this align with targeting the appropriate client group?

7. What have been the key needs that clients have brought to PIR?

8. How is PIR impacting consumers? What outcomes have you been observing?

9. In what ways are carers interacting with PIR and what support are they receiving? What in your view is the main role of PIR in supporting or assisting carers?

10. How is PIR impacting carers? What outcomes have you been observing?

11. How do referral pathways and the coordination and support model facilitate access among key equity groups (such as Culturally and Linguistically Diverse, Indigenous and rural/remote client populations)?

(C) Partnerships and governance
How well are your governance and partnership structures working?

12. To what extent has the level of coordination between clinical and community support service providers improved across the PIR regional network?

13. How has this improved the delivery of person-centred supports individually tailored to meet client need? What does this look like? What is working well? What have been the critical factors in this?

14. To what extent is there a common understanding of a community based recovery approach among service providers? Can you please provide examples of what this looks like and how it changes (or not) what services are doing? How has this been influenced by PIR?

15. Recovery is often defined by a set of practice principles. Can you please give me some of examples of how your PIR Organisation…
   a. Resists adopting service responsibility for clients, and instead negotiates shared responsibility?
   b. Avoids using the language of limits, and instead uses the language of possibilities?
   c. Resists low expectations, and instead operates in an environment of high expectations for clients?
   d. Resists working in an expert role, and instead encourages clients to be the expert?
   e. Avoids creating dependence, and instead fosters a sense of independence?

16. In what ways is your PIR Organisation partnering with clients and carers in the governance and structures of PIR? How is this impacting the quality of decision making? Can you provide some examples?

(D) System reform
What has been the impact of PIR on the service system? How can this be improved?

17. What system reform activities are you undertaking?

18. What sorts of improvements/outcomes are beginning to emerge from these activities?

19. To what extent have PIROs and the PIR Networks improved referral pathways and increased access to required services for PIR clients and families/carers?
(E) **Locality specific implementation**

20. What are the specific challenges faced by your geographical location (metro, regional, rural) in delivering PIR? 

21. And what measures have you adopted to address these challenges? 

22. Do you think these challenges principally relate to the PIR model itself or the operationalisation of the model? 

(F) **NDIS (only for sites where the NDIS is in place)**

What is the relationship between PIR and the NDIS in your area? 

23. To what extent has the NDIS had an impact on PIR clients’ and carers’ ability to access services? 

24. How have PIR and the NDIS worked together to meet the needs of the target group? 

(G) **The future**

What are the key lessons from PIR over the past year? 

25. What will be your main focus for PIR over for the next six months or so, eg improving systems, addressing system reform, increasing client uptake? 

26. Have you any ideas about how PIR management, capacity-building or implementation could be strengthened in the next year or so? 

27. Are there any other comments that you would like to make that are relevant to the evaluation? 

THANK YOU FOR YOUR PARTICIPATION
Introduction

My name is XXX and I work for social research consulting firm Urbis. As you are aware, Urbis has been commissioned by the Australian Government Department of Health to conduct an evaluation of PIR from 2013 to 2016. The primary focus in this second year of the evaluation is early outcomes and achievements, including any evidence of impact on the mental health system, clients and carers.

This visit is one of twelve site visits that we will be conducting this year. In selecting sites for visits, we have sought a variety in terms of Lead agency type (Medicare Local, NGO), geographic location (States/Territories and urban, regional and remote localities), size of target population, population demographics (including PIRs servicing high proportion of Aboriginal or CALD clients) and PIR service model.

Six of the twelve sites we visit this year are longitudinal sites and are being visited each year. This will enable us to track and report on issues, challenges and outcomes for these PIRs, their service systems, clients and carers over a three year period. Each year six additional sites are being chosen to enable us to visit as many PIRs as possible over the three years.

PIRs that do not receive a visit will be consulted by telephone over the next few months.

Consultations for the evaluation are confidential. No comments will be attributed to any individual or organisation in other discussions or in reports, except with express permission.

Have you any questions to ask before we start?

I would like to confirm that you consent to this interview being recorded.

(A) PIR Organisation

Please describe your PIR

1. What is the nature of your PIR model, eg lead agency and number and type of consortium members? [for longitudinal sites: What, if anything, has changed from a year ago?]

2. How is your PIR operational model structured, eg types and number of staff? How well is this model working at this point?

3. [for Support Facilitators only] To what extent is the PIR model enabling your role to meet the needs of clients? How is this different from other care coordination or support roles across the mental health service system?

(B) Clients and carers

How have clients engaged with PIR and what has been the impact on clients and carers?

4. What is the size and nature of your target population? What, if anything, is different or unexpected about the number and type of clients who are participating in PIR from your original expectations?

5. What measures are in place in your PIR Organisation to ensure you are targeting the correct client group? How are you attempting to reach the hard to reach client group? And what success are you
6. What are the predominant referral pathways for clients entering PIR? How does this compare to the expected channels through which clients would be identified and engaged? What things have progressed well? What factors have assisted with this?
   a. Based on the first 12 months of PIR, the most common referral pathway at 20%, is referrals from public sector mental health service clinics. How does this align with targeting the appropriate client group?
   b. A further 10% of referrals are self-referrals. Can you define self-referrals for me? What do these comprise in terms of the journey to PIR?

7. What have been the key needs that clients have brought to PIR?

8. How is PIR impacting consumers? What outcomes have you been observing?

9. In what ways are carers interacting with PIR and what support are they receiving? What in your view is the main role of PIR in supporting or assisting carers?

10. How is PIR impacting carers? What outcomes have you been observing?

11. How do referral pathways and the coordination and support model facilitate access among key equity groups (such as Culturally and Linguistically Diverse, Indigenous and rural/remote client populations)?

12. What has the flexible funding been used for and what impact has this had for clients and carers?

13. At June 30 2014, 802 clients had exited PIR, although in about 40% of cases the reason was not clear. What are the key reasons clients are exiting PIR? If people are exiting PIR prematurely, why is this?

14. [for Support Facilitators only] What is the ideal number of clients on your list at any one time? What drives this? And how many do you currently have? How are you coping?

(C) Partnerships and governance

How well are your governance and partnership structures working?

15. To what extent has the level of coordination between clinical and community support service providers improved across the PIR regional network? Can you please provide examples?

16. How has this improved the delivery of person-centred supports individually tailored to meet client need? What does this look like? What is working well? What have been the critical factors in this?

17. To what extent is there a common understanding of a community based recovery approach among service providers? Can you please provide examples of what this looks like and how it changes (or not) what services are doing? How has this been influenced by PIR?

18. Recovery is often defined by a set of practice principles. Can you please give me some of examples of how you and your PIR Organisation…
   a. Resists adopting service responsibility for clients, and instead negotiates shared responsibility?
   b.Avoids using the language of limits, and instead uses the language of possibilities?
   c. Resists low expectations, and instead operates in an environment of high expectations for clients?
   d. Resists working in an expert role, and instead encourages clients to be the expert?
   e. Avoids creating dependence, and instead fosters a sense of independence?
19. In what ways is your PIR Organisation partnering with clients and carers in the governance and structures of PIR? How is this impacting the quality of decision making? Can you provide some examples?

**(D) System reform**
What has been the impact of PIR on the service system? How can this be improved?

20. What system reform activities are you undertaking?

21. What sorts of improvements/outcomes are beginning to emerge from these activities?

22. To what extent have PIROs and the PIR Networks improved referral pathways and increased access to required services for PIR clients and families/carers?

**(E) Locality specific implementation**

23. What are the specific challenges faced by your geographical location (metro, regional, rural) in delivering PIR?

24. And what measures have you adopted to address these challenges?

25. Do you think these challenges principally relate to the PIR model itself or the operationalisation of the model?

**(F) NDIS (only for sites where the NDIS is in place)**
What is the relationship between PIR and the NDIS in your area?

26. To what extent has the NDIS had an impact on PIR clients’ and carers’ ability to access services?

27. How have PIR and the NDIS worked together to meet the needs of the target group?

**(G) The future**
What are the key lessons from PIR over the past year?

28. What will be your main focus for PIR over for the next six months or so, eg improving systems, addressing system reform, increasing client uptake?

29. Have you any ideas about how PIR management, capacity-building or implementation could be strengthened in the next year or so?

30. Are there any other comments that you would like to make that are relevant to the evaluation?

THANK YOU FOR YOUR PARTICIPATION
Evaluation of Partners in Recovery (PIR)
Stakeholder Discussion Guide 2014

My name is XXX and I work for social research consulting firm Urbis. Urbis has been commissioned by the Department of Health to conduct an evaluation of PIR from 2013-16. The primary focus in this second year of the evaluation is early outcomes and achievements, including any evidence of impact on the mental health system, clients and carers.

Consultations for the evaluation are confidential. No comments will be attributed to any individual or organisation in other discussions or in reports, except with express permission.

Have you any questions to ask before we start?

1. How familiar are you with PIR? What, if any, role have you had in developing, supporting or implementing the programme?

2. What is your understanding of the key aims and objectives of PIR? How do you think the PIR model or approach compares with other programmes or initiatives targeting people with multiple and complex mental health and related needs?

3. What are the key strengths of the model in your view? Any limitations or drawbacks? What evidence have you seen of the model making an impact to date?

4. Is there any overlap or duplication with other initiatives, to your knowledge?

5. What sort of evidence would you be looking for to assess the effectiveness of PIR after three years?

6. Most PIR Organisations have been accepting clients for 12 months now. What if any evidence have you seen of PIR having an impact for the target group of people with severe and persistent mental illness who have complex needs?

7. And specifically what is going well? What is going less well? (Prompt: Consortia arrangements, governance, staffing, service models, service system engagement, targeting the right clients)

8. What if any evidence have you seen of PIR having an impact on improved outcomes for clients?

9. What system reform activities are you aware of? What evidence have you seen of these having an impact?

10. [for National / State and Territory stakeholders only] Is this across the board or does it vary a lot across the PIRs? Why is that do you think?

11. [for National / State and Territory stakeholders only] Do you have a sense of which PIRs seem to be making most progress? What are the key success factors there?

12. [for National / State and Territory stakeholders only] Which PIRs seem to be making slower progress? What are the challenges and difficulties they are facing? How do you think they can be best supported to overcome these?

13. [for National / State and Territory stakeholders only] How critical or effective have the capacity building (Flinders University), tools and resources (Smiggins Miller) initiatives and Departmental programme management been in this PIR planning and implementation phase?

14. What do you think are the critical success factors for PIR going forward?

15. What do you think are the key challenges PIR faces? How do you think these will be best addressed?
Have you any ideas as to how PIR or its implementation could be strengthened at this stage?

Have you any other comments to make that are relevant to the evaluation?

THANKYOU FOR YOUR PARTICIPATION
Appendix B  PIR – Programme Background
B.1 PROGRAMME BACKGROUND

Partners in Recovery (PIR) aims to improve support for people with severe and persistent mental illness with complex needs, as well as their carers and families, by improving collaboration, coordination and integration of services and supports from the multiple sectors clients may come into contact with (and could benefit from). A total of $496 million of Federal funding has been allocated from 2011-12 to 2015-16 to support the PIR initiative.

PIR is considered innovative in the provision of services for those experiencing mental illness for a number of reasons:

- **Target population** - PIR is designed for those with severe and persistent mental illness with complex needs that require a response from multiple agencies across different sectors. These individuals are reported to often fall through the system gaps and require more intensive support to effectively address the complexity of their needs. A programme has never been designed specifically for this target group.

- **System reform** - By encouraging better coordination of services for the target group across multiple sectors and agencies, as well as the building of strong partnerships and improved referral pathways for individuals, the ultimate aim of PIR is to drive system reform and build a community-based recovery model for assisting the PIR target group.

- **Flexible pool of funding** - PIR involves a unique funding model in which PIR Organisations have access to a limited amount of flexible funding to purchase services and appropriate supports when client needs are identified but are not immediately able to be met through normal channels. The flexible funding pool enables the PIR Organisations to buy these services and supports on behalf of clients, and is intended to be used to build system capacity for the benefit of PIR clients within the region, rather than divert responsibility from existing service providers.

- **PIR modelling system reform**: PIR Organisations responsible for delivering PIR are required to function as a consortium both in the preparation of the PIR funding bid and in the ongoing management and delivery of PIR.

There are a number of sectors central to the success of this initiative – primary health care, the state and territory mental health systems, the mental health and broader non-government sector, alcohol and other drug treatment services, and income support services, as well as education, employment and housing supports. PIR will support the multi-service integration and coordination needed to ensure services and supports are matched to individuals’ need (DOH, 2013).

The PIR initiative is underpinned by the following guiding principles:

- **Recovery-oriented and client-focused**: PIR operates under a recovery framework using a personalised approach tailored to address the specific support requirements of an individual and assisting them to maximise their capabilities through social and environmental opportunities. Recovery is not focused on curing illness so much as empowering consumers with the tools to lead meaningful and satisfying lives.

- **Flexible in roll out**: The operation of PIR may look different from one region to the next, as a result of PIR Organisations tailoring their model to best meet the needs of the local target group and existing service delivery systems in the region.

- **Complementary to existing service systems**: PIR Organisations have been established to assist with, not complicate or duplicate, system navigation. PIR does not seek to fully address issues of service availability but focuses on multi-service integration and coordination to deliver better outcomes for the most vulnerable clients.

- **Able to better coordinate systems**: PIR is not intended to offer a new ‘service’ in the traditional sense. Rather, it will coordinate existing services and supports to achieve better client outcomes. PIR provides a ‘support facilitation’ service focusing on building pathways and networks between the sectors, services and supports needed by the target group (DOH, 2013).
Appendix C  Reference List
C.1 REFERENCE LIST


Edwards, A Building common knowledge at the boundaries between professional practices: Relational agency and relational expertise in systems of distributed expertise International Journal of Educational Research 50 (2011) 33–39


Appendix D

Expert Reference Group
<table>
<thead>
<tr>
<th>PREFIX</th>
<th>FIRST NAME</th>
<th>LAST NAME</th>
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<tbody>
<tr>
<td>Ms</td>
<td>Judy</td>
<td>Bentley</td>
<td>Carer representative</td>
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<tr>
<td>Ms</td>
<td>Karen</td>
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<td>Ms</td>
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<td>Meagher AM</td>
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<tr>
<td>Mr</td>
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<td>Meldrum</td>
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