Partners in Recovery Evaluation
Final report

UNSW SYDNEY

Never Stand Still   Art & Social Sciences   Social Policy Research Centre

Prepared for: Central and Eastern Sydney PHN
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Glossary

CALD   Culturally and Linguistically Diverse

CESPHN   Central and Eastern Sydney PHN

HASI   Housing and Accommodation Support Initiative

MDS   Minimum Data Set

MHCC   Mental Health Coordinating Council

NDIS   National Disability Insurance Scheme

NGO   Non-government organisation

PIR   Partners in Recovery

SESLHD   South Eastern Sydney Local Health District

SESPIR   South Eastern Sydney Partners in Recovery

SPRC   Social Policy Research Centre

Executive summary

This is the final report from the process and outcomes evaluation of the South Eastern Sydney Partners in Recovery (SESPIR) program. Partners in Recovery (PIR) is a program that supports people who experience severe and persistent mental illness and have complex support needs, as well as their families, to access services and supports to assist them in their recovery. The program aims to:

- connect the multiple services people may come into contact with to work in a more collaborative and integrated way
- improve systems, address gaps and barriers in support
- improve referral pathways, and
- support service navigation.

The evaluation was conducted between July 2015 and May 2016. It involved multiple methodologies with two primary elements:

1. a **process component**, which described the effectiveness of the PIR program, including structure and governance, stakeholder relationships and collaboration, and consumer/family experiences of receiving services and support, and

2. an **outcomes component**, which described the impact of SESPIR for consumers in areas including quality of life, mental health and community participation.

The evaluation was designed to gather information on the impact and effectiveness of SESPIR from key groups, including consumers, PIR staff, and the broader service system. To this end, the findings are primarily qualitative, and this report should be read in conjunction with other evaluations of PIR.

Characteristics of people participating in PIR

SESPIR reached its intended population of people with severe and persistent mental illness and complex support needs, as indicated by the program's administrative data. The primary source of income for most was the Disability Support Pension or some other income support payment, and more than half had at least one co-existing factor with impact on their health and wellbeing. The highest levels of unmet need at commencement of the program were in the domains of psychological distress, company, accommodation, and daytime activities.

Supporting Aboriginal and Torres Strait Islander people and culturally and linguistically diverse (CALD) communities are priorities for SESPIR. Around 7% of PIR consumers were Aboriginal and/or Torres Strait Islander. Most SESPIR consumers were born in Australia, but a high number of countries of birth were represented. This reflects the cultural and linguistic diversity of the region.

Outcomes for PIR consumers, their family members and friends

All interviewees felt that PIR was effective in facilitating access to the supports and services that a consumer needed and wanted. A main reason for its effectiveness appeared to be that Support Facilitation Agencies were well-known in the community and had long-established links with other local services. Interviews with all stakeholders indicated that it was important to take time to build trust with consumers so they felt more comfortable to engage with the program. Consumers and stakeholders appreciated the person-centred nature of PIR, and Support Facilitators felt this distinguished PIR from other mental health services. Skilled Support Facilitators, who had training and experience in mental health, an ability to connect with people, and compatible cultural and language backgrounds, appeared instrumental to achieving the intended characteristics of PIR support.

When discussing the positive impacts of PIR support for consumers and their families, consumers emphasised emotional and mental health support, while stakeholders mainly talked about housing stability. Other positive impact areas mentioned were social inclusion, physical health, financial assistance, and general increases in quality of life through linking with appropriate supports. There were some challenges in achieving positive outcomes for consumers, such as a shortage of available mental health services and the time limitations of the care coordination model.

Outcomes for services

SESPIR invested significant time and resources in building networks and sector capacity, and interviews with Support Facilitation Agencies and other external services indicated that this was in many respects successful. Some of this was around improving knowledge among service providers about what is available in the area, which was achieved through initiatives such as service mapping, but also the ongoing efforts by SESPIR to enhance collaboration and communication between services at both a practitioner and management level.

Other initiatives, such as the innovation grants and funding for specific projects to address key identified service gaps and build new networks, were especially valued. Stakeholders said the flexible funding available through SESPIR provided a corrective to previous and current funding cuts in the South Eastern Sydney area. The funding enabled the provision of support to people who had not been previously targeted, including those experiencing difficulties with squalor and hoarding or homelessness.

SESPIR was also described by interviewees as promoting a recovery-oriented approach to practice, which represented a shift in organisational culture for some organisations in the area. The flexibility afforded by the PIR model, in which Support Facilitators were not constrained by particularly strict referral criteria or service delivery parameters, was seen to help the Facilitators to work within a recovery-orientated framework. Having a recovery measure embedded within the data collection systems for SESPIR, to measure the effectiveness of working within a recovery-orientated framework, was viewed as something worth considering in the future.

Governance and implementation

The governance structure of SESPIR included a consortium of local service providers and

stakeholders which acted similarly to an advisory committee, with the Lead Agency being responsible for managing the strategic direction and operations of the SESPIR program, and the Support Facilitation Agencies responsible for employing the Support Facilitators and delivering the PIR program. The consortium functioned well, according to interviewees, and the Support Facilitation Agencies contributed wide and diverse expertise to the program. However, this governance structure also had challenges, especially relating to the different organisational processes and cultures of the five agencies. Several interviewees recommended changes to the governance model, including the stipulation of a PIR team leader position with each agency and more streamlined opportunities for agencies to share information.

Support Facilitation Agencies strongly supported the aims of SESPIR but found the role definition for Support Facilitators and the subsequent workload challenging. In providing care coordination, Support Facilitators were required to think creatively and be flexible. Some Support Facilitators felt that the lack of guidelines had made it more challenging to work within a care coordination model. However, interviewees from the Lead Agency felt it was not easy to provide definitive guidelines around support facilitation due to the flexibility of the role.

Another challenge identified by Support Facilitators was managing data input responsibilities alongside the core task of support facilitation. While there was broad recognition of the importance of robust data for planning and evaluation purposes, the software that SESPIR (and some other PIR Organisations) had acquired was described as time-intensive and inefficient. There was wide support for improving the data management process.

The inclusion of organisations in the SESPIR consortium with existing relationships in the local Aboriginal and CALD communities was viewed positively. Being able to provide culturally appropriate support in a consumer's primary language helped to engage consumers with the program and have their needs identified quickly. The CALD-specific organisation had lower targets for referrals than the other Support Facilitation Agencies as they had an increased role in promotion and community engagement activities to facilitate entry into the program for CALD communities.

Conclusion

PIR strengthened the support provided by community mental health and non-government organisation (NGO) services in South Eastern Sydney. Consumers have benefited from individualised assistance and improved access and response from services. The flexibility of brokerage funding has also contributed to the wellbeing of individual consumers.

The participation of Aboriginal and CALD agencies in support facilitation was instrumental in enabling culturally safe and valued support to communities.

SESPIR's sustained efforts at building sector capacity relationships, which sometimes included resourcing of these relationships through innovation grants, brought about new ways of working.

Early activities of mapping gaps and barriers resulted in planning for new services for people to whom services had been unable to provide effective support. In particular, unique and valued contributions by SESPIR were the resources invested to support people who

were experiencing homelessness and sleeping rough, and to address issues associated with hoarding and squalor.

Opportunities for improvement of PIR and its implementation related to managing the demands of data input and monitoring; different understandings of the function and tasks of support facilitation, especially the intensity of individualised support to consumers; and the resource constraints of the service system in supporting consumers facing significant social and economic disadvantage and complexities.

1   Introduction

Central and Eastern Sydney PHN (CESPHN) commissioned the Social Policy Research Centre (SPRC) at UNSW Australia to undertake a process and outcomes evaluation of the South Eastern Sydney Partners in Recovery (SESPIR) program that operates in the Sutherland and St George Local Government Areas. Along with researchers from SPRC, this project partnered with a consumer researcher to design, implement and report on the evaluation.

1.1   Partners in Recovery program overview

The Partners in Recovery (PIR) program is a national initiative, funded through the Australian Government Department of Health, formerly the Department of Health and Ageing, and is delivered through a national network of 48 PIR consortia. Each consortium comprises of local service providers who commit to the implementation of PIR in their local area.

PIR supports people who experience severe and persistent mental illness with complex needs, and their families, to access services and supports to assist them in their recovery. To this end, the program aims to connect the multiple services people may come into contact with to work in a more collaborative and integrated way, and to encourage innovative solutions to ensure people have access to the services and supports they need to sustain optimal health and wellbeing. PIR is an example of an emerging practice focused on service collaboration and community-based service delivery working alongside participants' clinical and community support services (Australian Government Department of Health and Ageing, 2012).

The information outlined in the following subsections has been obtained from the Partners in Recovery (PIR) Program Guidelines for the engagement of PIR Organisations (2012-13 to 2015-16), released by the Australian Government Department of Health and Ageing (2012).

1.1.1   PIR aims

As per the national PIR program guidelines, the program aims to improve the coordination and integration of services, and thereby improve the outcomes for people with severe and persistent mental illness, by:

- facilitating better coordination of clinical and other support and services to deliver 'wrap around' care individually tailored to the person's needs

- strengthening partnerships and building better links between various clinical and community support organisations responsible for delivering services to the PIR target group

- improving referral pathways that facilitate access to the range of services and

supports needed by the PIR target group

- promoting a community based recovery model to underpin all clinical and community support services delivered to people experiencing severe and persistent mental illness with complex needs.

1.1.2   PIR target groups

As per the national PIR program guidelines, the inclusion criteria for being able to access PIR are:

- the consumer has complex needs that require services and supports from multiple agencies

- the consumer has a mental illness that is severe in degree and persistent in duration

- the consumer or their legal guardian has indicated their willingness to participate in PIR

- the consumer requires substantial support and assistance to engage with the various services to meet their needs

- the consumer had recent engagement with services where there was a pressing concern about their mental health and/or related issues (for instance, while in hospital), or

- there are no existing coordination arrangements in place to assist the consumer in accessing the necessary services, or where they are in place, those arrangements have failed, have contributed to the problems experienced by the consumer, and are likely to be addressed by acceptance into PIR.

1.1.3   Role of PIR Organisations

Within each PIR region, which corresponds to areas previously known as Medicare Local geographic regions, a PIR Organisation is contracted by the Australian Government to implement the PIR program. The Government recognises that flexibility in how the PIR program is operationalised in each of the PIR regions is necessary to ensure that each PIR Organisation is able to tailor the model to best suit the needs of the target group and existing service systems in their region.

It is intended that PIR Organisations work at a systems level to proactively encourage collaboration between relevant sectors, services and supports, and support innovative solutions to identified gaps and barriers within the local service sector. They are also required to establish the framework to oversee implementation of the PIR program at a local level, establish governance protocols with consortium partners, actively participate in PIR capacity building projects, and monitor the ongoing effectiveness of the PIR program.

1.2   South Eastern Sydney Partners in Recovery

South Eastern Sydney Partners in Recovery (SESPIR) operates across four Local Government Areas: Sutherland Shire, Hurstville, Kogarah and Rockdale. SESPIR's vision is 'a community where recovery, wellbeing and a satisfying life is possible and achievable for all' (South Eastern Sydney Partners In Recovery, 2015). To achieve the aims of the PIR program,

SESPIR operates through two core functions:

1. **Systems improvement**: identifying gaps and barriers within the local service system; working in partnership with service providers to bridge those gaps; and working with local services to improve access to services.

2. **Support facilitation**: working alongside consumers to link them to the services and support they want; and connecting services to ensure they are integrated and coordinated in their support of the consumer.

1.2.1 Governance

Within SESPIR, the PIR Organisation consists of a consortium of local service providers, with CESPHN assigned the role of Lead Agency. The role of the consortium is to inform and support the initial PIR application and continue to provide input into the program's implementation and administration (South Eastern Sydney Partners In Recovery, n.d). The consortium includes senior representatives from different local stakeholders:

- CESPHN (Lead Agency)

- Support Facilitation Agencies: Aftercare, Neami National, The Benevolent Society, Advance Diversity Services and Kurranulla Aboriginal Corporation

- Consumer representatives

- South Eastern Sydney Local Health District

- UNSW Australia

- St George Community Housing.

CESPHN, as the Lead Agency, is responsible for managing the strategic direction and operations of the SESPIR program. The CESPHN team includes a PIR Program Manager, PIR Project Coordinator, PIR Intake Officer, IT specialist, three PIR Coordinators and an Administration Officer.

The Support Facilitation Agencies are responsible for employing the Support Facilitators and delivering the PIR program within the South Eastern Sydney region. The SESPIR program was implemented using a 'ramp-up' model in that, every six months, either a new Support Facilitation Agency joined the consortium or the number of Support Facilitators was increased. SESPIR began with two Support Facilitation Agencies when the program commenced, and this was expanded to five Agencies. During the evaluation period, one Agency worked specifically with consumers from Aboriginal and Torres Strait Islander backgrounds, another with consumers from culturally and linguistically diverse (CALD) backgrounds.

The PIR Coordinators work alongside an assigned Support Facilitation Agency, supporting practice development and providing mentoring or coaching to individual Support Facilitators. Through this process, PIR Coordinators work with each individual Support Facilitator to identify areas of skill improvement and possible training needs. Over time, the Coordinators' role changed, and they now work with team managers to review and evaluate progress against key performance indicators (KPIs), and to support escalation of issues to be resolved on a regional level. The Support Facilitation Agencies remain the line managers for

each Support Facilitator and are responsible for performance management and for the day-to-day operational needs of their PIR team.

1.2.2 Care coordination

Support Facilitators are employed to work directly with consumers, as well as people within their support network, to assist in identifying and prioritising what is important to them in their recovery, and assisting them to navigate the care system. Within SESPIR, Support Facilitators work within a care coordination model, which involves a focus on enhancing communication and partnerships between services, thus ensuring they can work together for the benefit of the consumer. This is achieved through:

- receiving and reviewing referrals; conducting an assessment of a consumer's needs; coordinating community and clinical supports; developing, monitoring and reviewing PIR action plans; and collecting data for monitoring, reporting and evaluation purposes

- playing a role in identifying service gaps; building partnerships, pathways and networks of services and supports for consumers, their families and carers; and working closely with existing service providers to ensure service functions and collaborative relationships are maintained.

1.2.3 Flexible funding

PIR Organisations are provided with a limited amount of flexible funding that can be used in a responsive manner to purchase services and supports when consumers' needs cannot be met within the existing service system. PIR flexible funding is not attached to an individual consumer but can be pooled by the PIR Organisation and used to build system capacity at the regional level to benefit PIR consumers.

Within SESPIR, individual flexible funding is provided, which amounted to a maximum of $800 per consumer per calendar year during the evaluation period. At this individual level, the flexible funding can be used to ensure that access to necessary services can be met in the short term. The flexible funding guidelines stress the importance of accessing available services in the area whenever possible, rather than building a reliance on flexible funding. The flexible funding can be used for:

- medical assistance, such as purchasing medication while awaiting a health care card or paying for private medical services when the need is immediate and cannot be met through the public health system

- short-term accommodation assistance, such as paying bond or rent while rental assistance arrangements are being finalised, and

- ad hoc items, such as purchasing financial management services, purchasing essential household items or assisting with essential transport costs.

At a regional level, flexible funding is used to address identified service gaps. One of the initial activities that SESPIR undertook when the PIR program was implemented was to complete a comprehensive analysis of the gaps and barriers within the region's service system (refer to Section 1.2.4). The PIR Lead Agency also coordinated an Innovation Grants Program, as well as provided funding for other key projects, using pooled flexible funding.

1.2.4 Priority areas for SESPIR

When the PIR program was first implemented within South Eastern Sydney, SESPIR undertook a comprehensive analysis of the gaps and barriers within the region's service system. As part of the analysis, the Lead Agency reviewed the National Report Card on Mental Health and Suicide Prevention (National Mental Health Commission, 2013), reviewed consumers' case notes and needs assessments for potential service gaps, periodically surveyed the SESPIR Support Facilitators and stakeholders in the region to determine what the main barriers and challenges were for the consumers, and built mechanisms into the regular reporting framework to receive service gap information. The Lead Agency then facilitated action working parties involving the SESPIR consortium and Support Facilitation Agencies to map out the factors contributing to service gaps and/or barriers, and to identify priorities for action within the region. The 10 priority areas identified during this process are (South Eastern Sydney Partners in Recovery, 2014):

- Increase opportunities for social inclusion and participation in the community.
- Enhance access to employment, education and training.
- Improve access to affordable and social housing as well as emergency accommodation.
- Develop the capacity of the community to address squalor and hoarding.
- Improve access to:
    - Psychiatry across the public and private sectors
    - Psychological services that can meet long term support needs
    - General Practitioners
    - Community-based support services.
- Develop the capacity of the sector to support people experiencing Complex PTSD or personality disorders.
- Grow the capacity of the sector to provide culturally appropriate services to:
    - Aboriginal and Torres Strait Islander communities and individuals
    - CALD communities and individuals.
- Develop a 'No Wrong Door' approach to mental health and community services in the region.
- Increase access to healthy living supports.
- Improve integration of mental health and drug and alcohol supports.

2 Evaluation methodology

This evaluation was conducted between July 2015 and May 2016. It involved a process and outcomes evaluation component. The process evaluation was intended to determine the effectiveness of the PIR program including structure and governance, stakeholder relationships and collaboration, and consumer/family experiences of receiving services and support. The outcomes evaluation was intended to describe the impact of PIR for consumers in areas including quality of life, mental health and community participation.

This evaluation was informed by a review of program documentation and the collection and analysis of data from a range of sources. Furthermore, an external consumer researcher was employed to use his experience to assist in informing the research process where applicable.

The evaluation methodology consisted of the following components:

- employing a consumer researcher to inform the work
- reviewing program documentation including program policy documents
- analysing program data
- interviewing consumers, family members and/or friends, service providers and other stakeholders
- analysing and triangulating the data.

2.1 Evaluation questions

The evaluation questions, in relation to the PIR objectives, are outlined in Table 1.

Table 1 Evaluation questions

PIR objective	Evaluation question (process)	Evaluation question (outcomes)
Promoting a community based recovery model	Does PIR facilitate support based on the principles of community based recovery?	How effective are PIR structure and governance in meeting the needs of people with severe and persistent mental illness and complex needs, and their families and carers?
		Does PIR reflect the principles of recovery oriented mental health practice?
Strengthening and supporting partnerships in the region	Does the PIR model strengthen and support partnerships in South Eastern Sydney?	How effective has PIR been in strengthening and supporting partnerships in the region?

PIR objective	Evaluation question (process)	Evaluation question (outcomes)
Facilitating the coordination and integration of services so they are flexible and responsive to a person's needs over time	How, and to what extent, is PIR enhancing service integration and developing new programs?	Is PIR enabling consumers to meet their goals, and does it support social inclusion and participation?
Improving access and referral pathways into supports that people need and want	Is PIR accessible to different population groups? (e.g. CALD, Aboriginal people, different age groups, people who are experiencing homelessness or at risk of experiencing homelessness)	Is PIR developing sector capacity to meet identified community needs?

Table 2 summarises how the components of the evaluation fulfil the research objectives and research questions.

Table 2 Evaluation questions and data sources

		Program Data	Consumer interviews	Carer interviews	Stakeholder focus groups and interviews
Outcomes	How effective are PIR structure and governance in meeting the needs of people with severe and persistent mental illness and complex needs, and their families and carers?	✓	✓	✓	✓
	Does PIR reflect the principles of recovery oriented mental health practice?		✓	✓	✓
	How effective is PIR in strengthening and supporting partnerships in South Eastern Sydney?			✓	✓
	Is PIR enabling consumers to meet their goals, and does it support social inclusion and participation?		✓	✓	✓
	Is PIR developing sector capacity to meet identified community needs?				✓
Process	Does PIR support its intended recipients?	✓			✓
	Is PIR accessible to different population groups? (e.g. CALD, Aboriginal people, different age groups, people who are experiencing or at risk of experiencing homelessness)	✓	✓	✓	✓
	Does the PIR model strengthen and support partnerships in South Eastern Sydney?				✓
	How and to what extent is PIR enhancing service integration and developing new programs?				✓

2.2 Consumer researcher

Evidence is emerging about the positive ways in which consumers can contribute to research and evaluation (Carrick, Mitchell, & Lloyd, 2001; Oliver et al., 2001; Trivedi & Wykes, 2002). In recent years, service providers, government agencies and other funding bodies have emphasised the importance of actively involving consumers in research and evaluation (Telford & Faulkner, 2004; Thornicroft & Tansella, 2005; Trivedi & Wykes, 2002). Proponents argue this trend has now come to be seen as best practice (Grayson et al., 2013) because it 'adds value' to the research project (Kara, 2013) while others state it as 'essential' and 'necessary' (Thornicroft & Tansella, 2005).

The benefits of having consumers actively involved touch on a broad range of domains, including those in Table 3.

Table 3 Benefits of consumer involvement in research

For the research body/group working with consumer researchers	For consumers themselves	For society
Accessing an untapped community resource (Viney, Oades, Malins, Strang, & Eman, 2004)	Improving their recovery and mastery of life (Viney et al., 2004)	Improving consumer outcomes (Viney et al., 2004)
Giving credibility to the research project being conducted	Feeling valued and contributing to society	Breaking down stigma
Funding agencies more likely to fund a project knowing people with lived experience are part of the process (National Institue for Health Research, 2014)	Modelling to other consumers	Enhancing the 'democratic' process with public involvement being an intrinsic part of democracy, citizenship, public accountability and transparency (Kitcher, 2003)
Improved research processes and data outcomes (Morgan, 2006)	Providing a route to influence change on issues that concern consumers most	Establishing a 'well-ordered' science, with consumers guiding research preferences to avoid a 'tyranny of ignorance' that is caused by academics, industry and government bodies not deliberating with people with lived experience on what matters to them (Kitcher, 2003)
Increasing recruitment and participation rates (Victorian Government Department of Human Services, 2005)	Feeling a sense of equality	
Increasing sense of ownership of the project resulting in enhanced data collection and its relevance and reliability (Victorian Government Department of Human Services, 2005)	Gaining new knowledge, skills, consumer support and friendships (Viney et al., 2004)	
Enhanced research validity, because sometimes consumers are the only possible source for valid information in certain research areas (Thornicroft & Tansella, 2005)		
Decolonising methodologies and reducing power differentials (Viney et al., 2004, p14)		

As a result of this growing body of evidence, SPRC were funded by CESPHN to employ a consumer researcher who contributed to the research team in research design, data collection and analysis.

2.3 Review of program documentation

To better understand the program, its objectives, partnership arrangements and governance structure, the research team reviewed a small number of key program policy documents and other related documents that have informed the research design and approach. The documents include those referred to in Section 1.

2.4 Quantitative data

Data on client demographics and needs is presented to provide contextual information on the program. SESPIR provided program data extracted from the PIR Client Minimum Data Set to the SPRC research team in de-identified format.

2.5 Qualitative data

Interviews were conducted with SESPIR program participants, their family members and/or friends, PIR staff, consortium partners and key stakeholders involved in the PIR program.

2.5.1 Consumer interviews

The SPRC research team interviewed consumers who were participating in the program and those who had left the program, including a couple who exited early because the program was not meeting their needs. Interviews with consumers covered their experience in receiving PIR services and their assessment of its impact on their lives.

The interviews focused on the experiences and outcomes of SESPIR, including:

- referral/introduction to PIR
- relationship with Support Facilitator
- goal setting/recovery orientation of support
- types of support and services received
- perceived benefits (e.g. quality of life, access to services, community participation)
- gaps/recommendations for change.

The interview guide is outlined in Appendix A. Consumer interviews were conducted by the SPRC research team and were held according to the participant's preferences, either face-to-face in locations of the participants' choosing, or on the phone.

2.5.2 Interviews with family and friends

Interviews with the consumers' family members and/or friends focused on better understanding the experience of the consumer with PIR and whether families felt supported and connected to their local communities. The interview guide is outlined in Appendix B. Like the consumer interviews, family member/friend interviews were conducted by the SPRC

research team and were held in a location the participant chose.

Family members/friends who meet the following inclusion criteria were invited to participate in interviews:

- aged 18 years and over

- have a family member or friend who is in, or who has left, the PIR program.

2.5.3 Stakeholder focus groups and interviews

Interviews and/or focus groups with stakeholders assisted in identifying how processes and governance arrangements impacted on the effectiveness of the PIR program and how any issues could be addressed. Topics included:

- implementation of PIR, e.g. training and policy implementation

- delivering recovery-oriented support

- inter-agency collaboration and referral processes

- reporting, governance and resourcing

- system capacity building.

The interview/focus group guide is outlined in Appendix C. Stakeholder interviews and focus groups were conducted by the SPRC research team and held in a location both parties agreed upon.

2.6 Sample and recruitment

The number of people from different groups who participated in interviews or focus groups is outlined in Table 4.

Table 4 Sample for interviews and focus groups

	Number
Lead Agency	6
Support Facilitation Agencies (Support Facilitators and managers)	20
Consortium members	3
Other stakeholders	7
Consumers	24
Family members	2
Total	62

Stakeholder interviewees were recruited directly by the SPRC research team, following initial recommendations from SESPIR. Interviewees included line managers from all five Support Facilitation Agencies, who also organised for their Support Facilitators to take part in interviews or focus groups.

Consumer and family recruitment occurred via two pathways: through the Support Facilitators, who approached consumers directly and, if they agreed, passed on their

contact details to the SPRC research team; and via a mail-out from SESPIR to all consumers who were invited to contact the SPRC research team directly should they wish to take part. Support Facilitators were asked to nominate any consumers for whom it would not be appropriate to send a letter and these were removed from the mail-out. Fourteen consumers were recruited through Support Facilitators and 12 through the mail-out. Consumers received a shopping voucher as reimbursement for their time and expenses in taking part in the interview.

Few family members and friends participated in the interviews. They were approached for interviews only if a consumer gave permission for the researchers to do so. Many consumers who took part in the interviews lived by themselves and said they had no family members or friends whom they were close to who could talk about the consumer's experience with PIR, or said that they have not told anyone about their recovery journey through PIR and therefore could not offer anyone to take part in the family members or friends interviews.

2.7 Ethical considerations

Human research activities are governed by the principles outlined in the National Statement on Ethical Conduct in Research Involving Humans (National Health and Medical Research Council, 2007). The Research Code of Conduct sets out the obligations on all UNSW Australia researchers, staff and students to be aware of the ethical framework governing research at the University and to comply with institutional and regulatory requirements. Ethics approval for this project was provided by South Eastern Sydney Local Health District Human Research Ethics Committee (Ref no. HREC/15/POW/368). One of the Support Facilitation Agencies, Neami National, also required a Participation Agreement which was granted.

2.8 Limitations

The evaluation was designed to gather information on the impact and effectiveness of SESPIR from key groups, including consumers, PIR staff and the broader service network. To this end, the findings are primarily qualitative and this report should be read in conjunction with other evaluation studies of PIR.

Participation in the study was voluntary and may not be representative of all PIR consumers and service providers. We attempted to minimise selection bias by recruiting consumers by mail-out but this was not random selection.

3 Characteristics of consumers who participated in Partners in Recovery

3.1 Demographic profile

3.1.1 Number of consumers who registered to participate in PIR

According to PIR program data, as at 24 March 2016, a total of 494 registered consumers had participated in SESPIR, and 230 were currently in the program.[1]

Active	201
Active: monitoring only*	32
Exited	261

Source: MDS 24 March 2016

* These are PIR consumers for whom effective coordination and support arrangements are established by the PIR Organisation but where relatively low-intensity monitoring of arrangements is required to ensure they can be sustained. The consumer remains registered with the PIR Organisation until they no longer need specific PIR Organisation assistance, or their situation changes in a way that requires them to move back to 'Active' client status.

The reason for most people's exiting the program was 'no longer needs assistance' (147). The other most frequent reasons were 'client can no longer be contacted' (51) and 'consumer terminated service' (23). Smaller numbers exited for other reasons, including that they moved out of the area, were referred to another PIR agency, or found that their needs had changed and the agency could no longer assist.

3.1.2 Consumer characteristics

Gender

Around 56% of current and exited PIR consumers were female, 44% were male, and one consumer identified as intersex.

Gender	n
Female	279
Male	214
Intersex	1

Source: MDS 24 March 2016

Age

Around 50% of current and exited PIR consumers were aged between 40 and 60 in March 2016. Five were under 20 years old, and 11 over 70.

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1   The total number of consumers participating in PIR was higher. The data in this section relates to those consumers who provided initial consent to participate in the program.

Age range	n
<20	5
21-30	53
31-40	102
41-50	124
51-60	128
61-70	60
71-80	11
Not stated	11

Source: MDS 24 March 2016

Aboriginal and Torres Strait Islander

Thirty-three people, or around 7% of PIR consumers, identified as Aboriginal and/or Torres Strait Islander.

Aboriginal and/or Torres Strait Islander	33
Neither Aboriginal or Torres Strait Islander	394
Not stated	67

Source: MDS 24 March 2016

Education

Information on education shows a diversity of attainment levels; however data was available for only around 40% of consumers so these findings are not reported in detail here.

Country of birth

Around 80% of PIR consumers were born in Australia. Of consumers born in other countries, the highest numbers were born in Lebanon and China, however it is notable that no one cultural or language group is significantly represented. People from around 40 countries in total are, or have been, SESPIR consumers.

Country of birth	n
Australia	387
China	12
Lebanon	10
Egypt	8
United Kingdom	7
NZ	6
Philippines, Hungary, Greece, Bosnia and Herzegovina (4 each) (total)	16
Chile	3
American Samoa, Brazil, Germany, Hong Kong, Iran, Macedonia, Russian Fed, South Africa, United States (2 each)	18
Argentina, Bahrain, Bangladesh, Canada, Ethiopia, Fiji, Indonesia, Italy, Jordan, Democratic People's Republic of Korea, Kuwait, Malaysia, Mauritius, Portugal, Sudan, Tonga, Turkey, Ukraine, Serbia, Yugoslavia (1 each)	20
Not stated	7

Source: MDS 24 March 2016

Income

The primary source of cash income for consumers was the Disability Support Pension (n=241), or another pension or benefit (n=124). Paid employment was the primary source of income for 33 people, and superannuation and investments for 23 people. Small numbers received compensation payments or no income.

Housing

At the time of entry to the program, the majority of PIR consumers (around 64%) lived in a private residence. Twenty-seven people were experiencing homelessness, including nine accommodated in a refuge, shelter or boarding house. It is likely that homelessness is under-reported in this data due to data input errors. A proportion of the people classed as 'other accommodation' category are thought to be experiencing homelessness. In addition, feedback from SESPIR is that people experiencing homelessness are less likely to be registered PIR consumers, so a large number of people experiencing homelessness are not captured in this 'registered only' data.

More than 20% of consumers lived in 'other accommodation' or did not state their housing arrangements.

Accommodation type	n
Private residence	317
Other accommodation, not elsewhere classified[a]	130
Homelessness[b]	27
Supported accommodation[c]	9
Residential aged care service	6
Prison/remand centre/youth training centre	5

[a] Includes not stated.

[b] Includes boarding house (n=6) and shelter/refuge (n=3).

[c] Includes specialised mental health community-based residential support service; other supported accommodation.

Source: MDS 24 March 2016

3.2 Diagnosis

The PIR Minimum Data Set (MDS) records primary mental health diagnosis. The most frequently recorded diagnosis was mood (affective) disorders. This category describes disorders in which the fundamental disturbance is a change in affect or mood to depression (with or without associated anxiety) or to elation (World Health Organization, 1992). The second largest category was 'schizophrenia, schizotypal and delusional disorders'.

Primary diagnosis	n
Schizophrenia, schizotypal and delusional disorders	105
Mood (affective) disorders	243
Neurotic, stress-related and somatoform disorders	69
Disorders of adult personality and behaviour	27
Other[a]	9
Not stated	44

[a] Includes behavioural and emotional disorders with onset usually occurring in childhood and adolescence; organic, including symptomatic, mental disorders; mental and behavioural disorders due to psychoactive substance use; disorders of psychological development; unspecified mental disorder. More than one diagnosis was recorded in some cases so total is greater than 494.

Source: MDS 24 March 2016

In addition to primary diagnosis, around half of the consumers had co-existing physical health issues; and around a third experienced problematic alcohol or other drug use.

Co-existing factor	n
Significant physical health issues	269
Alcohol or other drug use	161
Intellectual disability	69
Physical disability	61
Acquired brain injury	24
Sensory/speech disability	11
Dementia	6

Source: MDS 24 March 2016. Based on information provided by the referring agency, the client and/or carer that specify any apparent co-existing factors impacting on the client's mental illness. More than one co-existing factor was recorded in some cases so total is greater than 494.

3.3   Support needs

The Camberwell Assessment of Needs Short Appraisal Schedule (CANSAS) is the standard needs assessment measure for use at all collection occasions in the PIR Program. Developed by the Royal College of Psychiatrists in London (Slade, Beck, Bindman, Thornicroft, & Wright, 1999), the CANSAS is a comprehensive needs assessment and outcome tool that is widely used in both Australian and overseas settings. It assesses need in 22 areas: accommodation, food, self-care, looking after the home, daytime activities, physical health, psychotic symptoms, information about condition and treatment, psychological distress, safety to self and others, alcohol, (misuse of) drugs, company, intimate relationships, sexual expression, child care, access to a telephone, education, transport, budgeting and benefits. Multiple versions of the tool exist, with the CANSAS being the shorter version.

An additional three domains have been added to the CANSAS, specifically for PIR purposes: employment and volunteering, cultural and spiritual, and other services.

For each topic, examples are given in the CANSAS for what constitutes a need, and the presence of a need is rated on a 3-point scale:

- no problem/need

- met need, or no/moderate problem because of continuing intervention
- unmet need, or current serious problem

(Slade, Phelan, Thornicroft, & Parkman, 1996).

The tool recognises the subjective nature of 'need' and allows information to be gathered from the professional, the individual they are supporting, and that individual's carer; the purpose of the assessment is that all viewpoints can then inform a care plan (Institute of Psychiatry Psychology & Neuroscience, n.d.).

There are CANSAS assessments at different points in time: at entry to and exit from the program, as well as every six months while in the program. Each time, three separate CANSAS assessments are completed: by a staff member, a consumer, and a carer. (A small number (n=8) of carer-completed CANSAS assessments are included in the SESPIR data, and these are not included here.) The results of the CANSAS provide a baseline measure of level of need, for charting changes over time, and for identifying the range of domains for which an individual is likely to require further assessment and (possibly) support. The consumer-rated and staff-rated scores for met need, unmet need, and total need are at Appendix D.

The highest levels of unmet need at commencement of the program were in the domains of psychological distress, company, accommodation, and daytime activities (Appendix D). Participating in PIR is associated with a decline in the levels of unmet need for consumers in all domains, as rated by both consumers and staff. For each CANSAS domain, there was a decline over time in the number of consumers with an unmet and total need. There was a significant decline over time in the average total need and unmet need, as rated by consumers[2] and staff[3]. This is potentially a positive finding for the effectiveness of PIR, because it indicates that participating in PIR could be associated with having fewer serious problems and unmet needs. However there are substantive limits to the use of CANSAS data as outcome measures. Research carried out by Slade and colleagues (1999) found that CANSAS should not be used as an outcome measure at the individual level. Other limitations on the CANSAS as an outcomes measure have been identified by Wiersma (2008) and Wennström and Wiesel (2006). In addition, data for both initial (commencing PIR) and close (exiting PIR) CANSAS scores were not available for all consumers.

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2 t-Test: Paired Two Sample for Means. Client-rated initial total need (M=49.64), close total need (M=38.16) score; t(24)=7.33, p=1.4. Client-rated initial unmet need (M=32.28), close unmet need (M=13.28); t(24)=7.17; p=1.71.
3 t-Test: Paired Two Sample for Means. Staff-rated initial total need (M=89.28), close total need (M=77.52) score, t(24)=7.5, p=1.7. Staff-rated initial unmet need (M=64.2), close unmet need (M=35.92): t(24)=7.5; p=1.71.

This section summarises outcomes of PIR for its consumers, their families and friends. It is based on the evaluation interviews and includes the viewpoints of consumers and families, as well as those of the Support Facilitation Agencies and other stakeholders. The interviewees talked mainly about outcomes for consumers, rarely about families or friends. Their comments concerned the characteristics of PIR support, how PIR facilitated consumers' access to supports and services, and the impacts of PIR support on consumers.

4.1 Characteristics of Partners in Recovery support

As described in Section 1, PIR works from a recovery-oriented framework, aiming to provide support that is person-centred, comprehensive and collaborative. Interviewees who commented on these aspects of the program unanimously felt that they had been implemented and were contributing to positive outcomes for consumers, their families and friends.

Consumers gave numerous examples of the types of support and service facilitation they had received, all relevant to them personally and responding to their individual needs. PIR support also included advocacy, such as when Support Facilitators helped consumers with banking issues or unreliable accommodation support services. A few consumer testaments highlight the characteristics of PIR support:

> I've been with this service for about a month, and the service they provide was getting me into a course so I can fill up my days better and I did a recovery wellbeing course that goes for four weeks and I've completed that. […] It's educational and helped me understand more about how to deal with friends and what to do in situations with relationships and stuff like that. My [support facilitator] is helping me getting activities, groups and just basically anything that I need help with, like writing up letters – stuff like that. (Consumer)

> [The Support Facilitator] already called the doctor for my kidney, and she already paid the doctor for my teeth, and she already wrote a report about my story for housing. (Consumer)

> [The Support Facilitator] sorted [the accommodation support providers] out with the money because they were charging me $300 a month for a lady to come for one and a half hours every week. And I thought that was a bit heavy, so I complained and [the Support Facilitator] complained and they knocked it down to about $140 a month. (Consumer)

Support Facilitation Agencies saw the person-centred nature of PIR as its main

characteristic. PIR, as they said, 'put the consumer in the middle of the conversation'. Support Facilitators felt this aspect distinguished PIR from other mental health services, which they described as often clinical and prescriptive. They reported 'the most common feedback from consumers' was that PIR was the first service that made them feel listened to and asked what they wanted. Consumers confirmed this in the interviews. For example, one person said:

> Yes, [the Support Facilitator] listened and really listened. It wasn't just doing her job and just saying 'yeah, yeah, whatever'… She tried to understand. (Consumer)

Interviewees felt that PIR's person-centred approach included flexibility and responsiveness (see also 4.2). For example, consumers described how they met their Support Facilitators at a place of their choosing, be it at a coffee shop, a park or the consumer's home:

> We met face to face every fortnight, in a public space, because at this time I was having to move because I was being abused by my housemate. So I didn't want to go home. (Consumer)

Consumers particularly appreciated PIR's flexible funds (see Section 1.2.3) and the short-term, practical support they provided. Examples included paying private psychiatrist fees, medical procedures or rental arrears; buying essential clothing items, for example for job interviews or if the person experienced homelessness; or arranging occasional child care. The importance of flexible funds was echoed in the stakeholder interviews, where Support Facilitation Agencies highly valued the ability to provide immediate, individualised support (see also 4.3).

From the consumers' point of view, a person-centred approach also included ready availability of the Support Facilitator. Most consumers who took part in the interviews emphasised that they could call on their Support Facilitator when needed and appreciated the Support Facilitator's commitment. A few said they would prefer more meetings and more intensive support (see 4.2), although this was outside the care coordination model of PIR.

Support Facilitators and managers pointed out that a person-centred approach sometimes meant a longer-term involvement with the consumer, especially when they needed time to build trust and a relationship before they could work with a consumer to address their needs, or when Support Facilitators changed and trust had to be re-established. However, some Support Facilitators perceived that the care coordination model put them under pressure to exit consumers and take in new referrals. Likewise, a consumer said:

> At the first interview I had with [the Support Facilitator], she was talking about exit. And I thought, I am getting abandoned.

Consumers described how PIR provided comprehensive, holistic support, by involving a variety of services according to the person's support need. For example:

> I was kind of stuck in Sydney and didn't have any money to come back home. So they helped me with rego and to get services to help move me up [to my home town], and even when I was in Sydney they found knitting groups and stuff I could join. (Consumer)

> [The Support Facilitator] got me a pass for a local aquatic centre, which is fantastic because I couldn't afford that otherwise. Also she tried to arrange for me to do some

volunteer work with horses, which is something I'd love to do. The other thing she has been trying to do is also to see if there's any courses I would like to do, to try and increase my chances of employment. I recently did a one-day creative writing course and that was fantastic. (Consumer)

Support Facilitation Agencies talked about having to be creative in working out which services would be most suitable to support a consumer. They gave several examples of consumers who had a mental illness and were also experiencing homelessness. Through PIR's holistic approach, the consumers found stable accommodation, which gave them the basis from which to work towards recovery, to access appropriate services and generally, as one stakeholder put it, 'start to try and live a life that's beyond just survival'.

According to interviewees from all groups, collaboration and integration among services were also crucial to achieving outcomes for consumers. Consumers described case conferencing, where they met with their Support Facilitator and case managers from other services, for example Mental Health, to discuss support strategies. Support Facilitators described how they tried to get different services working together and using their resources to help each other. They felt that case conferencing was useful for the consumers as well, because the consumers learned who to approach for which issue.

Some Support Facilitators pointed out how valuable they found the communities of practice meetings with the other Support Facilitators, where they workshopped options for supporting individual consumers. Discussions at these meetings also increased their knowledge of available support options, both inside and outside the mental health sector. They considered such knowledge crucial to linking consumers with appropriate services. For example, a Support Facilitator could then suggest to a consumer's case manager to refer the consumer to the Housing and Accommodation Support Initiative (HASI) to fill a gap in the person's support.

Collaboration with the consumer's family and friends is another aspect of PIR's recovery-oriented approach. A family member who participated in the interview confirmed that their facilitator was 'very, very helpful', by being available to speak on the phone when needed and by guiding and supporting the family member. One Support Facilitator said why they always involved the family or friends:

> We are looking at the big picture because if the carer's needs aren't met then it's a ricochet back onto the consumer. (Support Facilitation Agency stakeholder)

An interviewee from a Support Facilitation Agency pointed out that, in her view, the intended characteristics of PIR support could only be achieved with skilled Support Facilitators, who had training and experience working in mental health and the ability to connect with people:

> It's so crucial to have the right worker, I can't reiterate that enough […] You can't have people in the wrong job, not with mental health, it's too complex. (Support Facilitation Agency stakeholder)

In addition, it appears that cultural and language barriers could be overcome by matching consumers with Support Facilitators of similar backgrounds. A consumer who was a recent migrant said through an interpreter:

> When you are with a service provider who is speaking the same language as you, you

don't need to find the right words or how to structure the sentence. It's easier to talk, it's easier to understand, easier to listen and easier to read between the lines. (Consumer)

In a few cases consumers said they were disappointed with PIR – it had not delivered the intensive, one-on-one psychological support that they needed, or it had not yet provided them with housing. This may be because, as one Support Facilitation Agency manager reported, referrals into PIR were not always suitable; the manager felt that some referring agencies did not have a good understanding of the program:

All they know is that it's kind of mental-health related, so they'll refer to us if they have a client with anything to do with mental health that's a bit in the too-hard basket. (Support Facilitator Agency stakeholder)

The manager said this also impacted negatively on consumers, who may have developed expectations of PIR which it could not fulfil. The experience indicates that PIR would need to continue its efforts to make the program known in the local mental health service sector, and that Support Facilitators need to clarify with consumers the approach and limitations of PIR and the wider service system more effectively.

4.2 Facilitating access to supports and services

Most interviewees felt that PIR was effective in facilitating access to the supports and services that a consumer needed and wanted. A typical consumer response in the interviews was:

Yeah, I feel very good about the program. There is a wide range of services that they can look into for me and it's just great help. (Consumer)

People talked about referrals into PIR, about building trust between consumers and Support Facilitators, about linking consumers with services, and about issues specific to consumers from Aboriginal and Torres Strait Islander and CALD backgrounds. Regarding the first of these topics, consumers generally had good experiences with entering PIR. They said referrals happened easily through other agencies, or they made self-referrals after they had heard about the program through their private networks. Consumers appreciated the quick access to PIR and its supports, without any long waiting lists:

I called the number and […] then they called me the next day and I explained my situation. Then straight away, a case worker, this lady, was assigned to me. She rang me. She said, "Okay, what's happening? What's going on?" I told her all what was going on and I had nowhere to live and everything else. The next morning we had a meeting. Everything was sorted. Well, we started finding me accommodation, first of all, and then clothes […]. I couldn't have done it on my own, put it that way. (Consumer)

Once consumers had been referred to PIR, Support Facilitators endeavoured to develop trust and engage the person with the program. Often this appeared to be successful. Several consumers spoke about the high level of trust they had developed with Support Facilitators, for example:

I can trust them, I can talk with them, and they will help me. (Consumer)

I know that there's someone there if I get stuck and I can talk to them. (Consumer)

I always tell them everything. (Consumer)

Some Support Facilitators pointed out how important it was to take time to build trust with people so they became ready to engage with the program or with a particular Support Facilitator. This applied particularly to people who were disengaged from services, those from different culture and language backgrounds, Aboriginal and Torres Strait Islander people, and others who were marginalised, for example people experiencing homelessness. One Support Facilitator provided an example of a consumer who started talking about herself only at their third meeting; once trust had been established after several weeks, the consumer agreed to the Support Facilitator liaising with her doctor and other service providers, thus helping her access the supports she needed and wanted. Building trust with people experiencing homelessness could sometimes be a particularly long process because they had no regular address and often no phone, so Support Facilitators invested time finding them and building trust and rapport.

Interviewees felt that PIR was effective in linking people with suitable services, which is also reflected in the consumer- and staff-reported assessment of needs described in the previous section (CANSAS, see Section 3.3). Consumers and family members described how PIR had 'those connections that [could] do wonders' and 'the service couldn't do any more to help me than what they have'. Support Facilitators reached out to people to inform them about suitable services even before they had joined the program. This might happen at established services, for example a breakfast hub, or when community organisations alerted Support Facilitators to people who they thought might benefit from more support, such as people sleeping rough. Stakeholders said that effective referrals from within the program occurred because the Support Facilitation Agencies involved in PIR were well-known in the community and had long-established links with other local services.

The Agencies' knowledge of the local service system appeared to help link consumers with support that was sustainable. For example, stakeholders said when PIR Support Facilitators tried to meet the housing needs of consumers, their linkages and ongoing communication with community housing providers helped them find suitable accommodation, as well as additional support to maintain tenancies, for example HASI packages or tenancy support programs.

People from all groups interviewed – consumers as well as staff from the Lead Agency, Support Facilitation Agencies and external agencies – raised issues specific to CALD communities, such as a high prevalence of post-traumatic stress, cultural differences, and supporting consumers who did not have the same entitlements to services as Australian citizens. Some statements from consumers:

For example in my country, nobody cares anything about your feeling. For example when you go outside, all the time you are scared if your hair is outside, there is some police in the street, they take you and punish you. [In PIR] I'm not alone, and if I need to know anything about this country, they can help me. They help people to find themselves first, and what they can do here, how they can live. (Consumer)

When I came here and when I start to connect with [PIR], I feel more confident. I have two cousins here, but they can't help me because they haven't any idea of how this country can help them. (Consumer)

Supporting CALD communities posed a unique challenge for Support Facilitators, but they felt that PIR's flexible approach helped. Stakeholders expressed strong support for including Aboriginal and Torres Strait Islander and CALD organisations within SESPIR. They said that PIR's structure could build on the strengths of those organisations and make 'everything much quicker' and more effective as they engaged and supported consumers at the point of entry. Stakeholders stated that stigma about mental health issues was greater among Aboriginal and Torres Strait Islander and CALD populations than among others. Therefore they had to adapt their approach, for example avoid the term 'mental illness' and instead talk about 'wellbeing'.

4.3   Impacts of Partners in Recovery support

When discussing the positive impacts of PIR support for consumers and their families, consumers emphasised emotional and mental health support, while stakeholders mainly talked about housing stability. Other impact areas mentioned were social inclusion, physical health, practical and financial support, and general increases in quality of life through linking with appropriate supports. See also Section 3.3 for a summary of CANSAS data collected in the project, which indicates that participating in PIR might be associated with having fewer unmet needs.

Many consumers felt their emotional wellbeing and mental health had improved since joining PIR. For example:

> Now that I am with PIR and studying, that helps my lack of concentration and is just something to wake up to. I have a purpose and that helps me. (Consumer)

> I can say mainly the biggest help was you had someone to support you, to listen to you and be there for you in those moments. […] Apart from those emotional conversations that we had, she made me aware of my rights as a woman. (Consumer)

> I guess [PIR] does keep me out of hospital, because I feel there's hope and that my life is going to improve. Without feeling that hope, I'm ten times worse, mentally. (Consumer)

Confirming this point, external stakeholders observed that consumers' hospital admissions had reduced because PIR was able to arrange support as soon as people started becoming unwell. Support Facilitators said providing emotional support and listening to the consumer was important for establishing and maintaining trust, which they saw as a basis for linking consumers into sustainable support. Several Support Facilitators said they regularly spent time providing emotional support to consumers, although this was not measured as an outcome:

> I could be on the phone for 45 minutes with a consumer just because they're having a crap day and they're going through a really dark period, just having that chat with them to bring them back to a safe place, there's no way you can measure that. (Support Facilitation Agency stakeholder)

Consumers appreciated that their Support Facilitator was available to chat whenever necessary (also see Section 4.2), and said this had helped them to achieve their goals.

Regarding housing, consumers talked about how PIR had supported them to access

suitable, affordable accommodation:

> I'm still renting, but [the Support Facilitator] is trying to get me into [social housing]. She came with me to the housing commission, and she helped me with the meeting there. (Consumer)

> [The Support Facilitator] helped me look for a place by printing off places, rental places. (Consumer)

> Because I was looking to move, they helped me put together a really good application, they gave me a great reference because they know I've been a good tenant where I am, so they backed that up in writing. It was a support mechanism for when I was looking for new places. (Consumer)

Stakeholder interviewees also gave examples of how PIR had helped consumers to access sustainable housing. For example, external stakeholders regarded PIR's Sutherland Street to Home project 'wonderfully effective – to get people off the streets'. It appears PIR achieved this success through its links with council and community housing providers and through its approach to seek out people in the open, at locations where they were sleeping rough, rather than offering a desk-based service. Stakeholders said PIR helped to find stable housing for people who had been experiencing homelessness for years. In one case, PIR secured housing for a woman and her two young children, illustrating how the program could benefit families as well as the consumers themselves. The Support Facilitator credited effective collaboration with Housing NSW and another case manager for the success.

Social inclusion was another area where PIR appeared to have positive impact. Consumers who were born overseas said that Support Facilitators helped them feel more at home in Australia by informing them about the local culture, the service system and their citizenship rights. For example, one consumer said:

> When I came in Australia, I was all alone. All the time I was at home, I didn't go outside, I was worried. I had really bad time. [But PIR], they help us to know how is the Australian culture, what is the best way to live in Australia. I feel I'm part of this country now. I'm not a person who came here just looking. (Consumer)

A Support Facilitator gave an example of how a consumer's social inclusion was enhanced through inviting him into the Support Facilitation Agency's men's group.

Other areas where PIR had positive impacts are outlined below. Each is illustrated with one consumer quote.

- Consumers' physical health improved because PIR facilitated access to GPs and medical specialists, thus getting necessary tests performed and medication prescribed:

> Yes [Support Facilitator] is very helpful. It is not only taking us to the appointment or something like that, she's usually making the appointments for us. She explains to the doctor that we have a referral from the GP, as well as she gives them an idea about my health condition as well as about my financial situation. (Consumer)

- Some consumers had found jobs through direct support from their Support Facilitator, and others had been linked with an effective employment service:

[The Support Facilitator], she got me another job search consultant. I've been with job search since 2012. But this new lady is really good, and she said I might have a chance of getting a job. (Consumer)

- PIR provided practical support, for example by helping with paperwork:

[The Support Facilitator] helps me with writing letters, like eBay – my PayPal being suspended and he's helping me getting it reinstated because I really need it for buying and selling online. (Consumer)

- Financial support included accessing funds to buy clothes, food or basic household goods:

[The Support Facilitator] assisted me. I had nothing. I didn't so much have a knife and fork. I had nothing. She helped me get settled in a home. I found the home, but she helped me get set up. She sorted me out so I could start to rebuild. She bought me clothes. She got me on my feet, food, everything. She's been a rock, complete rock. (Consumer)

Most consumers felt the program had been generally effective in raising their quality of life and linking them with appropriate support, for example:

I couldn't have got through without [Support Facilitator] or without the program. (Consumer)

[I'm not] 100 per cent but I'm getting there. (Consumer)

Several stakeholders echoed this sentiment, for example:

I think Partners in Recovery are giving her the right person to lead her to where she's got to go. I think if Partners in Recovery weren't there, she wouldn't know where to go or to get help from. (External organisation stakeholder)

At the same time, the interviews showed there were instances where PIR had not been effective because the program was not what the consumer needed or wanted. It also seems that PIR was less effective than it could have been due to difficulties implementing its care coordination framework which is discussed further in Section 6.1.2.

5   Outcomes for services

This section summarises outcomes of PIR for services within the South Eastern Sydney region. It is based on information obtained from the evaluation interviews and focus groups and includes the viewpoints of the Lead Agency, Support Facilitation Agencies and other external stakeholders.

5.1   Supporting service partnerships

As described in Section 1.1, when the Australian Government Department of Health funded the PIR initiative, one of the stipulated aims of PIR was to strengthen partnerships and improve the links between the various clinical and community support organisations responsible for delivering services to the PIR target group (Australian Government Department of Health and Ageing, 2012). The SESPIR governance structure supported this aim, with CESPHN as the Lead Agency and then up to five local organisations as Support Facilitation Agencies, as well as a consortium of local organisations on the advisory committee.

Further service mapping was then completed (refer to Section 1.2.4) and, as the SESPIR team worked alongside other organisations at a practitioner level, they were able to share this information. The SESPIR team was often seen as a point of contact when organisations wished to know what other service options were available in the area for people experiencing severe and persistent mental illness:

> So one of the things that I really noticed in the early days with PIR, was when they would link in with the different agencies […] that the frontline workers in those organisations were like 'wow there's all these programs out there really, and you can access them?'. So Support Facilitators were really seen as an ally and a portal into the broader infrastructure that they could be linking in with. (Lead Agency stakeholder)

> Obviously there's other services you don't know about […] because [PIR] are doing a lot service mapping, we can tap into that so we can pick their brain for stuff, or a therapist, when we're not sure where to go. (External organisation stakeholder)

While a number of interviewees noted that collaboration and communication between many services within South Eastern Sydney had been relatively strong prior to the implementation of PIR, SESPIR was viewed as being particularly successful in enhancing links between the non-government organisations (NGOs) and government agencies. Of particular note was the improved links between Housing NSW as well as with the mental health services within South Eastern Sydney Local Health District (SESLHD) (St George and Sutherland). Interviewees noted this was important because, although many agencies worked together

routinely, this had historically been done in specific ways. Several interviewees noted that the flexibility of the PIR model and being able to provide PIR in locations alongside other existing services or community supports, either through colocation or attending community service hubs or services, helped to foster relationships and provide opportunities for two-way information sharing and joint planning between organisations:

> They base themselves at local services […] they will work a day out of there so that they can be local. So that sort of integration into the community sector and the real participation has been really beneficial (External organisation stakeholder)

> If I look at the work that we were trying to do with them before we started co-locating, and what partnerships we've been able to support each other with since the co-location, I think the outreach and the colocations have made a huge difference (Lead Agency stakeholder)

Alongside the collaboration between organisations at the practitioner level, the Lead Agency worked at improving these collaborations and partnerships at a management level:

> We've been able to […] firm up some of those more collaborative meetings at a higher level, one with Housing, one with Mental Health, and the meetings been really instrumental in actually even revisiting some of their policy interpretations. (Lead Agency stakeholder)

> People come to us about partnerships – 'I've got this idea can we collaborate on this?' […] then we have the high level meetings where we meet with managers, we have operations meetings, we have the community meetings where there are a whole lot of organisations around the table. So there's a whole lot of different ways that we're adding value and creating those partnerships and maintaining them. (Lead Agency stakeholder)

Establishing partnerships or links at the management level was seen by some interviewees as being particularly important given that resourcing remained an ongoing barrier to successful collaboration at the practitioner level, whether this was due to people being time poor, or because there was a high turnover of staff across organisations within the sector.

Some stakeholders mentioned that referral mechanisms into PIR had been simplified since the program began, making it easier for government and community agencies to link people to PIR. For example, the manager of a community service said when PIR first started, the service sometimes had to complete several forms to refer a person to the program, but after a few months the process was streamlined to just sending an email to PIR. Lead Agency staff said they only ever had one online form.

Many of the positive links that were established between SESPIR and other organisations or services were further enhanced through the SESPIR capacity building projects. As outlined in Section 1.2.4, CESPHN as the Lead Agency coordinated an Innovation Grants Program and provided funding for other key projects (discussed further in Section 5.2). The project funding aimed to introduce new ways of working between organisations in order to address systemic gaps and barriers for people who experience severe and persistent mental illness. One of the stipulations of the innovation grants funding was that the project must include collaboration between two or more service providers.

In addition to the Innovation Grants, several interviews spoke of the success of other PIR-funded projects in forming successful partnerships within the area. These projects were supported by flexible funds that were provided to assist with filling gaps in the service system and included:

- Sutherland Street to Home project, which involved collaboration between SESPIR, Neami National and St George Community Housing

- South Eastern Sydney Hospital to Home project, which involved collaboration between CAN Mental Health and SESLHD

- SESLHD Clinical Coordinator and Health Promotion Officer for People with Co-existing Mental Health and Substance Use Disorders, which involved collaboration between SESLHD Mental Health and Drug and Alcohol Services.

Further information on the SESPIR-funded projects can be found in Appendix E.

5.2 Identifying and addressing service gaps

Given PIR was operating in a service environment of considerable uncertainty and change, including funding cuts to services and the imminent introduction of the National Disability Insurance Scheme (NDIS), it was seen by several interviewees to be one of the few programs to be well resourced. As outlined in Section 1.2.4, one of the initial activities that SESPIR undertook was to complete a comprehensive analysis of the gaps and barriers within the region's service system. Interviewees expressed strong support for the consultation processes that the Lead Agency undertook to identify the gaps and/or barriers and determine the local priorities for action.

The identified action areas provided the focus for system improvement activities facilitated by SESPIR. As mentioned previously, CESPHN, as the Lead Agency coordinated an Innovation Grants Program as well as provided funding for other key projects that were consistent with the identified action areas. Project funds were made available through the use of PIR's flexible funding arrangements (refer to Section 1.2.3):

> We funded directly specific projects that we developed and approached people directly to do. And in other parts we did the innovation grant where we went out to the market and said we want you to solve these issues and here are the resources to do that, come to us with your ideas and so that's kind of how that evolved. (Lead Agency Stakeholder)

Several interviewees acknowledged that the flexibility within the PIR model, which enabled CESPHN to decide how to best use this funding, was central in enabling the strengthening of existing services and the creation of new programs to address the service gaps identified in the region. The decision made by CESPHN to open up access to the project funding to other local organisations, through an open competitive tendering process, was viewed positively by interviewees:

> So instead of [the Lead Agency] deciding themselves what it was that would be the best they kind of opened it up which I think was a really good idea because a whole lot of us would have had fantastic ideas and them just saying what would happen would have been completely against the whole idea of PIR. (Support Facilitation Agency

stakeholder)

Many of the projects funded were viewed by interviewees as having a really positive impact within South Eastern Sydney, through building partnerships and improving capacity within the service network. A couple of the projects were particularly seen as adding value to the region, such as the Squalor and Hoarding Case Management Program facilitated through The Benevolent Society, and Pathways through the Maze facilitated through Catholic Community Services. A number of interviewees, both from within SESPIR and from external organisations, spoke of the benefits for the region in having programs aimed at addressing squalor and hoarding:

> We're one of the only regions I think, from what we could tell, who never got any of the squalor and hoarding money when Ageing, Disability and Home Care originally provided it a few years ago. So having those workers [..] is pretty excellent after having to be a little bit ad hoc. (External organisation stakeholder)

Given the perceived benefits for the region in having programs aimed at addressing squalor and hoarding, this was one of the key areas that interviewees felt required ongoing funding. A couple of interviewees noted that the onus was now on the sector to attempt to find ways to support these types of initiatives independent of PIR funding:

> I guess part of the benefit of those was around how are you going to sustain these long term? That's allowed all of us to go okay well if we can get some upfront money and show that this works we can find a way to continue it ourselves knowing that we will already have good outcomes. (Support Facilitation Agency stakeholder)

Housing and homelessness was another area where funding provided through SESPIR was seen to have made a significant contribution to the service system. A couple of interviewees noted that the number of people experiencing homelessness or sleeping rough was increasing in the region and hence this was a growing area of support need. SESPIR partnered with Neami National and Sutherland Shire Council to deliver an Assertive Street Outreach Program. This program aimed to provide support to people sleeping rough and assist by linking them in to the appropriate services, including accommodation, health and employment. This program was viewed highly by a number of interviewees who felt that it addressed an identified and growing service gap in the region:

> We haven't had a service that was able to provide support to men who were homeless very much in the Shire so it was really good having them there. (External organisation stakeholder)

The Sutherland Shire Registry Week, in which staff from local community organisations volunteered to survey people sleeping rough in the region, was another project mentioned by an interviewee. One interviewee noted that the majority of people identified as sleeping rough during Registry Week were already known to services or organisations working in the region. However, as part of Registry Week, the Vulnerability Index (VI) and Service Prioritisation Decision Assistance Tool (SPDAT) were completed with individuals, providing important information on the support and housing needs for people experiencing homelessness in the region. This information was viewed by a couple of interviewees as being an important resource for service planning into the future:

> The PIR in our area were strongly involved with doing the first ever homeless count in the Sutherland Shire. So over three mornings workers would go out to do a count of the homeless people living in the national park here or on the streets or all the rest of it. We've never had that done before, so even having that kind of information to come back to later and to use for further funding options was wonderful. (External organisation stakeholder)

That said, a couple of interviewees noted that not all of the projects funded through this process had necessarily been as successful as others. However, as one interviewee noted, innovation is inherently risky and the benefits of the grants outweighed the occasional project not fully realising its anticipated outcomes.

5.3 Promoting a community based recovery model

As outlined in Section 1.1.1, one of the aims of PIR is to promote a 'community based recovery model to underpin all clinical and community support services' (Australian Government Department of Health and Ageing, 2012: 4). Within SESPIR, interviewees felt that this aim had been achieved to the extent that Support Facilitators had modelled, in the main, a recovery model approach when working with PIR consumers.

This was particularly the case when Support Facilitation Agencies were already familiar with working within a recovery model. PIR Coordinators also provided coaching and mentoring to Support Facilitators around working with consumers within a recovery-orientated framework. This was complemented by CESPHN, as the Lead Agency, promoting the approach in their PIR publications, resources and training, as well as in any of their meetings or collaborations with other organisations and services.

A few interviewees from external organisations noted that having a program that modelled a recovery approach had been beneficial for other staff working within their services, especially for services in the process of transitioning to working within a recovery framework:

> I think PIR definitely are [recovery-orientated] and I think that certainly the language and culture they have is really good for some of our staff to work alongside. (External organisation stakeholder)

SESPIR were seen to be in a unique position to engage consumers and to work within a recovery-orientated framework given the flexibility the PIR model afforded, which was not constrained by particularly strict referral criteria or service delivery parameters. However, without embedding a recovery measure within the data collection systems for SESPIR, it was difficult to determine how successful the approach had been at improving consumer outcomes. A recovery measure was viewed as something that would have been beneficial and was worth considering in the future:

> Maybe at least a measure of our success could be if people had higher self-ratings of wellbeing when they left the program. You know, we're linking into services; we're not actually providing recovery-based supports. It was going to be a bit longitudinal. But wellbeing could be a good measure. That would be something that would be worth looking into. (Lead Agency stakeholder)

Some interviewees expressed the opinion that possibly more could have been done to build

capacity for organisations and services to work within a recovery framework. CESPHN, as the Lead Agency, had recently released funding for ROSSAT (Recovery Oriented Service Self-Assessment Toolkit) training through the Mental Health Coordinating Council (MHCC). ROSSAT was developed to provide mental health services with a recovery-oriented quality improvement resource. The uptake of this training within South Eastern Sydney at the time of the evaluation had been small.

6 Partners in Recovery governance and implementation

This section summarises themes relating to the governance and implementation of PIR within the South Eastern Sydney region. It is based on information obtained from the evaluation interviews and focus groups and includes the viewpoints of the Lead Agency, Support Facilitation Agencies and other external stakeholders.

6.1 Effectiveness of governance structures

As outlined in Section 1.1.3, national PIR program guidelines recognise that flexibility in how the PIR program is operationalised in each of the 48 PIR regions is necessary to ensure that each PIR Organisation is able to tailor the model to best suit the needs of the target group and existing service systems in their region (Australian Government Department of Health and Ageing, 2012). In the SESPIR region, a consortium of organisations was formed and the Lead Agency selected by the consortium. Once PIR had started, the consortium continued to act as an advisory committee regarding the program's implementation and administration (refer to Section 1.2.1). Having a range of organisations on the consortium was seen as instrumental in PIR's efforts to enhance networks within the region:

> It's been great because particularly around things like engaging with culturally and linguistically diverse communities or having a housing partner on there like we do. Having the Local Health District, they've been really key and they've been really invested. So we've had good buy-in to support the growth, the proliferation, the buy-in to the program across the community. (Lead Agency stakeholder)

Interviewees on the consortium described the structure and running of the consortium as working well, and they felt that their contributions were valued by CESPHN:

> Everything's really transparent, the decisions are really clear, there's obviously a process for approval that's always been thorough and you can see the integrity and the accountability is there. (External organisation stakeholder)

According to interviewees, the consortium was responsible for selecting the governance model through which PIR would operate within the South Eastern Sydney region. Under this model, CESPHN as the Lead Agency was responsible for the strategic direction and operations of the program, and Support Facilitation Agencies employed PIR Support Facilitators and delivered the program. The strength of this governance model, according to some interviewees, was that it brought together the differing areas of expertise and community relationships that existed within each of the individual organisations: some Support Facilitation Agencies had long histories of working in the mental health field, while others had expertise in working with people from different cultural backgrounds, and all the

agencies had existing relationships with people and organisations within the local area.

Interviewees who viewed this as a positive aspect of the governance model also felt that the opportunity to access the PIR program through different organisations was a positive for consumers:

> I think it works better than having it all as one. I think you get more choices and there's more variety. And there's more access for different people. I think if you put it all into one organisation, there would be a lot of people that wouldn't feel comfortable going to places. (Support Facilitation Agency stakeholder)

However, the PIR program being operationalised by up to five Support Facilitation Agencies, and governed by a separate Lead Agency, also posed challenges. Each of the organisations had their own policies, procedures and management structures, which created differences in the way the PIR model was operationalised and differences in the interactions between the Lead Agency and each Support Facilitation Agency:

> It's great that you can fund a diverse workforce, but then you have to communicate with them differently and they work in different ways, so you have to be flexible with how you cater to them, and that creates issues where people are getting different messages. But that's because you're trying to support them for how they work, not how other people work. (Lead Agency stakeholder)

These issues are discussed further in the following section.

6.1.1 SESPIR management structures

As outlined in Section 1.2.1, a senior representative from each of the Support Facilitation Agencies was on the consortium, and each Agency employed the Support Facilitators and was responsible for their performance management and for the day-to-day operational needs of their PIR team. The funding provided by the Lead Agency to the Support Facilitation Agencies included funds for a team leader position; the Agencies employed managers as part-time or full-time team leaders, or a senior worker filled the role.

The PIR Coordinators, situated within the Lead Agency, were available to provide support in the field to Support Facilitators and provide training and mentoring to individuals and teams. However, because PIR Coordinators were also responsible for monitoring the data collected by Support Facilitators and other key performance indicators, interviewees felt that the distinction between the role of the PIR Coordinator and the management role of the Support Facilitation Agency was challenging to operationalise. Support Facilitators said they initially felt like they were reporting to two separate management lines. This resulted in the Lead Agency and Support Facilitation Agencies negotiating individual agreements around staff management and operational issues:

> There was a lot of murkiness around that and having the external Coordinators [..] it made it too complicated and it didn't really feed the most positive working dynamic to start with [..] you'd just have too many people that people would be answering to. (Support Facilitation Agency stakeholder)

> It has been an issue particularly having the PIR Coordinator role sit within the Lead Agency. The agencies have found that very difficult to negotiate in terms of where

is the line of coaching, mentoring, resourcing and line management. (Lead Agency stakeholder)

Several interviewees noted that, while change was not unusual when operationalising a new program, the process with SESPIR had taken longer than they had anticipated, and in some aspects was still ongoing. Several interviewees noted that having dedicated team leaders in each of the Support Facilitation Agencies would most likely have assisted in the implementation and operation of the PIR program within the South Eastern Sydney region. While each Support Facilitation Agency had a person responsible for line management of Support Facilitators, the manager often had responsibilities across multiple programs. Interviewees suggested that a dedicated, full-time team leader would ensure there was someone within each Agency solely responsible for the skill development and performance management of Support Facilitators, and for overseeing how the PIR model was implemented in practice.

The PIR Organisations came together regularly as a group to discuss how the program was progressing; initially meetings were fortnightly and then, in response to feedback, they were shifted to monthly. The meeting involved all Support Facilitators, Support Facilitation Agency Line Managers and PIR Coordinators. Although these meetings were valued by some interviewees, others felt that the large size and the format of the groups were not effective for sharing concerns or for peer support. This was expressed in interviews by both Support Facilitators and managers. In response to this feedback, the structure of the meetings was altered to ensure opportunities for small group discussions. The Lead Agency felt this change had been positively received.

6.1.2 Operationalising support facilitation

As outlined in Section 1.2.2, the role of Support Facilitators is to work directly with consumers and people within their support network, and to assist in identifying and prioritising what is important to them in their recovery. This involves working within a care coordination model, whereby Support Facilitators connect with and coordinate the various services that each consumer wants and needs. As part of this, Support Facilitators are required to build and maintain collaborative partnerships across the various sectors, including medical, housing, income support and employment sectors, in order to contribute to enhanced service integration and system change.

The focus on encouraging or enhancing partnerships across services as well as identifying service gaps, rather than directly providing services, is intended to differentiate Support Facilitation from existing services:

> I find that one of the primary ways it sort of differentiates is that care coordination is more of a collaborative effort of communication between supports - you're sort of like the middle man - networking and developing connections and ensuring that when you do pull out (as we do eventually) that the services are in place and supports are there that are capable of assisting the consumer in times of need. (Support Facilitation Agency stakeholder)

Several interviewees noted that this approach, along with the flexibility inherent in the PIR model, was of particular benefit for consumers who were not yet linked in with many existing services, particularly those consumers who were most marginalised:

> For [consumers] who are sleeping rough or on the edge of homelessness. [PIR] have made a significant difference to their lives […] it's done really well and the capacity to do it through forming partnerships and not just thinking "Well we're here now, everybody can stop doing what they've been doing previously". (External stakeholder)

> I think it's getting out to those people who aren't linked up anywhere that's the big part of this service rather than having somebody with a case manager and every other service already looking after them. I also think that a model with the Support Facilitators identifying gaps, that advocacy sort of part of this model has been fantastic. (External stakeholder)

How exactly to conceptualise and operationalise the role of Support Facilitators, and differentiate case coordination from case management, was something that interviewees noted had evolved over time within SESPIR:

> If I look back I think there was a perception that it was a little closer to case management, and then as we've done a lot of work along the way with Support Facilitators and the Agencies around what care coordination is, what the PIR model is trying to evoke. We moved towards care coordination. (Lead Agency stakeholder)

However, interviewees, particularly Support Facilitators, spoke about the ongoing tension between the intended care coordination role of a Support Facilitator and the actual requirements of support facilitation, which could sometimes involve sustained, intense support of consumers. As described in Section 4.2, trust and relationships were thought to be crucial contributors to the success of PIR, and interviewees pointed out that building trust takes time, particularly for the most marginalised of consumers:

> Just to go back and the nature of the complexities of some of the people we are working with, especially if they're rough sleeping. They may not be connected to any other service provider, the Support Facilitators have to step in to a whole bunch of areas that they wouldn't normally be doing, with the intention that it's transitioning them towards services where that is the services role. (Lead Agency stakeholder)

Many Support Facilitators felt that they had adequate previous training for their role, for example in psychology or counselling, and that they had received much additional training while with PIR concerning different aspects of mental illness and the PIR approach. They felt this helped them to work effectively with consumers and achieve good outcomes. Other Support Facilitators said they felt ill-prepared to deal with the more severe symptoms of mental illness. They wanted more training and supervision.

The flexibility within the role of Support Facilitator, while positive in terms of encouraging Support Facilitators to think creatively about how best to support consumers, also meant there was a lack of specific guidelines about what was and was not the role of a Support Facilitator. Some interviewees recognised the reason for this, but others felt that it made the task of operationalising support facilitation much harder:

> Our role is very much – I mean there is flexibility within it – that's just what I love so much about this role and I think that's why it's been really hard to tackle the issue of discrepancies and inconsistency in what becoming a Support Facilitator is, because I think the Support Facilitator is what you make it to be, you need the general guidelines

but you really need to have that experience and learn from doing. (Support Facilitation Agency stakeholder)

I think what was hard too is there's a lot of grey area. It's not black and white, what it is and how you do a role. There's flexibility, you move in and out, and that didn't sit well with a lot of people […] for some people it's hard to think a little bit bigger and be a little bit more outside of the box and flexible with that. Others fit into that really well and work with that really well. (Lead Agency stakeholder)

The perceived lack of specific guidelines relating to the role of Support Facilitators, and the experienced gap between what was expected of Support Facilitators and what they felt was actually required in fulfilling the role, were described by interviewees as stressful. Several Support Facilitators spoke of significant stress due to what they perceived as unrealistic timeframes and managing workloads they felt were too large, combined with extensive data collection requirements (discussed further in Section 6.1.3) and evolving expectations of what the role of Support Facilitator involved. These tensions left many Support Facilitators feeling burnt out and was cited as one of the contributing factors to a significant turnover of staff within most of the Support Facilitation Agencies in the region.

Interviewees from the Lead Agency felt that the issues around the difficulty managing large consumer numbers was due, in part, to some Support Facilitation Agencies finding it challenging to shift their approach from case management to care coordination. Hence the Lead Agency attempted to support Agencies in the transition. Several interviewees from SESPIR acknowledged that operating within a care coordination framework required specific skills of a Support Facilitator, including skills in network building, negotiation, conflict management and community engagement:

So if you want to be able to engage this particular client group you have [to be able to] understand someone and help them kind of picture a way of things being different. So you've got to have that really kind of skilled role, which I think is very common in the sector. But the next part is that confidence and experience to maybe negotiate a little higher level in terms of bringing together case conferences and practitioners [and] hold people a bit accountable and also building a working alliance with them too. (Lead Agency stakeholder)

The ability of Support Facilitators to work within a care coordination framework, alongside effective leadership at all levels of each organisation, were seen by interviewees as critical to the successful implementation of the PIR program.

6.1.3 Monitoring data and record-keeping

The national PIR guidelines specify that Support Facilitators are responsible for developing, monitoring and reviewing PIR Action Plans for consumers, for information provision to PIR organisation management, in addition to playing a role in data collection for monitoring and reporting (Australian Government Department of Health and Ageing, 2012). Interviewees acknowledged the importance of collecting data, not only for providing evidence of the potential effectiveness of the PIR program, but also for highlighting service gaps across the sectors:

I think one of the things we're doing is capturing data and I think that's really important

when we say there's this many people who are at risk of homelessness, and there is inadequate resources regardless of the wait list, and they're not creating more. Especially for the particular demographic that we're working with, sometimes they require more than just a physical dwelling, it's actually that supported housing model. (Lead Agency stakeholder)

However, interviewees from the Lead Agency and from Support Facilitation Agencies acknowledged the challenge for Support Facilitators in both ensuring that consumers were provided with the support they required, while at the same time meeting the data monitoring and record keeping requirements for PIR. The interviewees also acknowledged that the role of the PIR Coordinators in ensuring that data was completed and collected led to some difficulties in the relationships between the Lead Agency and the Support Facilitation Agencies.

Coupled with the tension between providing the PIR program and maintaining the data requirements, was the inadequacy of the software package, Penelope, which SESPIR used to manage consumer records and data collection. Interviewees almost universally felt that the software package was not the best fit for the PIR program in terms of extracting the data required for reporting purposes. The Lead Agency invested time and resources to modify the software program to improve the quality of data they could extract for the Department of Health, which they were able to share with other PIRs who used the same software package:

We really have put a focus on trying to improve the quality of the data, and so in terms of the data that we are able to collect and pull out of the database, is a lot more robust than some of the other PIRs that use Penelope have been able to pull […] and we've shared a lot of our experiences and resources to be able to support other PIRs to improve Penelope. (Lead Agency stakeholder)

However, sometimes modification to the program resulted in the need for Support Facilitation Agencies to re-enter consumer data. This had time implications for Support Facilitators and Agencies. Another concern voiced regarding the software package was that at a national level different PIR Organisations were using different software packages, which potentially reduced the consistency of the data at a national level.

6.2 Supporting intended population groups

Two of the five Support Facilitation Agencies had specific expertise in supporting people from CALD backgrounds and Aboriginal and Torres Strait Islander people. The SESPIR two-year anniversary report identified better provision of support to these groups as a priority for the area (South Eastern Sydney Partners In Recovery, 2015). The CALD-specific organisation Advance Diversity Services (ADS) had slightly lower caseloads than the other Support Facilitation Agencies due to an increased need for community development, where they spent time engaging consumers in their target communities to facilitate intake into the program. The interviewees noted that while the involvement of ADS and Kurranulla Aboriginal Corporation was beneficial to SESPIR and the Aboriginal and CALD communities, they could not address all of the challenges of supporting people from those communities.

Interviewees said that ADS could provide culturally safe and accessible support to CALD people in their first language, and this was described as extremely beneficial in engaging

consumers and identifying their needs quickly. ADS could address culturally specific barriers to effective support provision, as noted in Section 4.1, such as the stigma associated with severe and persistent mental illness in some communities. As noted in Section 3.1.2, SESPIR consumers come from a large number of countries and four main language groups. SESPIR did employ speakers of each of these languages, but it is not possible for either mainstream or CALD organisations to employ culture-specific workers for all of the languages spoken in the area.

Interviewees reported that Kurranulla Aboriginal Corporation could provide culturally safe and accessible support to Aboriginal and Torres Strait Islander people and their families, and that this was highly valued. SESPIR also identified the need to build Aboriginal workforce capacity, and CESPHN funded positions in a customised Certificate IV in Mental Health training course for existing Aboriginal staff in the region, as well as training for supervisors of Aboriginal staff to increase their cultural competence.

SESPIR also improved provision of support to groups of people who had not been well supported in the area, including people experiencing homelessness, as described in Section 5.2.

7 Conclusion

Partners in Recovery is designed to support people with severe and persistent mental illness with complex needs, and their carers, by improving collaboration between services and sector capacity. In South Eastern Sydney, as in other areas, the implementation of PIR has seen the strengthening of the support provided by community mental health and NGO services, which has benefited consumers and service providers and built the capacity of the service system.

PIR has strengthened the support delivered to individual consumers, because Support Facilitators have provided individualised assistance to consumers and ensured access to other services. Consumers emphasised the benefits of the emotional and mental health support they received. Flexible funding (brokerage) also contributed to the wellbeing of individual consumers, by securing appropriate supports and services that would otherwise not have been available. The participation of Aboriginal and CALD organisations in support facilitation enabled culturally safe and valued support to communities which PIR may not have otherwise been able to achieve.

SESPIR's sustained efforts at building sector relationships, which included resourcing of these relationships through innovation grants, have brought about new ways of working for service providers. SESPIR was built on a base of historically strong relationships between services, but it expanded them and built new relationships between historically disconnected sectors.

Regarding the capacity of the service system, the early activities of mapping service gaps and barriers, which involved extensive consultation to identify local priorities, resulted in new services for people to whom services had previously been unable to provide effective support. In particular, sustained resourcing to improve the support provided to people who are experiencing homelessness and sleeping rough, and to address experiences in squalor and hoarding, were unique and valued contributions by SESPIR.

The PIR model, and its implementation in South Eastern Sydney, also faced challenges. Four challenges are outlined below. These present opportunities for making PIR even more effective in the future, and they are important in the broader policy context of implementing the NDIS over the coming years.

First, the distinction between support facilitation and case management was not always clear to interviewees, and in practice, support facilitation varied over time and between Support Facilitation Agencies. Although most Support Facilitators carried out multiple tasks in responding to the needs of consumers, it is possible to characterise their understanding of support facilitation as having two distinct forms. At one extreme, the role played by Support Facilitators was close to those of case management and involved, for example, lengthy

periods of time with consumers, accompanying them to appointments, and being available to talk on the phone in times of crisis. At the other extreme, support facilitation was closer to 'project management', as one interviewee described it, and was focused on coordinating services rather than supporting consumers. Again, it is important to emphasise that Support Facilitators performed both these roles. However, if workloads for Support Facilitators were based on the assumption that Support Facilitators would not be spending a great deal of time directly with consumers, and in practice they were spending a lot of time this way, it is not surprising that client loads quickly became unsustainable. This challenge was discussed by Support Facilitators primarily in terms of workload and sustainability, i.e. an allocation of 20 consumers or more was not realistic for the provision of meaningful support, especially given the time and skills needed to build relationships and trust with people with complex histories and vulnerabilities. From the perspective of the PIR guidelines and Lead Agency, however, it was not so much a question of workload as of understanding and managing the task of support facilitation, i.e. the role of Support Facilitators was not to provide direct practical support themselves but to identify and coordinate other services.

Related to this, the second challenge was about the balance between flexibility and guidance for Support Facilitators. According to many interviewees, a strength of the PIR service model was its flexibility. The program guidelines allow case management by Support Facilitators for short periods, if needed. This delivery of intensive support also happened in order for SESPIR to build relationships with consumers and other services, especially in the early stages of the program. On the other hand, this flexibility was confusing and unhelpful for some staff in Support Facilitation Agencies, who did not feel supported in understanding their role and the difference between support facilitation and case management. Interviewees considered this one reason for high staff turnover in several Agencies.

The third key challenge was managing the demands of data input and monitoring. Support Facilitators described difficult and time-consuming data input responsibilities, which were closely monitored by PIR Coordinators. PIR Coordinators confirmed that a problematic part of their role was to monitor the performance of the Agencies and ensure that they were meeting the KPIs set by the Department of Health. SESPIR used Penelope, a proprietary software package. Interviewees voiced strong and universal dissatisfaction with Penelope, finding it difficult to use and navigate. As a consequence, workload pressures relating to data entry were thought to be unreasonable, and relationships between the Lead Agency and Support Facilitation Agencies were compromised. However, all interviewees recognised the value of action plans for consumers and of robust monitoring and administrative data.

Finally, the fourth key challenge was the social and economic disadvantage experienced by many consumers, who described in their interviews circumstances of material and social disadvantage, often compounded by significant physical health problems. The primary income for most PIR consumers was the Disability Support Pension or other benefit. The significant economic costs associated with complex support needs and the inadequacy of income support payments, especially Newstart, places significant constraints on the capacity of consumers to meet their needs. This is particularly true in areas where costs of living are high, as in South Eastern Sydney. For example, in its 2016 rental affordability snapshot, Anglicare Australia found no affordable properties in Greater Sydney and the Illawarra for single people aged over 21 years receiving either Newstart or the Disability

Support Pension (Anglicare Australia, 2016). While PIR cannot address all systemic and resource constraints, it did deliver projects that filled gaps, for example providing some affordable housing through the Sutherland Street to Home project.

In the policy context of implementing the NDIS, the emphasis that PIR places on recovery principles and care coordination is relevant and timely. This timeliness is also reflected in the planned role of PIR in the NDIS: PIR has been extended for three years to support the transition of programme funding to the NDIS (Department of Health, 2014). PIR is not intended to deliver a new service but to improve the quality of already-existing services by improving referrals and coordination and promoting a community based recovery model. These aspirations align with the NDIS, which also prioritises referrals, access to services and person-centred planning.

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Appendix A

Consumer interview guide

1. Firstly, it is useful to find out a little background information from you. You have been invited to take part in this interview because you receive/or have received support through Partners in Recovery.

    a. Are you currently receiving support through Partners in Recovery?

    b. What organisation is/was this through? (Neami/Aftercare/Benevolent Society/ Advance Diversity Services/Kurranulla)

    c. How long have you been receiving support through PIR/How long did you receive support through PIR? (in months)

    d. You don't need to provide specific details, but have you used other mental health services in the past?

2. Can you tell me about how the PIR program works for you?

    Prompts: what type of support, what services, how often?

3. Does PIR meet your needs and expectations? If so, how?

    Prompts: type, intensity, frequency and length of support, any other needs you have?

4. How supported do you feel by your Support Facilitator?

5. To what extent do your Support Facilitator and other services work together to assist you? Do you think PIR has had any effect on how well these agencies work together to support you?

6. Do you feel the support you receive is orientated towards your personal recovery?

    Prompts:

    • Do you get to decide what support you want and need?

    • Do you feel able to speak openly with your support facilitator about what is meaningful or important to you in your life?

    • Do you feel empowered to act on your own behalf to manage your mental health?

    • Do you feel that your achievements and successes are recognised?

7. The next question is about what impact PIR has had in your life. I will ask you to comment on specific areas of life. How well has the support you receive through PIR assisted you to:

    - Improve your mental health?

    - Increase your capacity to do and have the things that you want out of life?

    - Increase or improve your friendships, relationships and connection with others?

    - Participate in community life?

    - Increase your quality of life?

    - Find or maintain stable housing?

    - Have fewer and less severe crises, eg hospitalisation or use of emergency services such as the Emergency Department?

    - Increase your confidence in your ability to reach your goals (self-efficacy), for example by using flexible supports?

    - Any other impacts?

8. What parts of PIR do not work for you? Is there any feedback you would like to provide that would improve the service?

9. What do you find most beneficial about PIR?

10. Do you have anything else you want to say about PIR before we finish?

Appendix B

Family member/carer interview guide

1. What is your relationship to [name of PIR client]?

   Prompts

   - How long have you known [name of client]?

   - What kind of support do you provide for your family member/friend?

   - How often are you in contact with [name of client]?

2. What support does your friend/family member receive through PIR?

3. How well does the support meet your family member/friend's needs?

   Prompts: type, intensity, frequency and length of support, any other need?

4. Have you been included in the support provided through PIR?

   Prompts

   - Does the PIR program collaborate with you?

   - Do they include you in the decision making process?

   - What has been the impact on your understanding and ability to support your family member/friend?

5. How has your own life been impacted by PIR?

   - Is PIR responsive to your needs as a family member/carer?

   - Do you feel supported? If so, how?

6. How well do you think the Support Facilitator and other services involved in PIR work together to support you and your family member/friend? Do you think PIR has had any effect on how well these organisations work together to provide support?

7. What parts of PIR does not work for you? Is there any feedback you would like to provide that would improve the service?

8. What do you find most beneficial about PIR?

9. Do you have any other comments about PIR?

Stakeholder interview guide

1. To begin with, we'd like to get some background on your work in relation to PIR. Can you please describe your role? How long have you worked with PIR?

2. What is your overall perception of the PIR program and its effectiveness?

    Prompts - In terms of:

    • Support facilitation for consumers

    • System improvements

3. PIR aims to promote a process of recovery, how would you describe the recovery model as it operates in PIR? Is its support oriented to recovery and if so, how?

4. Is PIR enabling a system whereby there is flexibility and responsiveness to a consumer's need over time? If so, how?

5. How well do you think the lead PIR agency (CESPHN) and non-government organisations involved in PIR work together to support consumers? What works well/not so well?

    Prompts:

    • Communications systems

    • Sharing information

    • Coordinated approach

    • Processes for problem solving

6. Do you think PIR has had any effect on how well these organisations work together and with consumers and carers?

7. Has PIR had any impact on how supported and well-equipped service providers feel to meet the needs of people with severe mental ill-health?

    Prompts:

    • Network building amongst PIR organisations

    • Information sharing/enhanced knowledge base and expertise within PIR organisations

    • Keeping PIR organisations abreast of current research

8. What do you think is the effect of having a lead agency, such as CESPHN, coordinate and assist in the integration of services so they are flexible and responsive?

9. How effective is PIR governance? How well has CESPHN administered and monitored the PIR program? What works well/not so well?

10. How well does the PIR 'no wrong door' policy work? Do you feel access and referral pathways into supports have improved and meet the needs and expectations of consumers?

11. Were there any barriers to the implementation of the PIR program?

12. Where there any factors that enabled the implementation of the PIR program?

13. Do you have any other comments about PIR?

Change in unmet need

Table 5 Client rated needs at PIR entry and close (n=119)

		Initial	Close	Decline in unmet need (%)
Accommodation	Met Need	18	43	
	Unmet Need	61	22	64
	Total Need	79	65	
Safety to self	Met Need	18	22	
	Unmet Need	24	5	79
	Total Need	42	27	
Safety to others	Met Need	11	10	
	Unmet Need	6	2	67
	Total Need	17	12	
Alcohol	Met Need	10	11	
	Unmet Need	13	12	8
	Total Need	23	23	
Drugs	Met Need	11	12	
	Unmet Need	10	6	40
	Total Need	21	18	
Company	Met Need	24	36	
	Unmet Need	74	34	54
	Total Need	98	70	
Intimacy	Met Need	10	9	
	Unmet Need	45	25	44
	Total Need	55	34	
Sexuality	Met Need	11	9	
	Unmet Need	22	11	50
	Total Need	33	20	

Child care	Met Need	8	20	
	Unmet Need	19	5	74
	Total Need	27	25	
Basic education	Met Need	15	10	
	Unmet Need	17	9	47
	Total Need	32	19	
Telephone	Met Need	15	11	
	Unmet Need	9	3	67
	Total Need	24	14	
Food	Met Need	29	31	
	Unmet Need	31	10	68
	Total Need	60	41	
Transport	Met Need	16	20	
	Unmet Need	15	11	27
	Total Need	31	31	
Money	Met Need	29	33	
	Unmet Need	45	18	60
	Total Need	74	51	
Benefits	Met Need	28	30	
	Unmet Need	18	10	44
	Total Need	46	40	
Looking after the home	Met Need	17	33	
	Unmet Need	28	7	45
	Total Need	45	40	
Self-care	Met Need	22	26	
	Unmet Need	17	9	
	Total Need	39	35	
Daytime activities	Met Need	11	45	
	Unmet Need	73	22	70
	Total Need	84	67	
Physical health	Met Need	26	34	
	Unmet Need	53	38	28
	Total Need	79	72	
Psychotic symptoms	Met Need	25	32	
	Unmet Need	27	6	78
	Total Need	52	38	

		Initial	Close	Decline in unmet need (%)
Information on condition and treatment	Met Need	36	37	
	Unmet Need	22	4	82
	Total Need	58	41	
Psychological Distress	Met Need	17	45	
	Unmet Need	78	30	62
	Total Need	95	75	
Cultural & Spiritual	Met Need	10	20	
	Unmet Need	13	0	100
	Total Need	23	20	
Employment & Volunteering	Met Need	8	22	
	Unmet Need	51	28	45
	Total Need	59	50	
Other	Met Need	19	21	
	Unmet Need	26	5	81
	Total Need	45	26	

Source: Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) as at May 24, 2016

Table 6 Staff rated needs at PIR entry and close (n=230)

		Initial	Close	Decline in unmet need (%)
Accommodation	Met Need	35	78	
	Unmet Need	118	55	53
	Total Need	153	133	
Safety to self	Met Need	22	38	
	Unmet Need	58	28	52
	Total Need	80	66	
Safety to others	Met Need	13	12	
	Unmet Need	22	14	36
	Total Need	35	26	
Alcohol	Met Need	17	23	
	Unmet Need	45	27	40
	Total Need	62	50	
Drugs	Met Need	17	14	
	Unmet Need	32	27	16
	Total Need	49	41	
Company	Met Need	22	57	
	Unmet Need	142	80	44
	Total Need	164	137	

Intimacy	Met Need	18	15	
	Unmet Need	68	45	34
	Total Need	86	60	
Sexuality	Met Need	7	12	
	Unmet Need	34	21	38
	Total Need	41	33	
Child care	Met Need	6	29	
	Unmet Need	40	15	63
	Total Need	46	44	
Basic education	Met Need	24	26	
	Unmet Need	27	22	19
	Total Need	51	48	
Telephone	Met Need	20	23	
	Unmet Need	11	9	18
	Total Need	31	32	
Food	Met Need	42	48	
	Unmet Need	65	26	60
	Total Need	107	74	
Transport	Met Need	32	44	
	Unmet Need	32	23	28
	Total Need	64	67	
Money	Met Need	35	53	
	Unmet Need	88	51	42
	Total Need	123	104	
Benefits	Met Need	36	53	
	Unmet Need	45	25	44
	Total Need	81	78	
Looking after the home	Met Need	28	50	
	Unmet Need	79	31	61
	Total Need	107	81	
Self-care	Met Need	35	41	
	Unmet Need	44	28	36
	Total Need	79	69	
Daytime activities	Met Need	31	64	
	Unmet Need	128	80	38
	Total Need	159	144	

Physical health	Met Need	37	76	
	Unmet Need	112	63	44
	Total Need	149	139	
Psychotic symptoms	Met Need	25	43	
	Unmet Need	63	37	41
	Total Need	88	80	
Information on Condition and treatment	Met Need	38	67	
	Unmet Need	47	26	45
	Total Need	85	93	
Psychological Distress	Met Need	36	77	
	Unmet Need	145	84	42
	Total Need	181	161	
Cultural & Spiritual	Met Need	10	24	
	Unmet Need	21	11	48
	Total Need	31	35	
Employment & Volunteering	Met Need	10	33	
	Unmet Need	93	57	39
	Total Need	103	90	
Other	Met Need	31	40	
	Unmet Need	46	13	72
	Total Need	77	53	

Source: Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) as at May 24, 2016

SESPIR funded projects

Innovation Grants Projects	
St George's Mental Health Services – *Physical Health Care of St George Community Mental Health Services Clients*	General Practitioners accompany Community Mental Health Case Managers on home visits to complete physical health checks and treatment to improve the physical health of Consumers who are unable to access a General Practitioner due to barriers presented by experiencing mental illness.
St George Community Housing – *Beginnings*	Beginnings is a community mentoring program for individuals who are experiencing mental illness and social disadvantage and who are at risk of homelessness; new community housing tenants are provided with support from a trained community mentor.
Neami National - *Individual Placement and Support (IPS) Initiative*	The IPS project places Consumers participating in SESPIR into sustainable and competitive employment through an evidence based employment model that supports individuals experiencing mental illness to achieve sustained competitive employment with a focus on the individual looking for work.
3 Bridges - *Community Circles*	Community Circles is an action learning project focused on improving wellness for people with severe and persistent mental health issues by delivering workshops focused on social participation, healthy living and wellness as well as local implementation of a recovery framework.
The Benevolent Society – *Squalor and Hoarding Case Management Program*	This project supports those experiencing squalor and hoarding with recovery oriented case management. A 'Buried in Treasures' peer run workshop will provide ongoing support.
Catholic Community Services – *Pathways through the Maze*	This project delivers a squalor and hoarding case management service underpinned by recovery orientated practice. Educational tools and activities will be implemented including training events, webinars and an e-learning module.
Riverwood Punchbowl Uniting Church – *Peer Connections*	The Peer Connections project fits into the existing Riverwood Lunch and Leisure Club. New peer mentors will be trained to facilitate one-on-one peer support to individuals who experience mental health concerns.

Other Projects	
South Eastern Sydney Hospital to Home project	SESPIR have developed a collaborative project in partnership with South Eastern Sydney Local Health District and CAN Mental Health Inc. in order to improve the transition processes from the Mental Health Inpatient Unit to Home for people in the PIR target group. This project covers Mental Health Inpatient Units at Sutherland and St George Hospitals and involves contracting CAN Mental Health to deliver the peer facilitated Hospital to Home program.

South Eastern Sydney Local Health District Clinical Coordinator and Health Promotion Officer for people with co-existing Mental Health and Substance Use Disorders	Clinical coordinator and health promotion officer positions have been created to improve the integration of the South Eastern Sydney Local Health District's Mental Health and Drug Health Services. These positions, funded by SESPIR, will focus on developing and embedding defined processes and improved structures for collaboration and communication between the two services.
Sutherland Street to Home project	This project is delivered in partnership between South Eastern Sydney Partners in Recovery, Neami National and St George Community Housing. The project was developed to address the barriers to permanent affordable housing for people experiencing long term homelessness. Sutherland Street to Home is a Housing First Project, which means that people exit rough sleeping and move into permanent accommodation with required supports very quickly. It is an evidence based model for supporting people who have been homeless for long periods of time and dispels the myth that long term homelessness cannot be addressed. St George Community Housing will source seven properties and provides supported tenancy management. Individuals housed through the project are provided with recovery oriented and goal based support from Neami National. This project will provide housing to 7 of the most vulnerable people in the region as well as further evidence of the effectiveness of a housing first response in addressing homelessness in the region.
Sutherland Shire Registry Week	Sutherland Shire Registry Week was held from the 31st of August to the 3rd of September, 2015. Staff from local community organisations volunteered to survey the Sutherland Shire region from 4.30am-8.30am and asked people sleeping outdoors to complete the Vulnerability Index (VI) and Service Prioritisation Decision Assistance Tool (SPDAT) known collectively as the VI-SPDAT. The VI-SPDAT is a validated questionnaire that measures the medical vulnerability of homeless people and helps identify the best type of support and housing intervention for individuals. This was done to prioritise individuals into housing and ensure assertive support is provided to those in need. The data collected during the week was the first time the number of rough sleepers have been counted in the region and this data will support advocacy around providing housing and support for homelessness in the region. South Eastern Sydney Partners in Recovery coordinated Sutherland Shire Registry with partner organisations Neami National, St George Community Housing, Sutherland Shire Council, Orana Inc, Wesley Mission and the Mercy Foundation. Staff from Micah Projects in Brisbane and NSW National Parks and Wildlife Service also supported the event.
The Mental Health Atlas	The Mental Health Atlas is a partnership project between Eastern Sydney and South Eastern Sydney Partners in Recovery and the University of Sydney who have been contracted to map services for people experiencing mental health concerns in the Eastern and South Eastern Sydney regions. This data will be available to service providers and planners with the aim to achieve improved planning of relevant services in the region. Services will be classified based on the main care activity and Geographical Information Systems will be used to inform locally relevant and equitable solutions for planning resources.

Recovery Libraries	SESPIR supported the St George and Sutherland Mental Health Service to establish Recovery and Wellness Libraries in four mental health inpatient units. The aim of the libraries is to increase access to resources about mental health, recovery and to support people in their personal recovery journey. Materials in a range on mediums including print, DVDs, audio tapes and interactive computer based software will be available and will cover themes of recovery, self-help, self-exploration, mindfulness and self-empowerment. The Recovery and Wellness Libraries will be available to individuals in the Acute Mental Health and Older Persons Sub-Acute Mental Health Units at St George Hospital and in the Acute Mental Health and Mental Health Rehabilitation Units at Sutherland Hospital.
Sector Workforce Development	Offering workforce development opportunities to relevant organisations and sectors in South Eastern Sydney is one of the ways in which SESPIR work toward the PIR objectives of promoting recovery oriented practice, strengthening partnerships and building better links between local organisations. SESPIR offered a range of different training and education options to staff from relevant services to build upon skills already present in the workforce, strengthen connections and provide opportunities for stronger collaboration between the organisations in attendance, and ultimately achieve better outcomes for people experiencing mental health concerns in our community.
Aboriginal Workforce Development	In recognition of the importance of providing culturally appropriate supports and services to Aboriginal and Torres Strait Islander people, SESPIR contracted the Mental Health Coordinating Council (MHCC) to deliver training for staff and managers working with Aboriginal communities. The MHCC provided a culturally customized version of the Certificate IV in Mental Health to Aboriginal mental health workers from the South Eastern Sydney region; staff completing the Certificate IV will develop practical skills in and be champions of both recovery oriented practice and social and emotional wellbeing. This will mean Aboriginal Consumers will have ongoing access to workers who are better resourced to support their needs. The MHCC will also deliver training for current and future managers of Aboriginal staff to promote culturally appropriate and strengths based ways of supporting staff. This training will promote retention of Aboriginal staff and improve service delivery to Consumers.
Recovery Oriented Service Self-Assessment Toolkit (ROSSAT) Project	The ROSSAT was developed by the MHCC in partnership with the Being: Mental Health and Wellbeing Consumer Advisory Group as a quality improvement reflective tool that organisations and individual workers can use to strengthen their recovery orientated service provision and practice. In collaboration with the Mental Health Coordinating Council (MHCC), we are supporting the delivery of training to organisations in the region on implementation of the ROSSAT. The training will provide an introduction to recovery and recovery orientated service provision through using the ROSSAT tool. The aim is to support staff from senior management through to frontline staff to utilise the tool to enhance their individual and organisational practices.

Rethinking Mental Health Forums	South Eastern Sydney Partners in Recovery in partnership with South Eastern Sydney Medicare Local delivered the 'Rethinking Mental Health: Supporting a Recovery Based approach in the community' Forum on the 25th of October 2014. The forum aimed to increase knowledge of and skill in delivering recovery orientated practice across sectors as well as highlight the latest innovations in mental health practice and support system navigation by increasing knowledge and awareness of services and supports in the region. Over 100 General Practitioners, allied health practitioners, community workers and Consumers and Carers were in attendance. Rethinking Mental Health 2.0 forum was held on the 23rd October 2015. Over 100 delegates attended with the focus of the forum on learning objectives, knowledge and practical skills in mental health, exploring new innovations and best practice through the application of a recovery model to primary healthcare. Speakers included MC Julie McCrossin and keynote speaker Fay Jackson – Deputy Commissioner, Mental Health Commission of NSW.