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- members of the PIR Expert Reference Group
- staff of the Department of Health responsible for managing PIR
- Bill Buckingham, consultant to the Department of Health, in relation to the development of the PIR Client Minimum Data Set
- management and staff of PIR Organisations, particularly the 12 visited in the first round of site visits
- staff from Flinders University responsible for the PIR Capacity Building Project, for assistance with attendance at National and State conferences and related matters
- John McLeod and VicHealth, in relation to the use of the Partnership Analysis Tool.
Acronyms

CALD  Culturally and Linguistically Diverse
CANSAS  Camberwell Assessment of Need Short Appraisal Schedule
DOH  Department of Health
LGBTI  Lesbian, Gay, Bisexual, Transgender and Intersex
MDS  Minimum Data Set
MHRS  Mental Health Recovery Star
NDIA  National Disability Insurance Agency
NDIS  National Disability Insurance Scheme
NGO  Non-government Organisation
PIR  Partners in Recovery
PHaMS  Personal Helpers and Mentors Programme
RAS  Recovery Assessment Scale
Executive Summary

1 THIS REPORT

- In March 2013, Urbis was commissioned by the (then) Department of Health and Ageing to conduct an evaluation of Partners in Recovery: Coordinated Support and Flexible Funding for People with Severe, Persistent Mental Illness and Complex Needs (PIR). The key aims of the evaluation are to:
  - examine the implementation and delivery of PIR
  - assess the impact on PIR clients, carers, PIR Organisations, other service providers and the wider health service-delivery system
  - evaluate PIR’s effectiveness in improving the system and care available to people with severe and persistent mental illness that have complex multi-agency needs
  - identify implications and develop recommendations to inform the ongoing roll-out of the initiative. The evaluation is being conducted over a three year period from 2013 to 2016.

- This is the Annual Evaluation Report for 2013-14. It includes an overview of PIR, the evaluation methodology, the evaluation activities conducted to date and analysis based on consultations and programme data. The key focus of this report is on the implementation of PIR in the first year of its establishment. The 2014-15 Annual Report and the Final Evaluation Report in 2016 will have an increasing focus on the outcomes that are being achieved for individuals participating in PIR and for the broader service system.

- This report has been based on:
  - consultations with over 300 people through a series of site visits to 12 PIR Organisations and in-depth telephone interviews: these involved PIR Organisation management and staff, consortium members and stakeholders and took place between December 2013 and April 2014
  - the first of a two-stage national survey of PIR consortium members to obtain their rating of the effectiveness of their partnership in the first year of the programme: this was conducted in March-April 2014 and resulted in 155 responses from 96% of the PIR Organisations. This survey will be repeated in two years’ time to compare partnership functioning against this benchmark
  - the identification and documentation of good practice implementation case studies
  - analysis of PIR documentation
  - selected data from the Minimum Data Set (MDS)
  - attendance at two national PIR conferences.

- This report does not include data from consultation with PIR clients or carers as it was considered to be too early in the initiative’s implementation to truly judge the impact of PIR on participants. Ethics approval was obtained in May 2014 and subsequent evaluation reports will include input from consumer and carer perspectives.

2. KEY EVALUATION ACTIVITIES CONDUCTED IN 2013-14

- Key evaluation activities conducted in 2013-14 included:
  - the finalisation of the MDS involving the collection of 44 data items across 7 domains to be collected by all PIR Organisations
  - the finalisation of the PIR Evaluation Framework setting out the evidence base for the evaluation of PIR over 2013-2016
  - the development of Reporting Frameworks for PIR Organisations
  - preparation of, and acceptance of the ethics application to the Department of Health Human Research Ethics Committee for the use of client data from the PIR MDS and interviews with PIR clients and carers
  - a report on key findings from site visits to 12 PIR Organisations
  - consultations with more than 300 stakeholders
  - a national survey of PIR consortium members.
3. ESTABLISHMENT AND IMPLEMENTATION

- The first six to eight months of the PIR initiative were focused on a range of establishment and early implementation activities. These included:
  - staff recruitment, induction and training
  - advertising for, selecting and contracting providers (as required)
  - development of organisational policies, procedures and protocols
  - development of IT systems to record and report on MDS and other data
  - development of promotional/branding material
  - extensive sector and community engagement
  - development of processes for progressing system reform (eg service mapping, consultations).

- The early establishment phase was also an important phase in cementing relationships between the Lead Agency and consortium members, and in establishing clear lines of communication, roles and responsibilities, and decision-making. The establishment phase required significant effort, and some aspects took longer than expected, in particular:
  - the IT systems, as the MDS took longer than expected to be finalised and new systems had to be developed in each PIR Organisation
  - the contracting arrangements with funded agencies (for Support Facilitator positions), which in some cases proved to be very complex
  - the recruitment of staff, in some locations.

- Various approaches have been taken to the staffing structure of PIR Organisations. In the main, most PIR Organisations have created several centralised positions (usually located within the Lead Agency) devoted to PIR Organisation-wide functions, including the PIR Manager, a System Reform Coordinator, and a Quality Assurance/Training Coordinator, with the majority placing Support Facilitator positions within other consortium agencies.

- There is some question about whether or not there will be a continuing need for all the centralised PIR Organisation positions after the establishment phase. A number of PIR Organisations employed people to undertake implementation tasks such as writing operational guidelines or developing the IT system, and not all these positions may be required in the longer term.

- Various approaches were taken to Support Facilitators staffing and recruitment. In essence, these differences relate to:
  - employment arrangements (Lead Agency, consortium members or other agency as a result of a competitive bid process)
  - location (in Lead Agency, consortium member or host agency) arrangement
  - temporary outposting to PIR Network agencies
  - role (the degree to which they are engaged in system reform in addition to client interface)
  - level of remuneration.

- The role of the Support Facilitator is still evolving. There is considerable diversity in the level and nature of the skills of those who have been employed to fill this role. It will be important to capture early learnings about what makes for an effective Support Facilitator, to ensure appropriate recruitment and professional development systems are put in place.

4. GOVERNANCE AND PROGRAMME INFRASTRUCTURE

- In recognition of the complexity of this initiative, the Department of Health has put in place strong programme infrastructure to support the establishment and implementation of PIR. This has included:
  - a dedicated programme management team
  - a Capacity Building Project to support the development of PIR across a national network
  - a Resources Project to identify the best available resources and tools to utilise in PIR
  - the development of a PIR MDS to support ongoing monitoring and evaluation
- a three year evaluation of PIR, commencing from the inception of the programme.

- There have been many advantages to this approach, including that it has:
  - facilitated clear communication between the Department and the funded bodies about operational procedures and guidelines
  - assisted in communication across PIR Organisations in the early establishment and implementation phase to share ideas, knowledge, learnings and strategies
  - supported rigorous monitoring and evaluation of PIR.

- A number of contextual factors has meant that the timing of some elements of the roll-out of PIR was delayed (in particular the resource development workshops, the MDS, national branding and marketing materials, permission to use the selected client needs assessment tool), which created an element of time pressure for PIR Organisations. However, it was generally recognised in the sector that there was a relatively short time-frame for contracting and then rolling out this new and complex initiative, and that the timing of the Federal election had impacted on decision-making in the Department.

- While the Capacity Building Project is valued by most PIR Organisations, many consider there is more scope for it to reach its full potential. The main aspiration of PIR Organisations is that the Project develops a more structured, proactive and ‘thought leadership’ role in identifying, documenting and disseminating good practice, rather than the role it has generally undertaken to date, which has primarily been as a facilitator of discussions and information exchange.

- Stable governance arrangements are in place in most PIR Organisations and are progressing well. The role of the Lead Agency within PIR Organisations varies considerably, and reflects the extent to which Lead Agencies see their role as either facilitating or leading the PIR Organisation’s activities.

- The partnership survey shows a relatively high level of functionality in relation to key aspects of PIR Organisation governance and management, including:
  - a shared understanding about the purpose of PIR (92%)
  - a shared understanding of the Recovery Model (90%)
  - the managers in each member organisation supporting the partnership (88%)
  - a clear goal for the partnership (87%)
  - all partners being involved in planning and setting priorities for collaborative action (81%)
  - a participatory decision-making system in place that is accountable, responsive and inclusive (74%).

- Aspects of governance and management that require further improvement in some PIR Organisations relate to:
  - increasing consumer and carer involvement in PIR Organisation design, decision-making and monitoring: as many as one in four consortium members surveyed indicated this is not occurring to a sufficient degree at the moment
  - streamlining referral protocols and service standards across consortium members
  - achieving greater clarity regarding administration, communication and decision-making structures
  - achieving greater clarity and shared understanding of roles, responsibilities and expectations of consortium members
  - providing opportunities for more informal contact between consortium members in order to develop a shared understanding, approach and a common ideology.

5. PROGRAMME REFERRAL, ASSESSMENT AND CASE COORDINATION

- Most PIR Organisations did not start opening their doors to clients until November or December 2013, and many did not start receiving their first intake until early 2014. Since then, the number of referrals has increased quite rapidly and at 30 June 2014 PIR had received a total of 7,913 referrals and registered 5,235 clients.
Whilst it might have been anticipated in some quarters that client intake would have commenced at an earlier date, this may have been an unrealistic expectation given the complexity of the establishment phase, although it is probably the case that more PIRs could have commenced intake prior to 2014.

Earlier client intake tended to occur in PIR Organisations where:
- there was a developmental approach to the process, with a corresponding view that they did not need to have all systems, processes and protocols in place before opening the door to client referrals.
- no delays in staff recruitment occurred (either due to the PIR Organisations commencing recruitment early or there being an available pool of appropriate candidates)
- PIR Organisations made the decision to have a ‘soft launch’, starting recruitment from within the client base of their own consortium membership initially to test the intake and assessment process
- there were no disputes or differences associated with the placement of Support Facilitators within the Lead Agency or other agencies, or delays in finalising contractual arrangements
- there was a shared understanding of PIR and/or a prior relationship between consortium members, so that less time was needed to spend on building new relationships.

At the time of consultation, referrals were being generated by PIR Organisations through four avenues:
- consortium members, largely as a means of assessing the PIR intake and assessment processes internally before receiving referrals from elsewhere
- other agencies, following proactive engagement by PIR staff through interagency meetings, presentations and meetings
- service providers in contact with a large number of people likely to be eligible for PIR (e.g. hospital discharge units, homelessness services, emergency relief agencies), often through co-location or liaison
- clients themselves, through informal engagement, (e.g. going into parks, local cafes, men’s clubs where ‘soft’ initial contact can be made with people who are thought to potentially benefit from PIR) this was seen to be particularly important in rural and regional areas.

The intake and assessment process to PIR involves a series of steps, including:
- an initial eligibility assessment
- an intake assessment to identify needs and confirm eligibility
- a consent process (e.g. to participate in PIR and in the PIR evaluation)
- an Action Plan, reviewed on a six monthly basis, together with an ongoing assessment.

Many PIR Organisations reported that the initial client intake and assessment process could take some considerable time, and rarely could be completed in one or two meetings. Many PIR clients have had poor experiences of the service system, are mistrustful of bureaucracies/service providers or, due to the nature of their illness, are fearful or suspicious about systems and processes or people they do not know. It can take a period of time to engage PIR clients and gain their trust and confidence to the point where they are willing to share information, sign consent forms and be formally assessed. The situation can be further complicated if the client has not had a formal diagnosis.

Finding ways to engage effectively with PIR clients and conduct the eligibility and needs assessments in a skilled and sensitive manner will be key to the success of PIR. The next phase of the evaluation will explore these issues in greater depth, as more clients are referred to the programme and practice learnings emerge about this critical aspect of PIR.

Service coordination is a critical component of PIR and PIR Organisations are seeking to define the appropriate boundaries between service coordination and case management. This too will be a focus of enquiry in the next round of fieldwork and consultations.
6. PROFILE OF PIR CLIENT ACTIVITY

- In the period between 1 July 2013 and 30 June 2014, PIR received a total of 7,913 referrals and went on to register 5,235 clients (66% of referrals progressed to registration).

- The demographic profile of PIR clients at 30 June 2013 was as follows:
  - Over half of these registered clients (54%) were female and 46% were male.
  - Over one quarter (28%) of registered clients were aged between 35-44 years, with a similar proportion (25%) aged between 45-54 years. Only 16% of clients were aged 55 and over.
  - A total of 12% of PIR clients identified as being Aboriginal or Torres Strait Islander, much higher than the proportion of Aboriginal and Torres Strait Islanders in the general population.

- With regard to clients’ living arrangements:
  - One third (32%) of clients lived in a lone person household, with one in seven living in other family households (12%) or in a one parent with child(ren) household (11%).
  - With regard to accommodation type, half (50%) of all clients lived in a private residence, 15% did not state their current accommodation type, and accommodation type was not reported for 12% of clients.
  - Only one in twenty (6%) clients are employed. Over one third (37%) are not in the labour force and 29% are unemployed. Of those clients who are in employment, the majority (87%) work part-time, with only 65 (13%) working full-time.
  - One third (33%) of registered clients are supported by public sector mental health services, 23% by a General Practitioner, and less than one in ten (7%) access a private psychiatrist as their principal clinical service provider. Only 5% of clients receive no mental health support.
  - Approximately one third of registered clients (32%) were reported as being diagnosed with a mood affective disorder with around one quarter (23%) diagnosed with schizophrenia, schizotypal and delusional disorders, and over one in ten (12%) diagnosed with an unspecified mental disorder.
  - One fifth (20%) of all referrals to PIR were made by public sector mental health service clinics with a further 16% provided by non-government community support and a similar proportion (16%) by other community or health care services. One in ten (10%) were also self-referrals to PIR. In total, over three quarters (78%) of referrals were accepted, equivalent to 6,178 referrals, with one in eight (13%) refused, 4% withdraw prior to assessment, and 4% with unknown outcomes to date.
  - The Needs Assessment revealed many clients had multiple unmet needs. Half (49%) of all clients had unmet needs for daytime activities, with 48% having unmet psychological distress needs, 45% unmet social life needs, 38% has unmet physical health needs and 35% unmet employment needs.

7. PARTNERSHIPS

- Overall, the partnership arrangements within the 48 PIR Organisations seem to be working well. The majority of the feedback from consultations and the first national partnership survey of consortium members indicates that the initial establishment and implementation phase has gone reasonably well, and that many partnerships have strengthened over this period.

- In only a small minority of PIR Organisations is the consortium arrangement struggling, and in one case the partnership has fallen through, with the Lead Agency now operating on a single purchaser-provider model.

- The fact that the great majority of partnerships have been functioning reasonably well in the early establishment and implementation phase is in no small measure due to the very high level of continuing enthusiasm for, and commitment to, PIR and its clientele amongst Lead Agencies and consortia members, and their staff.

- The key characteristics of PIR Organisations where the consortium arrangements are working particularly well include:
strong and clear governance structures
- strong leadership by the Lead Agency that is respectful, solutions-focussed and impartial
- a high level of goodwill and trust, often based on a previous history of working together
- good communication, including a willingness to have robust conversations that contribute to the development of collective growth and understanding about PIR
- shared vision and values for the collective PIR Organisation (as distinct from the organisations represented on the consortium)
- shared understanding about the purpose of PIR and of the Recovery Model underpinning it
- a willingness to put aside the interests of the member organisations for the interest of the collective in order to achieve better outcomes for PIR clients
- consortium members being willing and able to devote sufficient time to developing relationships and contributing to the many and varied processes, policies and protocols developed in the early establishment phase
- consortium membership being represented by senior members of their organisation with the authority to make decisions on behalf of their agency in relation to PIR
- having a considerable range of skills and experience represented in the consortium, that contributes to informed and robust decision-making.

PIR Organisations where the consortium is experiencing some difficulties do not tend to have the above characteristics (or have fewer of them) and in addition face one or more of the following challenges:
- the roles, responsibilities and expectations of partners are not clearly defined or understood
- administration, communication and decision-making structures are overly complex
- lines of communication are poor
- conflicts have occurred over processes and/or decisions regarding the placement of Support Facilitators
- consortium members are spread over a large geographic area, limiting the extent of face-to-face communication.

8. SYSTEM REFORM ELEMENTS OF PIR

- In the first six to eight months of PIR implementation, the primary focus was on establishing governance and consortium arrangements, designing and implementing systems, processes, policies, and procedures; recruiting and training staff; finalising contractual arrangements with funded services; establishing IT systems; conducting widespread promotion of the programme, and generally becoming ‘client-ready’. As a result of the substantial number of implementation tasks, the system reform element of PIR was less of a priority for many PIR Organisations in the initial establishment phase.

- Just over half (58%) of consortium members surveyed thought there was a clear approach to system reform in their PIR Organisation, with the remaining 42% unsure or of the view there was no clarity in the approach. However, in consultations, only a minority of PIR Organisations were able to demonstrate a clear and structured approach to system reform. A number had put in place some preliminary ideas and structures, while others had done relatively little. Many PIR Organisations were struggling to clearly define and articulate their role in system reform and to identify the priority areas of focus and a way of moving forward.

- There are differing interpretations and understandings of system reform within a PIR context, and different structures in place for identifying and driving system reform within PIR Organisations. Many PIR Organisations have created specific roles (usually within the Lead Agency) to lead and drive system reform activities within their region (in collaboration with Support Facilitators), whereas others have embedded this function in the role of the Support Facilitator. At the time of writing, there has been insufficient system reform activity undertaken to assess the relative effectiveness of these approaches, but this will be examined more closely in the future.
Despite a somewhat slow start to the system reform element of PIR, there were examples where system reform activities had commenced. Most commonly these were demonstrated through the operation of the PIR Organisation consortium – whereby the organisation modelled the system reform goals it wanted to achieve in the wider service system. These were clearly articulated in both the partnership survey and in consultations, and included:

- the sharing of information and resources
- conducting/participating in joint training
- participating in joint recruitment activities
- jointly working towards initiatives that would further support the goals of PIR (eg to meet service gaps)
- working towards consistent service standards (eg National Mental Health Standards) operating across consortium members.

Many PIR Organisations have undertaken activities to inform their system reform activities including sector consultation, carer and consumer consultation, service mapping, case file audits, and policy and programme reviews to identify both service gaps and potential strategies and partners for addressing these.

Through the consultations, a conceptual framework has been developed by Urbis to document the various types and levels of system reform that PIR Organisations may engage in. These relate to:

- the level of activity – eg PIR Organisation, PIR Network, regional service system or jurisdictional/national service system level
- the type of activity – eg information and tools, workforce development/training, resourcing, organisational development, regulations and policies, leadership and culture, interagency protocols and memorandums of understanding, communication and promotion.

It will be important for PIR Organisations to make a link between system reform activities and improved client outcomes, to the extent possible. The PIR Organisation evaluation workshops in year two of the evaluation will explore the ways in which PIR Organisations are undertaking system reform activities, and the impact of these activities to date.

9. THE PIR-NDIS INTERFACE

A critical issue for PIR is its interface with the National Disability Insurance Scheme (NDIS). In 2013/14, there was only one interface between PIR and the NDIS, in the Hunter Region of NSW.

There is little clarity and a considerable degree of uncertainty and confusion about the relationship between the two initiatives. Although there has been dialogue between the NDIA and the Hunter PIR Organisation, and a clear willingness by both to communicate and collaborate, this has been hampered by a lack of clarity about what constitutes permanency within a psychosocial disability context (in order to meet NDIS eligibility criteria) and uncertainty about which services coordinated and supported through PIR will be regarded as ‘in scope’ under the NDIS.

The key issues that will need to be closely monitored over the next year (and as the NDIS is trialled in three more regions in which PIR is in-scope) are:

- operational clarity about what constitutes ‘permanence’ in relation to psychosocial disability
- what aspects of PIR are in scope for NDIS participants.

10. CONCLUSIONS

PIR Organisations are generally collaborating well for collective impact, informed by the real issues clients are encountering and the real practice of service coordination. There is widespread enthusiasm for PIR not only among PIR Organisations, but mental health organisations, carer and consumer organisations. For some people, PIR represents a once-in-a-lifetime opportunity to work towards workforce and system change to improve outcomes for people who experience complex and ongoing mental health and related needs. There are also some who are more sceptical about what it
can achieve. This serves to emphasise the importance of the evaluation in independently assessing impact and outcomes.

- The key opportunities for PIR in the next 12 months are:
  - to focus on achieving meaningful outcomes for clients and for carers, after the initial establishment phase
  - to increase activity in relation to the system reform element of the initiative
  - to develop and share emerging practice learnings about client identification, engagement, assessment and service coordination as more clients are referred into the programme
  - to utilise the flexible funding pool in creative ways to support and assist PIR clients as they move towards recovery
  - to commence and report on their own evaluation activity to build the evidence base about effective models and approaches
  - to build on the very high level of goodwill and commitment embedded in many PIR Organisations.

- The key challenges for PIR for the next 12 months relate principally to wider sector and system reforms including:
  - the interface with the NDIS as it is rolled out into more PIR regions
  - the changes to Medicare Locals – who are the Lead Agencies in most PIR Organisations
  - changes to the service system in many jurisdictions, which is placing consortium members in direct competition for funding and which could undermine collaboration and cooperation.

- Suggestions to strengthen and enhance the delivery of the PIR Initiative are listed overleaf.
<table>
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<tr>
<th>AGENCY</th>
<th>SUGGESTIONS FOR STRENGTHENING</th>
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<td>PIR Organisations</td>
<td>1. Avenues for enhancing the involvement of consumers and carers in the governance and decision-making of PIR Organisations should be investigated.</td>
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<td>2. The scope, nature and desired outcomes of system reform and service coordination activities should be defined within each PIR Organisation.</td>
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<td>3. Policies and procedures for spending their flexible funding pool should be clarified as a matter of priority.</td>
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<td>4. Information on creative and effective ways of using the flexible funding pool should be disseminated across PIR Organisations.</td>
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<td>5. PIR Organisations should share strategies/approaches to targeting and assisting PIR clients who are Indigenous, Culturally and Linguistically Diverse (CALD)/refugee or Lesbian, Gay, Bi-sexual, Transgender, Intergender (LGBTI).</td>
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<td>6. More training and/or a clearer articulation of how a recovery-based approach can be translated into practice should be undertaken.</td>
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<td>7. Partnership development activities should focus on:</td>
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<td>a. developing participatory decision-making processes</td>
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<td>b. developing communication mechanism and processes</td>
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<td>c. developing procedures for identifying new partners and bringing them into the PIR Organisation or Network.</td>
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<td>Capacity Building Project</td>
<td>8. The Capacity Building Project should take a more strategic thought-leadership approach.</td>
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<td>9. Greater emphasis should be placed on highlighting and disseminating good practices and innovation.</td>
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<td>10. More emphasis should be placed on building capacity for partnership development and partnership strengthening.</td>
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<td>11. The PIR Initiative website should be reviewed to enhance navigability and searchability. The online forums should be changed to allow more unmediated communication between PIR Organisations.</td>
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<td>12. The operation of teleconferences with PIR Organisations should be reviewed to include clearer agendas and chairing procedures.</td>
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<td>13. Avenues should be explored for creating awards recognising achievement and innovation among PIR Organisations, possibly in collaboration with sector and/or consumer and carer peak bodies.</td>
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<tr>
<td>Department of Health/</td>
<td>14. PIR Organisations require information and guidance about the PIR-NDIS interface and NDIS eligibility for PIR clients.</td>
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<td>Government</td>
<td>15. Assistance and guidance is needed for PIR Organisations to initiate their own evaluations to complement the national evaluation.</td>
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<td>16. A mechanism should be established to conduct a meta-synthesis of the individual evaluations being conducted by PIR Organisations.</td>
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1 Introduction and methodology

1.1 THIS REPORT

Partners in Recovery: Coordinated Support and Flexible Funding for People with Severe, Persistent Mental Illness and Complex Needs (PIR) is an initiative by the Australian Government Department of Health. Commencing on 1 July 2013, the programme aims to support people with severe and persistent mental illness, their carers and their families through improved service collaboration, coordination and integration.

PIR is seeking to achieve:

- improved quality of life for clients
- improved social inclusion for clients
- improved clinical functioning for clients
- improved service system.

The programme aims to achieve these outcomes through:

- facilitating better coordination of clinical and other supports and services to deliver person-centred support 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.

In March 2013, Urbis was commissioned by the (then) Department of Health and Ageing to undertake a three-year evaluation of PIR. This is the first of three Annual Evaluation Reports to be prepared. The main focus of this report is on the implementation of PIR in its first year of operation. Subsequent reports will have a focus on the outcomes and impact of PIR on clients, carers and the service system.

1.2 EVALUATION AND MONITORING PROJECT

The PIR Evaluation and Monitoring Project is being conducted from 2013 to 2016. The key aims of the PIR Evaluation and Monitoring Project are to:

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

1.2.1 EVALUATION ACTIVITIES AND REPORTING

This report is part of a programme of reporting over the three-year life of the project. Figure 1 below outlines the nature of the evaluation activities to be undertaken over the course of the evaluation, and the reporting timeline.
FIGURE 1 – OVERVIEW OF PIR EVALUATION METHODOLOGY

<table>
<thead>
<tr>
<th>TIMEFRAME</th>
<th>PLANNING</th>
<th>PRIMARY DATA COLLECTION</th>
<th>ANALYSIS AND REPORTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2013 – June 2013</td>
<td>Commencement meeting Project plan Communication and stakeholder engagement strategy Preliminary knowledge review Initial key informant interviews Development of the evaluation and monitoring framework Development of PIR Client Minimum Data Set Development of PIR Reporting Framework</td>
<td>12 site visits to consult with PIR Organisations, partners and local services (including 6 longitudinal sites) PIR Organisations and key stakeholder telephone consultations Online partnership survey of PIR consortium members</td>
<td>Progress Report 1 PIR Client Minimum Data Set Reporting Framework Evaluation Framework</td>
</tr>
<tr>
<td>July 2013 – June 2014</td>
<td>Development of research tools Commencing negotiation with data custodians regarding data access and linkage Ethics application Fieldwork planning Communication to stakeholders regarding consultation processes</td>
<td>12 site visits to consult with PIR Organisations, partners, local services, clients and carers PIR Organisations and key stakeholder telephone consultations State and territory evaluation workshops with PIR Organisations</td>
<td>Qualitative analysis (site visits and telephone consultations) Analysis of first partnership survey Progress Report 2 Analysis of PIR MDS data (included in 2014 Annual Report) Case studies on implementation (included in 2014 Annual Report) Annual Report 1</td>
</tr>
<tr>
<td>July 2014 – June 2015</td>
<td>Review evaluation framework and project plan Finalise negotiations regarding data access and linkage, contingency planning if not possible Fieldwork planning Communication to stakeholders regarding consultation processes</td>
<td>12 site visits to consult with PIR Organisations, partners, local services, clients and carers PIR Organisations and key stakeholder telephone consultations State and territory evaluation workshops with PIR Organisations</td>
<td>Qualitative analysis (site visits, telephone consultations and workshops) Progress Report 3 Analysis of PIR MDS data (included in 2015 Annual Report) Case studies on location (included in 2015 Annual Report) Annual Report 2</td>
</tr>
<tr>
<td>July 2015 – June 2016</td>
<td>Review framework and project plan Fieldwork planning Communication to stakeholders regarding consultation processes</td>
<td>12 site visits to consult with PIR Organisations, partners, local services, clients and carers PIR Organisations and key stakeholder telephone consultations Online partnership survey of PIR consortium members Client and carer satisfaction surveys</td>
<td>Qualitative analysis (site visits and telephone consultations) Analysis of second partnership survey Consumer and carer satisfaction survey Economic analysis Analysis of linked data sets (if feasible) Progress Report 4 Analysis of PIR MDS data Case studies on specific consumer groups Final Evaluation Report</td>
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</table>

This report is based on data from the Round 1 site visits, stakeholder telephone consultations and the online partnership survey of PIR consortium members.
1.3 EVALUATION ACTIVITIES IN 2013-14

The first year of the PIR Evaluation and Monitoring project focused primarily on establishing the evaluation infrastructure and conducting the first round of data collection.

The evaluation infrastructure includes the development of the PIR Client Minimum Data Set (MDS), the Reporting Framework for PIR Organisations, the Evaluation Framework, research instruments and the preparation of an ethics application to the Department of Health Human Research Ethics Committee. Each of these activities is detailed below.

1.3.1 DEVELOPMENT OF PIR CLIENT MINIMUM DATA SET AND REPORTING FRAMEWORK

Data collected and reported by PIR Organisations throughout the programme constitutes a key information source for ongoing monitoring and evaluation of the initiative. The PIR Reporting Framework outlines the full scope of reporting requirements for PIR Organisations. Urbis developed the specifications for the MDS in consultation with the Department and PIR Organisations.

The consultation and development process sought to identify essential data required to inform the evaluation and monitoring process that are not already collected or feasibly accessible from existing data collections. The MDS was designed to include collection of a statistical linkage key for each PIR client to provide the capacity to link to external data sources and enable the construction of a broader data set across jurisdictions that might inform the evaluation of the initiative (should this be feasible).

The development of the MDS was informed by:

- the development of the PIR Evaluation Framework, which specifies the range of key questions and indicators used in the evaluation project
- a review of external data sets to assess the extent to which data required for the evaluation could potentially be obtained by linkage to external collections (including the consideration of feasibility, costs and potential risks associated with this approach)
- a review of existing relevant national data sets (such as the National Community Services Data Dictionary, the National Health Data Dictionary, Mental Health National Minimum Data Sets, the Specialist Homelessness Services collection)
- a review of relevant programme-specific minimum data sets (including the NSW Housing and Accommodation Support Initiative, the Home and Community Care Programme, the Personal Helpers and Mentors programme)
- a review of funding applications by PIR Organisations to examine information regarding existing Client Information Management Systems for client data collection.

The MDS includes 44 data items, covering 7 fields including:

- identifiers¹
- referral and eligibility assessment
- demographics and mental health
- needs assessment
- client status

¹ N.B. these identifiers relate to PIR Organisations, referring agencies and alphanumeric client identifiers. The data provided to the Department of Health has been de-identified so it is not possible to identify any individual PIR client.
All PIR Organisations delivering the PIR initiative must establish arrangements for the routine collection and reporting of the MDS. Where PIR is delivered through a consortium arrangement (with a network of Support Facilitators), the PIR Lead Agency within the Medicare Local Region is responsible for ensuring collection of PIR MDS items at the specified collection points in the client cycle (DOH, 2013).

A PIR Reporting Framework was also developed for PIR Organisations to use in fulfilling the Department’s monitoring requirements and informing the evaluation. This framework comprises the PIR MDS as well as additional qualitative and quantitative data requirements to inform evaluation and monitoring.

1.3.2 DEVELOPMENT OF THE PIR EVALUATION FRAMEWORK

The Department identified the following key evaluation questions and measures to be addressed through the evaluation, which have been integrated into a detailed PIR Evaluation Framework. The PIR Evaluation Framework was issued by the Department of Health in December 2013 and is available on the PIR Initiative website at http://www.pirinitiative.com.au

<table>
<thead>
<tr>
<th>TABLE 1 – KEY EVALUATION QUESTIONS</th>
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<tr>
<td><strong>KEY EVALUATION QUESTIONS</strong></td>
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</table>
| To what extent has the PIR initiative been an effective approach for people with severe and persistent mental illness who have complex multi-agency support needs? | - Whether the initiative has been able to effectively focus on, and provide appropriate responses to, the PIR target group  
- The extent to which the initiative contributes to improvements in key outcome domains experienced by PIR clients  
- The extent to which the initiative contributes to improvements in broader outcomes for families and carers of PIR clients, and the community more generally  
- The extent to which the initiative contributes to a more cost effective use of health and social care resources for the PIR target group. |
| To what extent has the PIR initiative improved the system of care available to people with severe and persistent mental illness who have complex multi-agency support needs? | - The level of coordination between clinical and community support service providers  
- The nature and strength of partnerships between service providers  
- The effectiveness of referral pathways in ensuring access to necessary services  
- The adoption of a recovery framework by clinical and community support providers who service people in the PIR target group. |
| What are the critical elements that support effective implementation of PIR and the barriers and challenges which hinder effective implementation? | - Elements of best practice in service delivery model and partnership approaches  
- Elements of best practice in governance and management structures  
- Key challenges, barriers and limitations in effective Programme implementation. |

A range of information was considered in developing the Evaluation Framework:

- **preliminary consultations**: the development of the Evaluation Framework was informed by preliminary consultations with a range of internal and external stakeholders including:
  - Departmental PIR Programme personnel and a technical adviser on mental health information
  - Members of the PIR Expert Reference Group
  - Siggins Miller (undertaking the PIR Resource Development Project)
Overview of key literature: An overview of key literature was undertaken to articulate the policy setting, identify evaluation research on any similar initiatives undertaken in Australia and overseas, and to articulate the fundamentals of a recovery model.

Review of programme documentation and products emerging from the PIR Resource Development Project: This included PIR Operational Guidelines, referral forms and other key tools and resources.

Development of the PIR MDS: This has been developed by Urbis in parallel with the Evaluation Framework, providing an excellent opportunity to ensure availability of programme data required for evaluation purposes.

Development of the PIR Reporting Framework: This has been developed with assistance from Urbis, again providing an excellent opportunity to ensure that PIR reports are providing content that can be used for evaluation as well as for monitoring and accountability purposes.

The Evaluation Framework facilitates both a formative and summative evaluation of PIR. The evaluation will identify impacts on the service system and outcomes for clients, as well as key learnings about barriers, facilitators and enablers to achieving change and making a difference to people’s lives.

The Evaluation Framework includes a range of qualitative and quantitative research methods and data to ensure strong and robust outcome and change measures. The Evaluation Framework is guided by programme logic theory and the use of a hierarchy of outcomes approach (see Figure 2 overleaf). For each outcome, the Evaluation Framework sets out:

- the key evaluation questions
- evaluation indicators which can be used to measure progress against intended outcomes
- the data sources and/or research methods used to collect the data
- the timing for collection and analysis through the evaluation.
### Ultimate outcomes (2015 onwards)
- Clients participating in PIR have improved clinical functioning
- Clients participating in PIR have improved access to stable housing and increased participation in employment, education and social activities
- Clients participating in PIR have an improved quality of life
- Clients and carers are satisfied with the support they have received through PIR
- Families and carers of people participating in PIR have an improved quality of life
- PIR is an effective coordination model for supporting people with severe and persistent mental illness with complex needs

### Intermediate outcomes (2014 onwards)
- Level of client intake is in line with expectations and funding
- Level of coordination between clinical and community support service providers is improved
- Service providers have engaged in new and more effective partnerships to meet the needs of people with severe and persistent mental illness with complex needs
- Clinical and community support services are operating according to a community-based recovery model
- PIR clients and their families/carers have improved access to required and culturally appropriate services and supports
- PIR Organisations are operating in an effective and cost-efficient manner

### Activities and immediate outcomes (2013 and ongoing)
- The network of PIR Organisations is established
- PIR Organisation staff are recruited and appropriate training and capacity building has been provided to staff as required
- Service coordination and support model is agreed and in place
- Referral, intake and assessment processes are developed and in place
- The Reporting Framework is developed and implemented effectively by the Department of Health and PIR Organisations
- Appropriate data systems are implemented to enable accurate and timely reporting, information sharing, and client information management
- Clear governance and management structures are in place at Programme and regional level
- Lead Agency and partner organisations operate effectively as a consortium in the establishment and early implementation phases
- PIR Organisations are accepting clients into the Programme in line with agreed inclusion criteria

### Needs
- Clients with severe and persistent mental illness require services from multiple agencies for complex health and social needs
- No or inadequate existing coordination arrangements are in place to assist clients in accessing the necessary services and supports

### 1.3.3 DEVELOPMENT OF RESEARCH TOOLS AND ETHICS APPLICATION FOR CLIENT CONTACT

#### RESEARCH TOOLS
The key questions outlined in the Evaluation Framework informed the development of a suite of tailored research tools to collect primary data for the evaluation. These tools included discussion guides (for key stakeholders, PIR Organisations, partners/consortia, clients, carers, local services and agencies), survey instruments (for PIR Organisations) and case study templates.

For consultation with clients and carers, an information and consent package was also developed to ensure clear understanding of the purposes of the research, the proposed use of information provided
during interviews, who to contact for further information, and the voluntary nature of participation (including the right to withdraw from the process at any time). Involvement of clients and carers in interviews requires written consent to acknowledge understanding of the process and agreement to participate in the research. Duty of care protocols were also developed to take account of the welfare of consumers during the interview/consultations phase, as well as the safety of interviewers.

All draft instruments were submitted to the Department for review and approval as part of the ethics application process.

ETHICS APPROVAL

The evaluation and monitoring project is being conducted in line with national research ethics standards. A number of the components of the methodology required approval by a human research ethics committee, including:

- the use of client data collected by PIR Organisations (as part of the MDS)
- consultation with individual clients and carers.
- the linkage of external datasets to track PIR client activity through health and community systems (if this proves possible).

The ethics application required the submission of all research instruments, information sheets and proposed data collection and consent processes.

An ethics application was prepared and submitted to the Department of Health Human Research Ethics Committee. Ethics approval was obtained in May 2014 for the use of client data from the MDS and for consultation with clients and carers. A subsequent ethics application will be required for the linkage of PIR with external data sets, should it be decided that this would be informative and feasible.

1.3.4 ROUND 1 SITE VISITS

The first annual round of twelve site visits was undertaken between November 2013 and January 2014. The fieldwork sites are listed in Table 2. Each year, six new sites will be selected for a site visit. Six sites have been selected as longitudinal sites and will be visited three times over 2013 – 2016.

TABLE 2 – 2013 FIELDWORK SITES

<table>
<thead>
<tr>
<th>2013 SITES</th>
<th>LONGITUDINAL SITES (2013 – 2016)</th>
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</thead>
<tbody>
<tr>
<td>Darling Downs (QLD)</td>
<td>Australian Capital Territory (ACT)</td>
</tr>
<tr>
<td>Eastern Melbourne (VIC)</td>
<td>Bentley-Armadale (WA)</td>
</tr>
<tr>
<td>Grampians (VIC)</td>
<td>Hunter (NSW)</td>
</tr>
<tr>
<td>New England (NSW)</td>
<td>Metro North Brisbane (QLD)</td>
</tr>
<tr>
<td>Southern Adelaide-Fleurieu-Kangaroo Island (SA)</td>
<td>Northern Territory (NT)</td>
</tr>
<tr>
<td>Tasmania (TAS)</td>
<td>Sydney South West (NSW)</td>
</tr>
</tbody>
</table>

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

- representation of all jurisdictions
- both large and small regions
- a range of geographies including metropolitan, outer urban, regional, rural and remote
- the proportion of the population who identify as Indigenous Australians
- the proportion of the population who are from culturally and linguistically diverse (CALD) populations
• a variety of Lead Agency organisations and service models – Medicare Local lead, mental health or other NGO lead, or joint lead

• a range of size of consortia

• different stages of progress through the PIR establishment and implementation phases

• early interface with the National Disability Insurance Scheme (NDIS).

Each nominated site was visited for up to two days and involved a series of interviews with key stakeholders. Across the 12 field visits, 129 individual interviews and group discussions were conducted, involving 250 people. These were conducted using tailored interview guides (see Appendix A) and were audio-recorded with consent of the participating individual(s). All recordings were transcribed for analysis purposes.

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

1.3.5 IN-DEPTH TELEPHONE CONSULTATIONS

Over 50 stakeholder telephone consultations were conducted between January and April 2014 with representation from PIR Organisations that were not included in the 2013 site visits. These organisations included mental health and human services agencies, state and territory governments, and members of the PIR Expert Reference Group. These interviews followed tailored interview guides (see Appendix B) and were audio-recorded with the consent of the participants. All recordings were transcribed for analysis purposes.

The transcripts of the site visit and telephone consultation interviews were imported into NVivo qualitative data analysis software (QSR, 2013) and then free coded (Richards, 2005) to identify:

• distinct concepts in the data, with reference to the key questions set out in the Evaluation Framework

• any concepts and topics in uncoded or sparsely coded portions of the data (portions of the interviews with only one code or no coding after the initial coding pass).

1.3.6 ONLINE PARTNERSHIP SURVEY OF PIR CONSORTIUM MEMBERS

An online survey was distributed to PIR Organisations Lead Agencies for distribution to their consortium members, for completion in a three week period over March-April 2014. The survey asked consortium members to rate their partnership based on a Partnership Analysis Tool developed by John McLeod on behalf of VicHealth (VicHealth, 2011) and adapted by Urbis to include additional PIR-specific indicators. It includes questions on the four key domains:

• networking

• coordinating

• cooperating

• collaborating.

The partnership survey instrument is attached at Appendix C. The survey will be re-administered in two years’ time and the results compared to the benchmark obtained in 2014.

Responses were received from 155 consortium members drawn from 96% of PIR Organisations.

1.3.7 ATTENDANCE AT NATIONAL AND REGIONAL PIR CONFERENCES AND WORKSHOPS

Urbis attended the two National PIR Conferences and two of the regional workshops held in 2013-2014.
2  Partners in Recovery

2.1  INTRODUCTION

Before presenting the results of the evaluation, it is important in this first Annual Report, to set the context for the evaluation by describing the programme structure and operational context.

2.2  PIR

Partners in Recovery (PIR) aims to improve support for people with severe and persistent mental illness with complex needs, as well as their carers and families, by improving collaboration, coordination and integration of services and supports from the multiple sectors clients may come into contact with (and could benefit from). A total of $496 million of Federal funding has been allocated from 2011-12 to 2015-16 to support the PIR initiative.

PIR is considered innovative in the provision of services for those experiencing mental illness for a number of reasons:

- **Target population** - PIR is designed for those with severe and persistent mental illness with complex needs that require a response from multiple agencies across different sectors. These individuals are reported to often fall through the system gaps and require more intensive support to effectively address the complexity of their needs. A programme has never been designed specifically for this target group.

- **System reform** - By encouraging better coordination of services for the target group across multiple sectors and agencies, as well as the building of strong partnerships and improved referral pathways for individuals, the ultimate aim of PIR is to drive system reform and build a community-based recovery model for assisting the PIR target group.

- **Flexible pool of funding** - PIR involves a unique funding model in which PIR Organisations have access to a limited amount of flexible funding to purchase services and appropriate supports when client needs are identified but are not immediately able to be met through normal channels. The flexible funding pool enables the PIR Organisations to buy these services and supports on behalf of clients, and is intended to be used to build system capacity for the benefit of PIR clients within the region, rather than divert responsibility from existing service providers.

- **PIR modelling system reform**: PIR Organisations responsible for delivering PIR are required to function as a consortium both in the preparation of the PIR funding bid and in the ongoing management and delivery of PIR.

There are a number of sectors central to the success of this initiative – primary health care, the state and territory mental health systems, the mental health and broader non-government sector, alcohol and other drug treatment services, and income support services, as well as education, employment and housing supports. PIR will support the multi-service integration and coordination needed to ensure services and supports are matched to individuals’ need (DOH, 2013).

2.3  GUIDING PRINCIPLES

The implementation of the PIR initiative is underpinned by the following guiding principles:

- **Recovery-oriented and client-focused**: PIR operates under a recovery framework using a personalised approach tailored to address the specific support requirements of an individual and assisting them to maximise their capabilities through social and environmental opportunities. Recovery is not focused on curing illness so much as empowering consumers with the tools to lead meaningful and satisfying lives.

- **Flexible in roll out**: The operation of PIR may look different from one region to the next, as a result of PIR Organisations tailoring their model to best meet the needs of the local target group and existing service delivery systems in the region.
- **Complementary to existing service systems**: PIR Organisations have been established to assist with, not complicate or duplicate, system navigation. PIR does not seek to fully address issues of service availability but focuses on multi-service integration and coordination to deliver better outcomes for the most vulnerable clients.

- **Able to better coordinate systems**: PIR is not intended to offer a new 'service' in the traditional sense. Rather, it will coordinate existing services and supports to achieve better client outcomes. PIR provides a 'support facilitation' service focusing on building pathways and networks between the sectors, services and supports needed by the target group (DOH, 2013).

### 2.4 ORIGINS OF PIR

Around one in three Australians experience mental illness at some stage in their life. People with severe and persistent mental illnesses have significantly shorter life expectancy – 16 years for males and 12 years for females (Kisely, Hancock, & Lawrence, 2013). Mental illness accounts for 13 per cent of the total burden of disease in Australia, and is the largest single cause of disability, comprising 24 per cent of the burden of non-fatal disease. Around 600,000 Australians experience severe mental illness and it has been estimated that some 60-64,000 people have enduring and disabling symptoms with complex, multi-agency support needs (SANE Australia, 2011). This group is the focus of PIR.

Addressing severe and persistent mental illness requires a complex system of treatment, care and support, and the engagement of multiple areas of government, including health, housing, income support, disability, education and employment. The Australian and state/territory governments, as well as the non-government sector, all deliver programs for people with mental illness and their carers. Building a coherent system of care is a challenging task.

Over recent years, all levels of government have been increasing their investment in mental health. The Commonwealth’s Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule initiative, Access to Allied Psychological Services, Mental Health Services in Rural and Remote Australia and Mental Health Nurse Incentive programs have brought treatment to many who previously missed out. The significant increase in community mental health services, including the Personal Helpers and Mentors program, respite services for mental health carers, and the Support for Day to Day Living in the Community program have also been widely welcomed by consumers, their carers and families.

Despite this increasing momentum and investment, one of the most consistent themes fed back to the Australian Government is that care for the most vulnerable people with severe and persistent mental illness is not adequately integrated or coordinated, and people with complex needs often fall through the resulting gaps (DOH, 2013). Many of the issues facing potential PIR clients do not relate directly to their mental illnesses. Their financial, social, general health and housing needs are often more pressing. The 2010 People living with psychotic illness report highlighted this (DoHA, 2010), showing the range of challenges consumers with severe and persistent mental illness reported, as illustrated in Figure 3.
Based on data in DoHA (2010)

2.5 PIR TARGET GROUP

The PIR initiative focuses on people who have a severe and persistent mental illness with complex support needs that require a response from multiple agencies. Severe and persistent mental illness is generally associated with psychotic disorders, including schizophrenia and bipolar disorder. These individuals have persistent symptoms, significant functional impairment and psychosocial disability, and may have become disconnected from social or family support networks. This can lead to extensive reliance on multiple health and community services for assistance to maintain their lives within community-based settings and outside of institutional care. These individuals may have comorbid substance use or physical health issues or both, are likely to experience difficulties maintaining stable accommodation, and experience difficulty in completing basic activities of daily living. They may require more intensive support to effectively address the complexity of their needs and current systems reportedly underserve this target group.
The PIR initiative aims to identify and support around a third (approximately 20,000) of the estimated national target population in the first three years of operation. Each PIR Organisation has specific target client numbers based on 40% of the estimated total potential client population in their regions.

It is anticipated PIR clients will generally be in their mid-twenties and older, reflective of the typical development of severe and persistent mental illness. At younger ages, there are a range of other government programs, such as the Expansion of the Early Psychosis Prevention and Intervention Centre (EPPIC) model programme and headspace, that aim to reduce the risk of long term disability, and provide early intervention for young people who may be developing a mental illness.

Alongside the PIR target group, the programme is also designed to support the carers of these individuals. A carer is defined as a person who has a caring role for a person with a mental health problem or mental illness. They could be family, friends or staff and be paid or unpaid (DoHA, 2009). PIR aims to acknowledge and support families and carers as partners in providing care to the target group.

2.6 KEY ROLES IN DELIVERING PIR

A PIR Organisation is the consortium that collectively implements PIR in a Medicare Local region. This includes a PIR Lead Agency and the PIR consortium members/partners who have committed to the implementation model of PIR for their region. PIR Organisations are designed to be the mechanism that brings together all the services and supports within the region that a PIR participant may require. PIR Organisations aim to coordinate sectors, services and supports at a regional level to promote seamless service delivery. This is expected to be achieved through forging stronger partnerships between service providers and support services, in order to increase efficiencies and improve overall service provision, care coordination, and systemic advocacy. In this way, PIR Organisations are required to work at the systems level as well as at the service delivery level.

The PIR Organisation Lead Agency, as the leading member of the consortium, has a formal contractual relationship with the Department of Health. The Lead Agency signs a Funding Agreement with the Department, receives the funding, assumes legal responsibility for undertaking the activities specified in the Funding Agreement, and is accountable to the Department. PIR Organisation Lead Agencies are required to be incorporated non-government health and welfare service providers. It is recognised that not all PIR Lead Agencies will directly deliver health and welfare services, but may be considered to indirectly deliver such services through brokerage arrangements (that is, sub-contracting and funding other organisations to deliver services directly on their behalf).

The PIR Network comprises the full range of services and supports within a region that deliver services to the PIR target group, including but not limited to, housing and accommodation, mental health and wellbeing, financial management, education, legal, employment, income support, physical health (such as GPs, allied and specialist health service providers) and parenting support organisations. PIR Network members may be engaged through formal governance or advisory structures, referral pathways, or direct liaison with Support Facilitators and other PIR Organisation staff for the purpose of supporting the implementation of PIR.

Support Facilitators are appropriately skilled and experienced individuals whose role is to improve coordination of services for PIR clients. Support Facilitators are engaged by PIR Organisations to implement PIR within the region. It is anticipated the tasks undertaken by Support Facilitators will vary from region to region depending on the PIR implementation model for that region. However, the types of tasks Support Facilitators could undertake include, but are not limited to: receiving, reviewing and assessing referrals; conducting an assessment of an individual’s care needs; developing, monitoring and reviewing PIR action plans; building service pathways and networks of services and supports needed; being a point of contact for PIR clients, their families and carers; working closely with existing case managers and support staff to ensure case management functions and existing relationships are maintained; maintaining necessary reporting to PIR Organisation management; and collecting data. Support Facilitators may also play an important role in system reform activities. PIR Organisations are required to specify the role, tasks, qualifications, skills and experience of a Support Facilitator, along with key performance indicators, in a job description/duty statement document.
2.7 PIR ORGANISATIONS

PIR Organisations have been funded in 48 Medicare Local regions across Australia. The 48 PIR consortia range in size from two partners to more than 20 partners, with most comprising between six and twelve members. There is little correlation between either the geographic or population size of a region and the size of the PIR consortium. It is more likely larger consortiums are reflective of service availability and/or pre-existing relationships between consortium members.

PIR consortium members include the following organisations:

- Medicare Locals
- Mental health organisations such as Schizophrenia Fellowship, Richmond PRA, Lifeline, Richmond Fellowship
- Large community service organisations such as Anglicare, Mission Australia, Centacare and the Red Cross
- Local offices of State Government Departments
- Carer organisations
- Drug and alcohol services
- Employment service agencies
- Special interest group organisations (e.g. Aboriginal services, services for migrants or humanitarian entrants, or for LGBTI)
- Homelessness and housing services
- Independent local community service organisations.

A total of 35 PIR Organisations are led by the region's Medicare Local as the Lead Agency. Three of these PIR Organisations describe themselves as a joint lead, involving a Medicare Local and a non-government agency. The remaining 13 PIR Organisations are led by large mental health or community service non-government organisations.

2.8 PIR CLIENT ELIGIBILITY, INTAKE AND ASSESSMENT

Referrals are made to PIR Organisations in line with a clear referral protocol which defines the target group and sets out the inclusion criteria to assist in assessing eligibility. This is outlined in Figure 4 and described in detail in the PIR Operational Guidelines (DOH, 2013).
2.8.1 ELIGIBILITY ASSESSMENT

The eligibility assessment screens all referrals to a PIR Organisation. The assessment can be based on referral information alone, or supported by additional information including interviews with the consumer being referred and other information from the referral source.

The eligibility assessment can have one of two outcomes:

- the person is accepted to progress to the needs assessment stage, at which stage a full assessment of the person’s needs is undertaken

- the person is determined not to meet eligibility requirements.

It is important to note that specific age criteria have not been set (DOH, 2013). Rather, in accepting individuals into PIR, discretion should be exercised, on a case by case basis, taking into account PIR’s suitability to meet the person’s needs. PIR clients are generally expected to be in their mid-twenties and older, which reflects the typical development of severe and persistent mental illness.

PIR Organisations report the full assessment process, from referral to registration of clients, can be quite time consuming. There are various approaches taken to the client assessment process, where some PIR Organisations adopt a centralised process with dedicated staff (intake officers), and others a multi-stage approach involving several roles across the PIR Organisation. The nature of the target group contributes to the complexity of the initial engagement and assessment process.

2.8.2 CLIENT NEEDS ASSESSMENT AND ACTION PLAN

If a potential PIR client meets the eligibility criteria they proceed to the needs assessment stage, at which stage they are registered as PIR clients (DOH, 2013). Support Facilitators undertake an initial assessment of the client’s service and support needs at this stage. The needs assessment identifies the client’s existing capacities and capabilities. This is the point at which the role of families and carers should be identified and discussed. The assessment of the client’s needs and capacities is intended to be repeated at regular intervals.

Based on the needs assessment, the Support Facilitator develops a PIR Action Plan in collaboration with the client, their carer(s) and family, relevant local networks of service providers, and other agencies in their PIR Network. The PIR Action Plan identifies how the clinical and other support needs will be addressed, and is ideally signed by the client, the Support Facilitator and all relevant service providers listed in the PIR Action Plan, thereby committing all stakeholders to deliver what has been agreed. A PIR client can ‘exit’ when stable arrangements are in place and they are accessing the services and supports they require.
3  Establishment and implementation

3.1  OVERVIEW

PIR Organisations undertook a wide range of activities in order to establish themselves as new entities within the service sector, including:

- staff recruitment and training
- contracting host agencies to employ Support Facilitators
- development of organisational policies, procedures and protocols
- development of IT systems to record and report on MDS and other data
- development of promotional and branding material
- extensive sector and community engagement activities.

This section describes the key establishment and implementation issues that PIR Organisations identified in the site visits and telephone consultations. They reflect the issues and activities that were most relevant at the time of the interviews and have been grouped under two broad areas: the staffing of the PIR Organisation as a whole, and operational issues.

In general the PIR Organisations who progressed well through establishment and implementation stages had the following characteristics:

- strong existing partnerships
- strong leadership
- early appointment of senior staff
- a sufficiently skilled regional workforce from which to recruit
- clear governance structures
- strong consumer and carer involvement.

PIR Organisations that struggled more during establishment and implementation each faced a unique set of challenges. In general, they often had Lead Agencies that did not have long histories of regional engagement with mental health agencies and stakeholders.

3.2  STAFF STRUCTURE

The size and complexity of PIR Organisations was usually linked to the size and geographical reach of their regions. The smallest PIR Organisation had a target of 125 potential clients. The largest was estimated to have 2,583. For this reason different staffing structures were used in different PIR Organisations.

PIR MANAGERS

There was a range of approaches to the centralisation of functions within PIR Organisations. Every PIR Organisation has employed a PIR Manager. This role, sometimes called a PIR Coordinator, has been critical in coordinating the establishment and implementation of the PIR Organisations. They have had responsibility for the development of most aspects of PIR in their regions, in particular the development of policies and procedures, information systems, assessment systems, the recruitment of PIR staff and the overall functioning of the PIR Organisation.
CENTRALISED TEAM
In addition to the PIR Manager, most PIR Organisations have employed administrative staff who performed a broad range of activities on behalf of the entire PIR Organisation. The number of people who made up this centralised team varied, ranging from 2 to 8 staff; in some cases this was only the PIR Manager and a single administrative staff member while in others the centralised team was more numerous. These teams were usually employed by, and located within, the PIR Lead Agency. It is important to note that many of these staff were employed to undertake establishment activities, such as developing client information management systems or guidelines and procedures. Consequently there the number of centralised staff is likely to contract in most PIR Organisations during ongoing operation.

The functions that were commonly centralised within PIR Organisations included:

- initial referral and intake
- partnership development
- communication and promotion
- Support Facilitator professional development and clinical support
- overseeing system reform activities
- developing and maintaining information and data management systems
- general administration and management.

The Lead Agency employed the centralised staff in the majority of PIR Organisations. There were some examples of centralised intake and referral, system reform and partnership development activities being led by agencies other than the Lead Agency, though not many.

The extent to which the functions described in the points above were centralised appeared to be linked to the geographical dispersal of the PIR Organisation. Geographically larger PIR Organisations appeared to have a greater proportion of staff employed in centralised roles, though this association was not uniform. Centralisation of some functions may have the potential to enhance efficiency by reducing travel time and transactional costs.

The optimal proportion or number of centralised staff was not clear at the stage of the site visits. Very few of the people interviewed described any concerns about the centralisation of functions within PIR Organisations.

SUPPORT FACILITATORS
Support Facilitators are the primary workforce for PIR. They are the frontline workers who coordinate care for PIR clients, liaise with other stakeholders and agencies and are contacts for many system reform activities. They work directly with PIR clients to develop action plans based on individuals’ needs and recovery goals. They negotiate with a range of services and coordinate arrangements.

A range of approaches to employing and locating Support Facilitators could be observed nationally:

- Support Facilitators employed and hosted by the Lead Agency
- Support Facilitators being employed by the Lead Agency but hosted in other agencies
- Support Facilitators being employed by several consortium agencies
- Support Facilitators employed by consortium agencies and non-consortium agencies following a competitive tender process to employ Support Facilitators (this approach has been adopted in order to tender out Support Facilitation for sub-regions in geographically large PIR regions).

In the cases where Support Facilitators were employed by the Lead Agency but hosted in other agencies, this was usually done to ensure equity in pay between Support Facilitators. Differences in pay and award
conditions between agencies meant that in several cases there was marked variation in Support Facilitator pay and conditions within a PIR Organisation.

Some PIR Organisations undertook open tender processes to identify host agencies for Support Facilitators. In two cases this resulted in Support Facilitators being employed by agencies who were not part of the original PIR consortium. In both cases this led to a new ‘Operations Group’ being convened that was distinct from the PIR consortium, in order to provide operational oversight and information-sharing between employing agencies.

TEAM LEADERS
Most PIRs have created dedicated Support Facilitator supervisory roles. These PIR Team Leaders provide day-to-day management of the Support Facilitators and generally have responsibility for liaising with other employing or contracting agencies in the PIR Organisation, as well as the PIR Manager. In most PIR Organisations, the Team Leaders themselves carried a smaller caseload of PIR clients. This was to ensure that their roles within teams of Support Facilitators were not only supervisory but modelled good practice as well. PIR Team Leaders were almost all described as being employed by host agencies.

3.3 STAFF RECRUITMENT, ACTIVITIES AND TRAINING

RECRUITMENT
There was considerable variation in the speed with which PIR Organisations were able to recruit staff, influenced by several factors:

- the depth of the local skilled labour force
- the extent of competition with nearby PIR Organisations for staff
- the extent to which PIR Organisations had a specific idea about what skills and experience Support Facilitators should have
- the extent to which Support Facilitator recruitment was done centrally across the PIR Organisation or by individual host agencies
- whether PIR Managers were appointed in advance of Support Facilitators or at the same time
- the extent to which staff who were already employed by PIR Organisation agencies were able to be seconded or redeployed.

The PIR Manager is the key person within the PIR Organisation responsible for the management of PIR, organisational arrangements and relationships between agencies. This role exists in almost all PIR Organisations, though the range of activities they are responsible for managing varies. Recruitment of PIR Managers was regarded as a key step, and several PIR Organisations delayed other aspects of the establishment stage until they were able to hire an appropriate manager.

In a couple of instances, Support Facilitators were employed before the permanent PIR Manager was appointed, and this created a number of problems and difficulties in relation to their understanding of their role and function in the context of the PIR Organisation.

Several PIR Organisations conducted a collective recruitment process across all hosting agencies. This was done to ensure there was a good mix of skills across the PIR Organisation as a whole, a consistent understanding of the role, and internal collaboration rather than for candidates. This collective process was described as strengthening the nature of the partnership between the host agencies and enhanced the understanding of the skills and qualifications available across the PIR Organisation as a whole.

Several PIR Organisations employed Support Facilitators centrally to ensure consistency of pay and conditions, but then located them in other services. In this situation the Support Facilitators were usually managed by team leaders employed by the host organisations. Whilst this led to consistency in pay between Support Facilitators, it created pay differentials in some cases between workers within the host agency.
SUPPORT FACILITATOR SKILLS AND REMUNERATION

Support Facilitators have been drawn from diverse professional groups. The Support Facilitators interviewed during the site visits had backgrounds in mental health, psychology, social work, community welfare, drug and alcohol services, art therapy, supported accommodation, child protection, personal care, hospitality, occupational therapy and government. This illustrates the broad range of skills and experience that are informing the development of PIR. In a small number of cases Support Facilitators have been recruited with limited formal qualifications but with relevant practical or life experience. Some Peer Support Facilitators have been employed as well, with lived experience of mental illness.

There is variation between PIR Organisations in the extent to which they require Support Facilitators to be clinically trained. This appeared to be related to how the Support Facilitator role is conceived within the local service setting. In some PIR Organisations, Support Facilitators were regarded as being primarily a clinical role oriented around mental health. The alternate approach was for Support Facilitators to be conceived as a community development or system development role, focused on resolving service system issues. Several PIR Organisations have created a hybrid approach by employing a mix of clinically and non-clinically oriented Support Facilitators across the agencies involved.

Support Facilitators were generally regarded as well paid, though there was considerable variation across the country. Site visit and stakeholder telephone consultation participants revealed up to a $30,000 per year difference in salary packaging for Support Facilitators between PIR Organisations. In some cases interviewees said that there had already been loss of staff to other PIR Organisations based on differences in pay.

SUPPORT FACILITATOR FOCUS ON SYSTEM REFORM

A number of PIR Organisations have differentiated the PIR client-facing aspects of the Support Facilitator role and the system reform functions by employing separate staff to focus on system reform activities. In other PIR Organisations, the system reform function is regarded as an important part of the Support Facilitator role and Support Facilitators are encouraged to conceptualise their work as influencing system reform organically. Most PIR Organisations had focused on PIR client referral and intake during the period of the site visits and stakeholder consultations, and the organisational arrangements required to support these activities. It was therefore too early for tangible changes to the service system to be evident. At the same time, consultation respondents were enthusiastic about the potential for PIR to lead to substantive improvements to the service system for clients in the future.

SUPPORT FACILITATOR FOCUS ON SERVICE COORDINATION

There was a clear recognition across all site visits and consultations that the Support Facilitator role is not a case management one. When prompted, some interviewees had difficulty articulating the difference between case management and service coordination. Those interviewees that could articulate a difference emphasised the need for Support Facilitators to play a linking and coordinating role, rather than trying to directly meet the needs of clients themselves. Emphasis was placed on equipping PIR clients with the skills and service networks they needed, rather than solving their immediate problems.

It was acknowledged that service coordination is a challenge in areas with fewer services, in particular in rural and remote areas. It will not be possible to coordinate services where few exist, and the Support Facilitators may have to focus more on sector capacity building and system reform in these locations.

What are you going to be able to put in place because there’s nothing on the ground? So I end up thinking we will probably deal with less individual clients in that facilitation space and we’ll have to spend more time in sector capacity building.

PIR Organisation consortium member

Several PIR Organisations were undertaking practical activities to ensure greater service coordination occurred, as described in the following case study.
OUTPOSTING – A PRACTICAL APPROACH TO ENHANCING SERVICE COORDINATION

Many aspects of PIR service coordination are enhanced by regular informal contact, in addition to more formal partnership arrangements and interagency activities. This informal contact enables information sharing and discussions about service activities without having to engage in formal referral processes or discussing specific cases.

One PIR Organisation has recognised that the location of workers plays an important role in forming and strengthening this contact. They have taken an innovative approach to enhancing informal contact and information sharing by posting Support Facilitators in agencies within their PIR Network for part of their time. The Support Facilitators spend varying amounts of time with these agencies, ranging between half a day a fortnight to one day every week and accounting for an average of 1-1.5 days of each Support Facilitator’s time per week.

The PIR Organisation regularly posts Support Facilitators in a range of services, including:

- community mental health centres
- an emergency assistance and material assistance agency
- social housing providers
- non-government mental health services
- general non-government community service provider
- a government drug and alcohol service
- an employment services provider.

The practice of outposting was valued by the agencies where the Support Facilitators were located. They regarded the Support Facilitators as an additional, complementary resource by the agencies. In addition to identifying potential PIR clients, Support Facilitators were able to refer other service users to appropriate mental health services, in cases where they were not eligible for PIR.

This was regarded as demonstrating the PIR Organisation’s commitment to working in meaningful, practical partnership with other agencies. The practice of outposting PIR Support Facilitators allowed:

- an improved understanding of PIR and its purpose
- ongoing informal information-sharing
- the development of trust between workers and agencies.

By experimenting with approaches to locating Support Facilitators, this PIR has enhanced the understanding of PIR, both within their PIR Organisation and Network. They have also fostered new avenues for referrals in to PIR and new avenues for outwards referrals.
Every PIR Organisation has provided training for their staff. The nature of this training varied, and included:

- PIR Organisation processes and reporting mechanisms
- the Recovery Model
- the role of Support Facilitators
- working with consumers with a mental illness
- working with homeless people and people living in insecure housing
- working with carers
- cultural sensitivity and cultural safety
- housing needs
- community development
- information systems and data management
- child protection.

The training was provided by a range of agencies, including:

- PIR Organisation and Network agencies
- State mental health NGOs and peak bodies
- consumers and carers
- universities
- commercial training providers.

One of the most sophisticated approaches to defining and supporting the Support Facilitator role is described in the following case study. It involved collaboration between a mental health NGO, consumer and carer groups, and several PIR Organisations to develop a competency framework for the Support Facilitator role, with an associated tool to identify and monitor existing skills and training needs, and a two day training programme (see Case Study 2 overleaf).

Many Support Facilitators and most PIR Managers had taken part in the training provided by the National Resource Development Project delivered by Siggins-Miller, which is discussed in Section 4.1.1. This training occurred before many PIR Organisations had appointed Support Facilitators.

The initial training stuff did happen too early for us and it wasn’t quite in our roles…

Understandably the [training has] focused on what is the role of the support facilitator in particular in relation to their work with individual clients

*PIR Organisation consortium member*

No specific gaps in training were identified during consultation, although it should be noted that at the time of consultation many PIR Organisations were still in the process of recruiting staff and establishing teams.
3.4 STAFF RETENTION

PIR funding is time-limited so the implications of staff turnover have been reasonably pronounced and may influence the implementation and delivery of PIR within regions. This issue is likely to become more important as PIR progresses. It will be more difficult to replace staff as PIR approaches the end of its existing funding period.

PIR Organisations that have experienced senior staff turnover during implementation and establishment phases identified this as a significant issue. This turnover was often due to staff leaving the agency, though in a small number of cases the turnover was planned. Several Lead Agencies appointed staff on short term contracts to handle the early aspects of establishment and implementation, at which stage responsibility for operational management was handed over to other staff. This was often done to ensure that progress was made during the establishment phase, where it had not been possible to appoint a PIR Manager.

The impact of this turnover has been threefold:

- loss of organisational knowledge
- reducing continuity of contact within PIR Organisations and with external agencies and stakeholders
- creating a sense of instability within PIR Organisations.

Several interviewees reported that the rates of attrition within PIR Organisations had been higher than they expected. Early staff turnover was identified as a significant factor in speeding up or slowing down the establishment phase.

[Our] service system is hampered in some ways by the high turnover… with many service providers, managers and administrators coming… to live and work in [our region] for a period of some years and then leaving again.

PIR Organisation consortium member

Retention posed a significant issue for PIR Organisations operating in rural and remote areas in particular. Two rural PIR Organisations described having pronounced difficulty in replacing staff who had left. Both organisations reported that they had undertaken several rounds of unsuccessful recruitment.
INVESTING IN TRAINING AND PROFESSIONAL DEVELOPMENT: A COORDINATED APPROACH TO DEVELOPING STRONG SUPPORT FACILITATORS

Reflecting the critical role of the Support Facilitator in PIR, a number of PIR Organisations took collective action to engage a provider to develop a two-day training course and a competency framework to assist with recruitment, induction and ongoing professional development of Support Facilitators. It was the collective view of this group that no single PIR Support Facilitator was likely to have skills or competencies across all the required areas of skill, knowledge, values and attitudes required to undertake the role. In recognition of the specific skill set required, the Mental Health Coordinating Council (MHCC) was engaged to develop appropriate training and other professional development support materials.

Adopting a partnership approach in developing these materials, the MHCC worked with key PIR stakeholders including a number of PIR Organisations, the Association of Relatives and Friends of the Mentally Ill (ARAFMI) and a Consumer Advisory Group to develop a two day training course, ‘Navigating Support Facilitation’, as well as a ‘Knowledge, Skill and Attitude Analysis’ tool for PIR Support Facilitators, to guide ongoing professional development. The PIR Organisations demonstrated a sophisticated and forward-thinking approach in developing a framework that will benefit the recruitment, training and performance review of Support Facilitators, and ultimately result in good outcomes for PIR clients.

The ‘Knowledge, Skill and Attitude Analysis’ tool guides the mapping of skills, knowledge, attitudes and approaches for each Support Facilitator against 71 measures across nine key categories:

- Core requirements of the role
- Desirable knowledge/experience for the role
- Provide a coordinated recovery oriented service
- Working with people and building relationships
- Communicating and facilitating
- Develop and foster partnerships and influence service improvement
- Planning and organising
- Maintains records and resources
- Adapting and responding to change and coping with challenges

For each Support Facilitator, this tool maps existing skills, critical areas for coverage at induction, professional development for on-the-job training in the first 12 months in the role and where formal training is required - amounting to a tailored professional development plan.

The two day ‘Navigating Support Facilitation’ training course was designed for PIR Support Facilitators, PIR Team Leaders and PIR Managers. The course is grounded in both theory and practice, with strong emphasis on the philosophical underpinnings of PIR including the recovery model, a person-centred approach to service delivery and coordination, and partnership development. The key components of the course include:

- PIR and Support Facilitation introduction
- Understanding recovery-oriented practice
- Building a shared understanding
- Understanding self and others
- Building and maintaining collaboration partnership
- Influencing change
- Reflecting on practice
3.5 OPERATIONAL ISSUES

PIR Organisations had to address a broad range of operational and practical issues during their establishment and implementation. The categories below reflect the issues that were most consistently discussed during site visit and stakeholder consultation interviews.

3.5.1 EMPLOYMENT AND HOSTING ARRANGEMENTS

FORMS OF EMPLOYMENT AND HOSTING

The employment and hosting of Support Facilitators has generally taken one or more of the following four forms:

- employed by the Lead Agency
- employed by the Lead Agency and hosted in other consortium agencies
- employed by several consortium agencies
- employed by consortium agencies and non-consortium agencies following a competitive tender process to employ Support Facilitators (this approach has been adopted in order to tender out Support Facilitation for sub-regions in geographically large PIR regions).

Each of these approaches has benefits and challenges and has been determined in response to each PIR Organisation’s context. For example, several PIR Organisations decided to have Support Facilitators employed by the Lead Agency but hosted in consortium agencies to ensure consistency of conditions and to minimise competition for Support Facilitator recruitment within PIR regions. Other factors that were described as influencing the employment structures include the geographic distribution of population and workforce within a region, existing availability of team leaders and support structures within organisations, and the extent to which the Lead Agency wanted to be directly engaged in support facilitation.

This variation in approaches to employing and hosting Support Facilitators has meant that the ongoing role and purpose of the consortium member agencies has varied between PIR Organisations. In some cases all PIR Organisation agencies have received funding and/or staff. In others only the Lead Agency has received funding and employed staff. In most cases it has been somewhere between these two extremes, with some agencies receiving funding and staff while other agencies in the PIR Organisation receive only a small amount of direct funding or none at all.

IMPACT OF COMPETITIVE TENDERING PROCESSES

Some PIR Organisations undertook further competitive tender processes to determine who would provide PIR services within their regions. For example, the employment and hosting of Support Facilitators was opened to tender in several PIR Organisations.

This process of further competitive tendering within PIR Organisations was identified as a major factor that slowed down the establishment of PIR Organisations. The process of developing tender documents and contracts was unfamiliar to many of the Lead Agencies, and appointing host agencies was a time-consuming legal process. Several stakeholders said that more guidance about the processes PIR Organisations should follow for establishing sub-contractual arrangements would have been helpful, as would the provision of templates or model contracts that the PIR Organisations could adapt for their own requirements.

In some cases it’s added four or five months and still people in those agencies aren’t sure whether they’re going to be asked to have a support facilitator or not, they’ve really tied themselves up in an overly bureaucratic knot about due process.

NGO Stakeholder

Where PIR Organisations undertook further tender processes within their regions, the financial benefits for consortium member agencies of participating in PIR were not necessarily clear. For example in some cases Support Facilitators were employed by agencies that had been part of competing bids for the original PIR tender process, while other consortium member agencies who had far more involvement in the establishment of the PIR received no funding.
3.5.2 INFORMATION AND DATA SYSTEMS

Every PIR Organisation reported spending considerable time on the development of information and data systems. For the most part this involved adapting existing data systems to ensure that elements stipulated in the MDS were recorded. In some cases this involved developing entirely new systems.

A wide range of commercial database and information management systems appear to have been adapted for client information management. In most cases these were adaptations of existing systems, though for a substantial portion they were wholly new. Most PIR Organisations had opted for web browser-based systems because:

- Support Facilitators were based in a number of agencies and web-based systems enabled the PIR Organisation to overcome different agencies' IT systems' technical and security requirements.
- in some cases, it made it possible to enter or access PIR client data while staff were in the field.

Some stakeholders described frustrations associated with browser-based systems being initially blocked for some agencies, though the issue was generally possible to resolve. Others based in rural and remote areas described frustrations relating to slow internet connections. One interviewee based in a rural area described an occasion where the internet connection had timed out five times while she was trying to access a PIR client record, at which point she gave up.

In addition to client information management systems, many PIR Organisations have developed systems for more information-sharing within their teams. This included databases of services and events as well as shared online calendars. Email, telephone calls and videoconferencing were described as being regularly used for communication within teams.

The MDS was generally regarded as a useful guide in designing the requirements for PIRs' reporting systems, though most stakeholders consulted noted that there were delays in it being issued. This was described as a significant factor in delays in creating client information management and reporting systems. Several PIR Organisations expressed the view that it would have been easier and more efficient for the Department of Health to mandate the use of a single data system, rather than setting out requirements for existing systems. There was recognition that this may not have been practical however, given many of the Lead Agencies had existing, well-developed client information management systems, in particular where the Lead Agencies were established NGO mental health service providers.

A practical question that has emerged is how PIR Organisations can transfer and share PIR client data between PIR Organisations. PIR clients were described as being relatively mobile, with many moving between regions; this movement is often unplanned. Mechanisms and protocols for transferring PIR client data had not been developed at the time of the site visits and telephone consultations.

A small number of PIR Organisations mentioned that they had given consideration to how their data systems might make use of, or interface with, the National Patient Controlled Electronic Health Record. No clear activities were described in the interviews.

3.5.3 DEVELOPMENT OF GUIDELINES AND POLICIES

The PIR Organisations reported that they had developed a broad array of guidelines, policies and operations documents during their establishment phase. The type of policies and guidelines reported included:

- risk management plans
- service gap analyses
- communication strategies
- contracting and procurement policies
- flexible funding policies
These policies and guidelines were regarded as important in order for Support Facilitators to have clarity and confidence about their role, as well as enhancing accountability and promoting effective programme management.

There was a difference between PIR Organisations in the extent to which they sought to finalise these policies and guidelines before they started on implementation activities. Some PIR Organisations delayed opening their doors to clients until there was certainty about how arrangements would operate. Others developed their guidance while starting their early system reform and service coordination activities, changing them as required. The extent to which PIR Organisations were able to operate without all procedures being finalised influenced the timing of each Organisation’s official date for beginning to operate as a service.

The Resource Development Project was described as helpful in prompting several PIR Organisations to think about their guidance and procedures. Several PIR Organisations said that mandated procedures would have been easier for PIR Organisations, though they acknowledged the need to adapt procedures for local service systems. Others suggested that more standardised templates that they could adapt for use in the PIR Organisation would have been helpful.

3.5.4 COMMUNICATION AND PROMOTION

PIR Organisations undertook a wide array of communication and promotion activities, including:

- presentations to external agencies and PIR Network members
- presentations to agencies within their PIR Organisations
- convening interagency fora
- organising regional conferences
- attending service expos
- attending other agencies’ meetings
- developing promotional materials for consumers and carers
- developing promotional materials for other agencies
- developing information brochures
- establishing websites
- recording promotional videos
- establishing social media accounts and blogs in some cases
- developing their PIR Organisation branding and uniforms in some cases.
This accounted for a significant portion of PIR Organisations’ overall activity during the establishment phase. Communication activities were intended to increase awareness of PIR in sectors relevant to PIR’s goals. At the time of the evaluation interviews there had been less activity promoting PIR to potential clients, although several PIR Organisations planned activities targeting consumers and carers.

Information and resource-sharing between PIR Organisations was regarded as particularly valuable for communication and promotional activities. Many PIR Organisations were willing to share resources and information that they had developed, which enabled other PIR Organisation to adapt material rather than starting from scratch. The Capacity Building Project’s teleconferences and website for were identified as important mechanisms for this.

The issue of branding and identification of PIR came up in more than half the interviews with PIR Organisations. Many suggested that there would have been value in highlighting PIR’s status as a major new national initiative, which would have assisted their work promoting service coordination and system reform. PIR Organisations have responded to the issue of branding in different ways. PIR Organisations had concern about delays in determining if PIR would have national branding or whether they should develop their own regional branding and marketing collateral.

*Branding, they need branding for the public, and they need the branding for the consumer.*

*Support Facilitator*

Many PIR Organisations have developed their own marketing collateral and information for consumers and carers, while others have waited to varying degrees for national leadership. The PIR Organisations that developed their own branding and marketing materials have generally been those who began seeing PIR clients earliest. PIR Organisations were also conscious that there is a need to ensure a cohesive identity for PIR when staff are employed across multiple agencies and working with disparate services. This suggested the need for investment in communication and branding activities.

### 3.5.5 FLEXIBLE FUNDING POOL

The flexible funding pool was included in the structure of PIR to provide access to a limited amount of flexible funding to be used to purchase services and supports for PIR clients that cannot be secured through normal avenues. The flexible funding pool represents a small proportion of the overall budget of each PIR Organisation. It was anticipated that it would be used to meet short-term or ad hoc needs, rather than medium- or long-term needs.

There had been little reported use of the flexible funding pool at the time the data for this report were collected. Flexible funding was widely regarded as an important avenue for system reform activity, suggesting that its use is conceived as more than just brokerage funds. At the time of the site visits, many of the PIR Organisations had creative ideas about how the flexible funding might be spent but very few had actually spent any flexible funds. The extent to which flexible funding will impact on local service access and system reform is unclear at this time.

Some PIR Organisations reportedly were reluctant to spend flexible funds because they were still developing internal guidelines for their use, consistent with the requirements for the use of the flexible funding set out by the Department of Health. There were concerns expressed that the PIR Organisations wanted to ensure activities were eligible and not outside the intended purpose.

*Our reference group is focusing a bit more on system reform, what it means and what it might look like. With some of that the flexible funding spends will come into sharper focus. There has been plenty of talk… There’s going to be stuff around access to services, transport, those kinds of things.*

*PIR Manager*

*Some people who are a bit bureaucratically inclined are so frightened about misspending the money that they are hardly spending any of it… They’re being a bit cautious.*

*NGO stakeholder*
An exception to this was one PIR Organisation that took a sophisticated approach to expending its flexible funding pool. It has created an innovation fund to address system reform, which is described in the case study below. This fund was intended to provide grants for projects to develop processes or resources to help overcome system barriers.

3.6 SUMMARY

The first six to eight months of PIR Organisations’ operations were focussed on a range of establishment and early implementation activities. These included:

- staff recruitment
- staff training
- negotiating and contracting employment and hosting of Support Facilitators
- development of organisation policies, procedures and protocols
- development of IT systems to record and report on MDS data
- development of promotional/branding material
- extensive sector and community engagement activities.

In several PIR Organisations some activities were delayed due to some activities taking longer than anticipated:

- the development of information systems and client information management systems
- contracting arrangements within the PIR Organisation
- staff recruitment.

There was a range of approaches to the centralisation of functions within PIR Organisations, in particular PIR Organisation coordination and management, initial intake, partnership development and communication and promotion. It is too early to tell what impact these arrangements will have on the delivery of PIR. At the time of the interviews there had been very little use of the flexible funding pool, as PIR Organisations were generally still developing their own guidelines and protocols for its use.
One PIR Organisation has used its flexible funding pool to create an Innovation Fund, a grants scheme for projects addressing service integration and system reform. Under the Innovation Fund, funding was made available for seven small projects ($5,000 to $20,000) and four larger projects ($80,000 to $100,000). Applicants for larger projects are required to provide some level of matched funding.

The Innovation Fund seeks Expressions of Interest for project funding that:

- focuses on system reform (not direct service-delivery)
- is for the benefit of people with long-term, severe problems with their mental health and have complex needs
- is delivered in the Medicare Local geographic area
- does not duplicate an existing project.

The PIR Organisation identified a series of priorities for the funded projects in the first year of the Innovation Fund. These themes were developed from information collected at a local PIR Forum, attended by over 200 consumers, carers and human service providers. A key purpose of the Forum was to identify and prioritise actions that could be funded, that would respond to service system gaps and inadequacies, and which could be undertaken within a six month period. Some of the priorities for funding from the 2013-14 Innovation Fund included:

- **Consumer Voice**
  - identifying best practice for building a stronger consumer voice and seeking the views of consumers on how they would reform the system to better meet their needs

- **Collaboration**
  - practice guidelines and resource packs for organisations seeking to co-locate
  - development of a common approach and understanding of care coordination and case management (including assessment and referral)
  - best practice guidelines and actions for effective discharge and transition planning

- **Community awareness**
  - developing mental illness awareness-raising activities for specific communities – including Aboriginal and Torres Strait Islander communities, CALD and LGBTI communities

- **Service navigation**
  - engaging with healthy living services/activities (including gyms, dieticians, Tai-chi instructors) to raise their awareness of mental illness and its impact on physical well-being, and increase the accessibility of their services to people with long term severe mental illness who have complex needs

To further the aim of the PIR system reform objectives, all funded projects have to involve collaboration, and funding applications have to involve more than one organisation.
4 Governance and management

4.1 NATIONAL PROGRAMME MANAGEMENT

PIR is managed by the Coordinated Care Section of the Primary Mental Care Division of the Department of Health. The Department has established an Expert Reference Group to provide advice on PIR and on the evaluation of the initiative. The membership of the Expert Reference Group is attached at Appendix E.

Through PIR the Department has made significant investment into programme infrastructure, to ensure successful implementation. This level of investment seeks to ensure adequate support and measurement of outcomes is in place, particularly given the large number of organisations involved with delivery of PIR.

Three national projects support implementation of PIR through:

- resource development
- capacity building
- evaluation and monitoring, including development of the MDS.

Overall these projects, describer further below, were valued and described as being innovative, though some avenues for enhancement were identified through the site visits and stakeholder consultations. In the view of those interviewed, considerable thought and attention had been given to the overall programme management and programme infrastructure to support PIR. This was considered to be good practice in the design and implementation of national health initiatives.

PIR Organisations must consider how best to draw on the supports and activities provided through these national projects, and how best to balance their investment in these areas at a regional level from within their own PIR Organisation budget.

4.1.1 DEPARTMENT OF HEALTH

Stakeholders recognised that PIR is a major new initiative that involves considerable complexity. There was widespread acknowledgement that the Department of Health had provided guidance on PIR that accommodated the need for flexibility, during a period of broader policy reform and a Federal election period. This political cycle had an impact on the establishment of PIR, requiring quick establishment and then some delays in decision-making due to the change in government.

A small number of stakeholders noted that changes to operational guidelines were occasionally confusing and required interpretation at the PIR Organisation level. They also reported that some of the reporting templates and tools did not always reflect changes to operational guidelines and that this could cause confusion within PIR Organisations. These stakeholders noted that updates to the operational guidelines had resolved many of these issues, though delays had caused some uncertainty.

Some also reported that the revisions to the MDS requirements had also caused some difficulties, although the changes were acknowledged to be attempts to clarify issues that had arisen through implementation. A number of PIR Organisations said that greater clarity regarding eligibility requirements, branding and marketing collateral, the use of assessment tools and reporting templates would have assisted them in the establishment phase.

4.1.2 RESOURCE DEVELOPMENT PROJECT

Siggins Miller Consultants Pty Ltd were engaged in 2012-13 to collate existing and develop a suite of new tools and resources to be made available for use by PIR Organisations and staff. The project also involves the delivery of training to PIR Organisations in the use of the suite of tools and resources.

The tools and resources included:

- PIR Operational Guidelines
- PIR referral tool (and instructional guide)
- PIR information booklet for consumers, carers and families
- examples of needs assessment frameworks and tools
- an example of a PIR Action Plan template
- examples of partnership-building and governance tools (such as Memorandums of Understanding, multiagency and regional/service level agreements).

Online and face-to-face training was provided to PIR Organisations, their staff and partner agencies to ensure all stakeholders were familiar with the tools and resources available to support them in their roles.

Resources were made available in a hard copy version to all PIR Organisations as well as on the PIR Capacity Building website (DOH, 2013). There was mixed feedback on the Resource Development Project from stakeholders, as outlined below.

<table>
<thead>
<tr>
<th>REGARDED FAVOURABLY</th>
<th>COULD HAVE BEEN IMPROVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practical tools and approaches that could be used for eligibility, assessment and needs assessment processes</td>
<td>The training occurred too early for most PIR Organisations, when they were still appointing key staff</td>
</tr>
<tr>
<td>Provided consistent training and messages nationally</td>
<td>More directive guidance about which tools to use and what assessment forms should look like</td>
</tr>
<tr>
<td>Highlighted the range of recovery-oriented resources that are available</td>
<td>Greater focus on recovery-oriented tools that had been developed and validated in the Australian context</td>
</tr>
</tbody>
</table>

The Resource Development Project was valued by PIR Organisations, however there was a view that the project may have been delivered too early for many PIR Organisations. Several interviewees reported that they found the range of resources useful. They also reported that the Resource Development Project made them consider aspects of their assessment, planning and reporting procedures that they had not considered previously.

This Resource Development Project coincided with the establishment of PIR Organisations. As such, some PIR Organisations were advanced in their planning and ready to make use of assessment tools and resources, whereas other organisations were still grappling with organisational arrangements. Workshop participants recognised the challenge faced by Siggins Miller in providing training to a broad range of participants who were at different stages in the establishment of their PIR Organisations. There was a view expressed that the workshops occurred too early in the establishment phase and that this prevented the benefits of the Resource Development Project from being fully recognised.

Many PIR Organisations expressed dissatisfaction with the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS), which is built into the MDS. A significant number of PIR Organisations have also opted to use additional recovery-oriented tools during their assessment processes, notably the Mental Health Recovery Star (MHRS) and the Recovery Assessment Scale (RAS).

4.1.3  CAPACITY BUILDING PROJECT

Flinders University has been engaged as the PIR Capacity Builder from 2012-13 until 2015-16. Its role is to:

- build strong networks amongst PIR Organisations through establishing formalised opportunities for face to face contact through an annual national workshop and state/territory workshops or network meetings/activities
- establish a central point of access to the tools and resources developed to support implementation of PIR, and provision of ongoing training and support to use the tools and resources as required
document and disseminate information/resources on successful, innovative and best practice approaches to implement PIR

develop a PIR web portal with social networking tools and other information technologies that enable dialogue, trouble-shooting, information exchange and dissemination, knowledge transfer, and a way to keep PIR Organisations abreast of trends and developments

have a direct link to the PIR evaluator to ensure information generated through the project is available to inform PIR evaluation and monitoring activities.

As part of the Capacity Building project, Flinders University funds two representatives from each PIR Organisation to attend an annual National Workshop (DOH, 2013).

PIR Organisations generally expressed appreciation for the Capacity Building Project. There were a range of views about the Capacity Building Project, with some regarding it extremely positively and some regarding it very negatively. The majority were somewhere in between and identified a number of activities that were valued as well as areas where there could be improvement. These issues are outlined in Table 4.

**TABLE 4 – FEEDBACK ON THE CAPACITY BUILDING PROJECT**

<table>
<thead>
<tr>
<th>REGARDED FAVOURABLY</th>
<th>COULD HAVE BEEN IMPROVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platform for sharing tools and resources</td>
<td>Website usability</td>
</tr>
<tr>
<td>Responsiveness and helpfulness of Capacity Building</td>
<td>Clearer agendas, chairing procedures and fewer participants for teleconferences</td>
</tr>
<tr>
<td>Project staff</td>
<td></td>
</tr>
<tr>
<td>National PIR workshop, and to a lesser extent regional</td>
<td>More ways for sharing information and resources that aren’t mediated by the Capacity</td>
</tr>
<tr>
<td>PIR workshops</td>
<td>Building Project</td>
</tr>
<tr>
<td>Willingness to acknowledge feedback from PIR Organisations and making plans to act on them</td>
<td>Researching, documenting and disseminating good evidence-based practices</td>
</tr>
<tr>
<td>Having an source of support outside the PIR Organisation</td>
<td>Moving beyond reflecting PIR Organisations’ concerns to highlighting solutions</td>
</tr>
<tr>
<td></td>
<td>More national leadership and advocacy</td>
</tr>
<tr>
<td></td>
<td>Producing evidence summaries and other activities being done by several PIR Organisations separately</td>
</tr>
</tbody>
</table>

Stakeholders recognised that the Capacity Building Project was an innovative aspect of the PIR. They described it as providing useful information and assistance during the establishment and implementation phases, though there was a number of ways it could be enhanced.

*"I think the Flinders people are very responsive and very helpful. Part of our training for our Support Facilitators, I asked could they give us a tour of their portal via a webinar and teleconference process, and they were very happy to do that and very enthusiastic about doing it, which was good."*

**PIR Organisation consortium member**

There was a desire expressed for the PIR Capacity Building Project to move beyond information-sharing to a more proactive approach that focuses on strategic issues facing PIR Organisations. This may reflect the concerns of the PIR Organisations when the interviews were conducted and most were transitioning from the implementation phase to ongoing operation.

There was a widespread view that many of the Capacity Building Project’s activities resulted in summaries of issues rather than ways to address them. The interviews highlighted a number of areas where the Capacity Building Project could provide a greater contribution:

- practical approaches to system reform and how to describe it
- workforce development
- leadership within PIR Organisations and across the programme nationally
- good practices and innovations
- partnership development and working intersectorally
- evidence reviews and evidence summaries
- the NDIS.

The first National Workshop was valued by those who had attended, and it was regarded as topical and well-organised. There was less satisfaction expressed with the regional workshops, for two reasons. The first was that there was a wide range of stakeholders attending, from Support Facilitators through to senior managers within PIR Organisations, making it difficult to ensure content was relevant for all attendees. The second was because the regional workshops often focused on well-known or less-salient issues.

Concern was expressed about the Capacity Building Project website. Though it was consistently described as a useful resource, most interviewees who mentioned it described it as being difficult to navigate. Its design was also described as limiting the extent of interaction and information-sharing between PIR Organisations. The teleconferences were also described as being a valuable initiative that was impaired by their implementation. The lack of a clear agenda, non-directive chairing and too many participants were the primary reasons for dissatisfaction. Stakeholders consulted later in the year considered that the staff of the Capacity Building Project were aware of these issues and were actively working to address them.

They said we’re going to be improving the website and I was like great because I just can’t stand it. It’s not very user friendly. You go in there and you can’t seem to find anything. It’s convoluted,. And they recognised that and said that the initial set up of that was speedy. So it was not what they wanted and now they are going to fix it, which is fabulous. I hope it’s going to be vastly improved.

PIR Manager

The Capacity Building Project staff were uniformly regarded as helpful and responsive. Criticisms of the Project related mostly to its strategic activities and the need for greater unmediated information and resource sharing between PIR Organisations.

I’m really happy with the support that’s available through Flinders Uni. The phone calls, and a couple of times I’ve had really dumb queries, just because I didn’t follow something in the right place or I couldn’t remember what was said. They’ve always come through with a response, so I’ve found that really valuable.

PIR Manager

4.2 PIR ORGANISATION GOVERNANCE

4.2.1 GOVERNANCE ARRANGEMENTS

Most PIR Organisations had retained the same consortium structure and membership as they had created while developing their original tender. A small number of PIR Organisations have changed the composition and membership of their consortia. In one case, the original consortium has been disbanded, with the Lead Agency developing a new approach involving advisory groups and sub-contractual arrangements. In some cases additional governance mechanisms have been developed by PIR Organisations to inform the management and governance of the program. These include:

- consumer and carer advisory groups
- agency reference groups
- leadership panels
- interagency networks
- regional fora.

These mechanisms were generally described as adjuncts to the PIR consortia meetings rather than replacements for them.

In less than half of the PIR Organisations, member agencies are provided with financial compensation for their service on PIR committees. Many PIR Organisations reported that it was desirable for agency participation to be unpaid to ensure that it was a genuine partnership rather than a fee-for-service approach.

I think probably the biggest thing that we’ve done is get a group of people together on the PIRO who really want to be here, and the idea of not paying them an honorarium or anything I think is a really good idea because it really sifts through the who’s here because they want to be there. I think our particular group of people is pretty committed so it’s the partnership, relationship-building sort of thing and it seems really functional to me.

PIR Manager

In the cases where payments were made they were described as a mechanism to address concerns in some PIR Organisations that some agencies were not being compensated for their involvement in PIR while others were receiving direct funding and support.

The two organisations that are not employing staff… they have been allocated just an annual amount and that’s $15,000 so that’s not a huge amount for their contribution, which does include meetings. In [one person’s] case that’s the chairing function, not just attending meetings, but a lot of responsibility that goes with that independent chair role so $15,000 in each case is more an honorarium, it’s not in any way a measure of the amount of time and contribution that is made by those two organisations.

PIR Organisation consortium member

In all cases where consumers and carers were reported as members of the PIR consortium they received compensation in the form of a sitting fee or honorarium in recognition for their time and costs associated with their service. This is consistent with recommended practice in the mental health sector (NCCF, 2004).

In several cases, the original consortium has split into separate operational and advisory/governance groups, based on the extent to which agencies are involved in the day-to-day activities of PIR and the employment of Support Facilitators. The operational groups meet regularly and focus on the details of support facilitation, service coordination and other consumer-facing activities. Where these operational groups exist, the governance or advisory groups generally meet less often and inform overall direction and system reform activities. Several PIR Organisations have also set up reference groups to involve and engage agencies that were not part of the original PIR consortium but have been identified as important for the success of PIR in their region. These are distinct from consortium meetings.

So we made a decision to step out of providing support facilitators in our organisation but we continue to sit on the governance group. We want to be involved… and I think that was done in a very honest and very respectful way and we can talk about difficult things and we are able to problem solve together.

PIR Organisation consortium member

4.2.2 VALUES AND PRINCIPLES

Several PIR Organisations have articulated statements of values to inform their activities. This has been done with specific reference to the overall objectives of PIR and recovery principles. Several of the sites visited described this as a useful exercise in the early development of their PIR Organisations, by enabling a shared understanding of what the group were collectively trying to achieve and the processes they would follow to achieve it. The extent to which these value statements have informed subsequent decision-making and implementation are unclear. Their contribution may have been most useful at the
formative stages in the PIR Organisations to build consensus and a shared culture between participating agencies.

As a counterpoint to this, several of stakeholders within PIR Organisations who described challenges in forming effective partnerships attributed this to the lack of shared values. There was a perception that the lack of consensus regarding the aims of the PIR Organisation impeded many subsequent activities.

A recovery approach is central to the values and principles of all PIR Organisations who have clearly articulated them. Every interviewee in the site visits and telephone consultations who spoke about values explicitly referred to a recovery approach.

The principles that drive [our service] is the importance of clients finding meaning and autonomy in their lives, but meaning and autonomy as they see it, recovery as they see it.

Support Facilitator

Whether or not the core values of the consortium had been explicitly agreed, most of the PIR Organisations indicated that a recovery approach was a core principle. Where it was not clearly articulated, it was often due to concerns that the approach would not be well understood by all agencies, in particular housing and material support services.

Our workers are completely recovery-focused and have been from the very start. They come from that background that is the way they think… That’s going to be interesting if we come up against people who aren’t recovery focused and how are we going to manage that. I would imagine we’ll get to that with housing.

PIR Manager

One interviewee noted that because PIR Organisations were based on contractual arrangements, there was a likelihood that they would focus on risk and responsibilities in their dealings with other agencies. They described this as being partially at odds with an approach that emphasises wraparound services for the client. Rather than focusing on risks to clients the interviewee suggested that agencies in PIR Organisations may focus on risks to themselves and their contractual obligations. This was a minority perspective however, and will be monitored in subsequent rounds of fieldwork.

I’m not sure even what a recovery model is, but everyone has their own view of what recovery is. I come from this point of view that we have created an organisation that’s built on contracts, so it naturally has an aversion to risk.

PIR Organisation consortium member

Several interviews identified the need for PIR Organisations to refer routinely to the purpose and objectives of the national PIR Initiative in order to ensure programme fidelity and to minimise ‘service drift’. It was noted that there is considerable variability between PIR Organisations due to the need to respond to local needs and service settings. There was a concern expressed that the overall objectives of PIR Organisations could begin to vary markedly between regions if measures aren’t adopted to ensure ongoing shared objectives and overall programme fidelity.

There was a view expressed by a small number of interviewees that while flexibility in activities between PIR Organisations was desirable, different understandings of the purpose of PIR could create challenges within PIR Organisations over time. This will be explored further during the course of the evaluation.

There’s variability. Some [PIR Organisations] specify how you’re expected to report back in terms of accounting for each line item of expenditure. Others have given you a lump sum and don’t specify how you should spend it. So there’s this variety that we’ve been able to see from being in several [PIR Organisations].

PIR Organisation consortium member
4.2.3 CONSUMER AND CARER INVOLVEMENT IN GOVERNANCE

The PIR Organisations that were most advanced in relation to consumer and carer involvement in the design of their model, and in decision-making and monitoring, typically had consumers and carers involved in a range of activities including:

- as a named member of the consortium
- as a member of an advisory group to the consortium
- as a member of an advisory group to inform the development of PIR projects, processes and policies
- as a member for review panels for tender arrangements
- as a participant in PIR Organisation staff recruitment processes, including interviews
- leading or participating in the training of PIR Organisation staff.

The case study overleaf describes one PIR Organisation that has taken a multi-pronged approach to involving consumers in the development and implementation model.

All PIR Organisations acknowledged the importance of consultation with consumers and carers in the implementation and operation of PIR. The majority of PIR Organisations interviewed stated that they have had some level of carer and consumer input into the development and establishment of PIR, though the timing, nature and extent of this input varied.

Many, though less than half, of all PIR Organisations reported that they have established consumer and carer reference or advisory groups. They have used these for consultation about aspects of the PIR model and service delivery. A minority reported that consumers and carers are included on the consortium or their governing decision-making body. In many cases PIR Organisations reported that they have had contact with consumer and carer organisations, though this was generally limited in scope.

"I sit in these conferences and I think 'don't get upset, don't get upset' but it's just like we've always been an afterthought, and what the service is about is the consumer and the carer. That's the real core of the service."

Carer representative

The state and territory mental health consumer organisations who were consulted reported that they had all had some contact with PIR, though usually at a jurisdictional national level through formal consultative processes. One state consumer organisation has had active involvement with several PIR Organisations and reported they are members of several PIR consortia and sit on several PIR Organisations’ advisory groups.

It appears that where a recovery model is most strongly and clearly articulated by the PIR Organisation, there is also stronger engagement with carers and consumers. The level of engagement with consumers and carers may also be related to the extent to which PIR Organisations are taking a more clinically focused approach, rather than a community development or service development one. In those cases it was suggested in the interviews that the clinically oriented PIR Organisations tend to have less consumer and carer engagement, however this trend is not universal. It is currently too early to confirm this association.

Four PIR Organisations reported that mental health consumers were involved in the process of recruiting Support Facilitators. This was described as useful because not only did it demonstrate commitment to consumer and carer involvement, it also helped to ensure that Support Facilitators were able to respond to consumer questions and concerns.

"If you have consumers and carers [on the interview panel] you’ll get much better feedback. If we’re asking bureaucratic standard questions we’ll get a certain standard answer, but if we’re asking sort of consumer-focused or carer-focused questions, then you might find what you’re looking for."

Consumer representative
Two PIR Organisations described consumer and carer involvement in their training for Support Facilitators. This was focused on the consumer and carer experience of service use, and how to work effectively with consumers and carers.
CASE STUDY 4 – CONSUMER AND CARER INVOLVEMENT: CREATING A MODEL WHERE CONSUMERS ARE CENTRAL TO THE PROCESS

While many PIR Organisations have consumer and carer representatives on their advisory boards or reference groups, one PIR Organisation has involved consumers in the implementation of the initiative in a number of different ways. In addition to having consumer and carer representatives on their reference group, this particular PIR Organisation has involved consumers and carers:

- as advisors in the initial establishment of the consortium
- in the development of a Credo and Practice Principles
- as workshop facilitators
- on recruitment panels to employ Support Facilitators
- on the participant advisory council of the Lead Agency
- to train staff in the Recovery Model.

The PIR Organisation recognised the importance of involving consumer and carer representatives early in the process. In the establishment phase of the PIR Organisation, a workshop was run by a consumer consultancy firm.

The workshop involved consultation with consumers, carers, and service providers to develop the PIR Organisation’s Credo and Practice Principles.

The process of developing the Credo involved participants sharing their experiences and from there, incorporating the different stories into common themes. The common themes identified on the day became the Credo and Practice Principles.

The Credo and Practice Principles represent a common understanding and commitment as to how the PIR will deliver services.

A strong consumer-centred and focused approach underpins the Credo and Practice Principles. In particular it recognises that:

- people are experts on their own lives
- all people have potential and are contributing members of their community in which they live
- relating and referring to people through labels may carry stigma or define and limit possibilities.

As a result of the workshop process and the development of the Credo and Practice Principles, consumers were committed and engaged in the implementation of the PIR organisation.

The Credo is included in job descriptions so that new employees are aware of the principles underpinning the PIR Organisation.

A consumer consultancy firm also delivered training to Support Facilitators in the Recovery Model. The training centred on recovery-oriented practice to strengthen the framework for the PIR Organisation.
4.2.4 ROLE OF THE LEAD AGENCY

The role of the Lead Agency varies between PIR Organisations, principally in the extent to which the Lead Agency sees decision-making and coordination as centralised. In some cases the Lead Agency described their role as being a purchaser-provider of services within their PIR Organisation. In others the Lead Agency saw their role as being a facilitating agency, with decision-making and implementation controlled by the PIR Organisation as a whole. This perception about the role of the Lead Agency had an impact on the role the consortium played, ranging from consensus-based decision-making through to being a mechanism for endorsing the Lead Agency’s decisions.

The other positions [on the PIR consortium] are held by the partner organisations… including the local health district, the consumer and carer reps and a number of other partner organisations. So it’s a fairly equal relationship at that level, although the Medicare Local has the funding. It’s the lead agency in terms of the governance of the organisation; it’s actually not very top heavy in terms of the governance of how we run the organisation.

PIR Manager

In most cases where Medicare Locals are Lead Agencies they have adopted a purchaser-provider model in their general operations. In these cases Medicare Locals have tended to employ staff to perform centralised functions and Support Facilitators have been employed by other agencies. A minority of Medicare Local Lead Agencies considered themselves to be service providers and have employed Support Facilitators as well as central PIR staff. The extent to which Medicare Locals have directly engaged in service delivery appears to be linked to the strength of existing partnerships between Medicare Locals and mental health service providers. In the cases where Medicare Locals were employing Support Facilitators directly they described having had fewer dealings with mental health agencies in the past, though this was not universally the case. In one case it was reported that the Medicare Local Lead Agency had disbanded the PIR Organisation’s consortium and was at the time of the visits in the process of establishing a new advisory group with a subsidiary operational management group consisting of agencies employing Support Facilitators.

I guess my concern is a really expensive programme [that] has the capacity to really change people’s lives and transform communities is being led by Medicare Locals who are not well versed in providing a service, they’re contractors, that’s what they say they’re designed to do.

PIR Organisation consortium member

In a one PIR Organisation this was identified as a potential conflict of interest, because the Lead Agency was coordinating activities and managing oversight processes. In this PIR Organisation they created a structure to separate out the Lead Agency from overall oversight of the PIR Organisation. The Lead Agency participates in what are known as operational group meetings and the consortium meets separately to oversee PIR and to provide advice, without the Lead Agency being involved.

We have obviously the operational level with the six service providers and the support facilitator staff, with the operational group guiding that, and then we had the consortium. So I think there is a confusion, we need to review the governance because there is confusion in terms of what is the consortium as opposed to the operational group, what’s the consortium in relation to the strategy group.

PIR Organisation staff

There were no changes reported in the agency performing the role of Lead at any of the site visits or telephone consultations. In one case the PIR Organisation was jointly-led as a close collaboration between a Medicare Local and a mental health NGO. This joint Lead Agency arrangement was negotiated during the tender process as a way to ensure both agencies were involved in the same tender bid.
4.3 SUMMARY

The national programme management of PIR has provided good support for a new national initiative. The activities that were done well are outlined below, along with activities that could have been enhanced.

The Department of Health:
- invested considerable time and thought into the overall design and implementation of the PIR Initiative
- provided extensive supportive infrastructure in the form of policy and implementation guidance, the Resource Development Project and the Capacity Building Project.

Some identified areas for improvement are:
- timely clarification of operational queries
- branding and marketing of PIR.

The Resource Development Project:
- provided practical tools for PIR Organisations to use
- delivered consistent training at the early stages in the establishment of PIR Organisations
- highlighted practical approaches to the assessment of needs and recovery.

Some identified areas for improvement are:
- timely provision of training, as initial training was too early for most PIR Organisations
- greater direction about which tools and resources to use in their assessment processes
- enhancing the focus on recovery in the assessment process.

The Capacity Building Project:
- provided well organised national and regional workshops that dealt with relevant issues
- provided an important platform for PIR Organisations to share information, resources and experiences
- has been helpful and responsive to PIR Organisations’ queries and concerns.

Some identified areas for improvement are:
- enhancing the usability of the website and the process for teleconferences with PIR Organisations
- highlighting good practices
- playing a thought leadership role, to identify key strategic issues and ideas on how PIR Organisations can address them.

The governance arrangements in most PIR Organisations are generally similar to those used for the original tenders. In general, these are progressing well and continue to provide effective oversight of PIR Organisations. The roles of the Lead Agencies within their PIR Organisations vary considerably, and reflect the extent to which Lead Agencies see their role as facilitating or leading the PIR Organisation’s activities.

There is a spectrum of involvement of consumers and carers in the governance of PIR Organisations, ranging from including consumer and carer representatives as part of the consortium through to having
no direct engagement with clients and carers. All PIR Organisations acknowledged the importance of consultation with consumers and carers in the implementation and operation of PIR. The majority of PIR Organisations interviewed stated that they have had some level of carer and consumer involvement, though the nature of this varied.
5 Programme referral, assessment and service coordination

5.1 PIR CLIENT REFERRAL AND INTAKE

As described in Section 5.4, at the time of the interviews most activity was focused on potential client identification, referral, assessment and registration, and the activities required to support this. Most PIR Organisations had a small number of registered clients. The qualitative data suggested that the sources of referrals varied between PIR Organisations and were closely linked to the activities undertaken to:

- generate referrals
- create referral pathways
- improve awareness of PIR amongst relevant services.

At the time of the site visits it was too early to identify the primary referral pathways for PIR Organisations. Analysis of the PIR client activity data will help to answer this question.

The anticipated avenues for referrals identified in the interviews included:

- government mental health services
- non-government mental health services
- primary health care providers, including GPS
- carers
- police
- material assistance agencies
- housing, homelessness and supported accommodation services
- employment agencies
- community transport agencies
- prisons and corrections health agencies.

Many PIR Organisations were devoting considerable amounts of time and effort in promoting PIR within their local service systems to generate referrals. Several PIR Organisations discussed the need to develop simple referral pathways with services who were likely to be in touch with potential PIR clients but who did not have sufficient time, resources or organisational support to take a recovery approach in their dealings with consumers.

[PIR] is going to break down so many barriers, particularly referrals from clinical services, referrals from sectors where they are seeing people for two seconds flat. They have an inkling [this consumer] could be good for PIR but they don’t have the time to go through complicated referrals processes. To make that as simple as possible will make a big difference to being useful to a wider range of people that we perhaps wouldn’t capture normally.

PIR Organisation consortium member
5.2 ELIGIBILITY

The process of determining PIR client eligibility involves multiple steps. There are five distinct criteria that have to be met when clients are referred to PIR Organisations.

1. The PIR client has a severe and persistent mental illness.
2. The PIR client has complex needs that require services from multiple agencies.
3. The PIR client requires substantial support and assistance to engage with various services.
4. There are no existing coordination arrangements in place to assist the PIR client in accessing the necessary services.
5. The PIR client or their legal guardian has indicated their willingness to participate in PIR (DOH, 2013).

The process for determining eligibility was described by most as being reasonably well-defined in the Operational Manual, though a number of practical issues were identified. Two issues that were identified in many of the interviews were:

- the age at which consumers could be considered to have a severe and persistent mental illness
- whether formal diagnosis was required in order for clients to be eligible for PIR.

These eligibility issues were described as being reasonably well addressed in updates from the Department of Health distributed through the Capacity Building Project website and directly to PIR Organisations. Many noted, however, that the Department allowed scope for some judgement at the PIR Organisation level.

There were concerns around the PIR programme as a whole, in terms of diagnosis and eligibility, which seems to replicate, I guess, exclusionary criteria onto the programme, which is a source of people falling through the gaps.

Consumer representative

Some stakeholders reported the need for discretion to be applied in relation to the inclusion criteria. In all cases, the interviewees characterised decision-making about eligibility as being about interpretation of the Operational Guidelines, rather than seeking to work around them. There was some frustration expressed in relation to this ambiguity about eligibility criteria. Most recognised that PIR is a new initiative and as a result issues like this were likely to be encountered.

Eligibility criteria is an issue but I also think it doesn’t need to be too precise, because if you make it too precise then you’re being too restrictive, and you have a whole country to look at. Maybe if things were a little bit more principle driven and a little less nuts and bolts? I think there’s too much jumping to the end point. Here’s an action plan. Here’s an eligibility criteria. Maybe we need, here are the principles. It’s that uncomfortable thing about design it from the ground up, but I need to do this, and that’s the tension all the way along I think.

PIR Manager

An issue identified in a small number of interviews was the strict application of PIR eligibility requirements that could potentially replicate existing service gaps, rather than overcoming them. An example of this is that some PIR Organisations require two staff members to undertake the assessment of new PIR clients. This might be difficult in less formal settings or with consumers who have had negative experiences of traditional services, and could act as a barrier to engagement.
5.3 ASSESSMENT OF NEEDS

The assessment process was described by most as rigorous and reasonably clear, based on the information provided in the Operational Guidelines and through the Resource Development and Capacity Building Projects. Several interviewees noted that in practice the PIR client engagement and assessment process can be quite prolonged and can take significant amounts of time. They noted that the period of time required to engage PIR clients, gain their trust, gain consent, undertake the intake assessment and develop the Action Plan can extend to several months.

In several cases, interviewees described the early assessments as being done in pairs, to ensure a shared understanding of the assessment process across the PIR and to ensure consistency in the assessment and acceptance of clients.

I've been going out and doing the assessments with each of the Support Facilitators for the first three, minimum of three times, so that we've got uniform and a high standard of assessments going on, so that they feel confident, comfortable. So we're all on the same page.

PIR Manager

The consent process was regarded as rigorous but potentially off-putting for many clients because of the level of detail required. Some interviewees described this as raising suspicion amongst clients, and requested that guidance be provided about which items in the assessment were critical to collect and which were not. They reported that it was difficult to collect information on all items from clients who did not have high levels of trust in PIR. The example one gave was that a potential client regarded a question about whether they were married as too personal and declined to continue with the assessment process.

Many PIR Organisations identified concerns in relation to the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) tool. The CANSAS is an assessment tool designed for use with consumers with a severe mental illness (Slade, Beck, Bindman, Thornicroft, & Wright, 1999). It records ratings for 22 domains and has been incorporated into the MDS.

Many PIR Organisations reported that the CANSAS was not strengths-based and poorly aligned with what they regarded as a recovery approach. Other stakeholders stated that the CANSAS had not been validated for use in Australian settings, and that validation studies were based on the CANSAS being administered in single, 30 minute sessions, whereas many PIR Organisations need to have multiple contacts with PIR clients over several weeks to complete the assessment. Many PIR Organisations are using other recovery-oriented tools to supplement the CANSAS.

I know the CANSAS has come under a lot of criticism, particularly for its use in the indigenous population… It was developed in the UK and the language is very UK-centric and it has a hard time even making sense to urban white Australians, but indigenous people are not going to understand things… so I think it’s not culturally appropriate, a lot of it.

NGO stakeholder

Wherever possible we like people to fill out the four pages. But if that can’t be done – because it does baulk people filling out four pages and we quite like our action plan and our assessment plan and we’ve merged our CANSAS and our MDS to make sure we are capturing all the reporting we need in a user friendly but recovery style document.

PIR Organisation staff

I haven’t worked with CANSAS personally and I understand lots of people use it. But I imagine from an evaluation perspective you really, really need to know whether anything is making a difference for participants and obviously that’s what the MDS is all about.

PIR Manager
Several stakeholders articulated the view that these concerns about CANSAS appear to be based on ideological objections with the approach rather than practical difficulties.

Many PIR Organisation staff expressed frustration with having to complete hard copy versions of the CANSAS, while the negotiations for licensing the CANSAS for incorporation into PIR client information management systems were being finalised. It should be noted that many of these issues have now been addressed following the licensing of the CANSAS for use across PIR.

The CANSAS and not having a licence to put it on your system and not want that to have a knock on effect – when people carry out their assessments with our CIMS that we’ve chosen the assessment is literally three boxes, that’s not an assessment. An assessment is a comprehensive look into somebody’s life and find out what their goals and those kinds of things.

PIR Manager

There’s a few things we changed just to make it more generic, so rather than having every single CANSAS item, here’s the goal and here’s the whatever, just to make it recovery focused. So the [clients] say this is the bit we’ve discussed, so you follow them rather than follow the form we were given. I think those were the core changes we made… it’s not massive.

PIR Manager

An issue that was identified in a small number of PIR Organisations is the location where assessments are undertaken. Most PIR Organisations undertook assessments during home visits and assessments, at other service locations, or in a PIR Organisation agency’s own offices. One PIR Organisation had a policy that they would not do home visits. PIR clients had to come to their office for appointments or meet them at services within their PIR Network.

No, we’re not doing home visits at all. It’s actually a policy that [the Lead Agency] is looking at, at the moment. So we are generally meeting them in, actually the ones we’ve seen have been in the [another primary health care service] so we have access to rooms down there.

Support Facilitator

Home visits were identified as a source of concern by some. Though all interviewees acknowledged the value of seeing PIR clients in their homes for both assessment and ongoing engagement, some identified concerns about the levels of personal risk to which Support Facilitators might be exposed. There was also a view expressed that encouraging PIR clients to engage with PIR in an organisation’s office was more likely to enable clients to access complementary clinical or social services, and to ensure that Support Facilitators were not forced into a case management approach. All PIR Organisations described having risk management policies in places, with associated risk assessment procedures. These were used when making determinations about home visiting and client contact.

It’s very much about going out and meeting the person wherever they are most comfortable. So the initial referral that normally comes through our intake and assessment coordinator basically takes that referral, whether on paper or over the phone, and then from there she basically books a meeting to come out and meet with the person and the referrer and potentially takes one of the Support Facilitators along. What that means basically is the same message is going out to all of the consumers and referrers.

PIR Manager

5.4 SERVICE COORDINATION

At the time of the site visits and consultations most PIR Organisations were focused on developing referral and assessment pathways. A relatively small number of clients had been registered at that time, and as such service coordination activities were less developed. Considerable planning and thought had been put into service coordination but there were few concrete activities occurring.
In the majority of PIR Organisations, the focus of planning for service coordination was on ensuring wraparound services for PIR clients. What this meant in practice was varied and was continuing to evolve. The characteristics of wraparound services that were described in the interviews included:

- involvement of new services, in particular housing
- identification of new resources, including the use of flexible funding
- proactive engagement with consumers
- longer term engagement with PIR clients
- ensuring PIR clients didn’t ‘fall through the cracks’.

The aim of service coordination was consistently described as being to ensure services worked together to achieve the clients’ long term goals. It was acknowledged that many services are routinely involved with potential PIR clients but there is often no worker or agency performing coordinating functions. Existing services were described as being poorly coordinated and focused on crisis and/or short-term engagement with clients.

*People with complex needs are invariably engaged with lots of services. They get fed up with appointments. They get fed up with getting various bits of information from one sector or another sector and the sectors don’t necessarily talk to each other. So it’s about trying to mobilise efficiency in the relationships between the different services – that we are all working really on a client-centred focus.*

*PIR Manager*

There had been discussion and debate in almost all PIR Organisations about the difference between case management and service coordination. A risk that was consistently identified in the interviews was that PIR Organisations could focus on case management activities that are familiar to many of the individuals and agencies involved, rather than pursuing the more challenging service coordination and system reform activities. Most stakeholders were aware of this risk however, and were pursuing distinct activities to achieve their desired system reform objectives.

*The two biggest risks for the programme are that the people who receive service weren’t the intended people for the service and the other risk being that it becomes a case management service.*

*NGO stakeholder*

*One of the barriers that we’ll be overcoming is trying to help people to understand that we are working in a different way and not just to revert to those old patterns for ourselves as well, in terms of case management, but towards the coordination and the system reform side.*

*PIR Organisation consortium member*

There were differing views about the differences between case management and service coordination, with no overall consensus about the range of activities that PIR Organisations’ work should undertake. The main points of difference, as described by consultation participants, are outlined in.
TABLE 5 – DIFFERENCES BETWEEN CASE MANAGEMENT AND SERVICE COORDINATION

<table>
<thead>
<tr>
<th>CASE MANAGEMENT</th>
<th>SERVICE COORDINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>More clinically oriented</td>
<td>More service system oriented</td>
</tr>
<tr>
<td>Focuses on presenting issue</td>
<td>Focuses on wraparound services with a broad range of services involved</td>
</tr>
<tr>
<td>Involved in arranging and delivering services</td>
<td>Involved in establishing and facilitating collaboration and coordination between services</td>
</tr>
<tr>
<td>Helping clients to address presenting issues</td>
<td>Helping clients to navigate the system</td>
</tr>
<tr>
<td>Is more of a service delivery role</td>
<td>Is more of a linking role</td>
</tr>
<tr>
<td></td>
<td>Works with case managers, does not replace them</td>
</tr>
</tbody>
</table>

There was a minority view amongst those interviewed that PIR did not represent a fundamentally different approach to service coordination and the provision of wraparound services. Amongst this subset of interviewees PIR was regarded as focusing on agency relationships and not trying to overcome issues about an underlying lack of resources.

*PIR is reinventing the wheel. It's another thing. It's just another place to refer and I'm not sure if that was the solution to link the sector to wraparound services for people in our community.*

_Government stakeholder_

5.5 CLIENT AND CARER IMPROVEMENT AND SATISFACTION

At the time of the site visits and stakeholder interviews it was still too early to determine if PIR has made a difference across the desired change domains:

- clinical functioning and management
- social inclusion
- quality of life
- improvement in carers’ and families’ quality of life
- satisfaction with support received
- satisfaction with particular aspects of support (Urbis, 2013).

A number of interviews were conducted with consumer and carer representatives during the Round 1 site visits and telephone consultations, though not directly with PIR clients or carers. Overall respondents were enthusiastic about the potential for person-centred supports to be tailored to meet PIR clients’ needs, but were unable to provide many examples of this occurring in practice. Similarly, PIR Managers, who tended to have the best overall perspective of the functioning of PIR Organisations as a whole, reported that while substantial progress had been made in identifying and engaging clients it was too early to determine if there were changes in clients’ quality of life, social inclusion and satisfaction with the service.

Several areas that could have an impact on PIR clients’ quality of life and satisfaction were identified in the interviews:

- security of housing tenure
- housing quality
- social isolation and loneliness
- communication and collaboration between service providers
- addressing physical health as well as mental health issues
- employment, in particular supported employment
- involvement of drug and alcohol services
- support for carers
- stigma.

The specific activities planned in relation to each of these issues were generally still being determined.

One issue highlighted through the interviews was the distinct role of carers and the need for PIR Organisations to consider how carers were involved in the programme. Carers were described as key enablers of a recovery approach. They were also recognised as an important source of referrals for potential PIR clients.

Some stakeholders identified a tension about the extent to which PIR should be regarded as a service for carers. There was a recognition that carers need to be supported in their caring roles, though it was unclear about the form the support provided to carers by PIR Organisations should take. Most stakeholders spoke about the need to ensure carers are linked in to carer support services or carer peer networks. In cases where these carer networks do not exist, stakeholders said that it would be appropriate for PIR Organisations to play a role in facilitating their creation, including providing venues and publicising the networks. Stakeholders were unsure about what direct services they could provide to carers. Stakeholders were also unsure about the range of services for carers that would be regarded as within scope for PIR.

5.6 SPECIFIC POPULATIONS

A number of populations with specific needs were identified in the interviews, which are described below.

5.6.1 PEOPLE IN RURAL AND REMOTE AREAS

A broad range of barriers for PIR clients living in rural and remote areas were identified in the site visit and telephone consultation interviews:

- distances to services
- sporadic or irregular contact with services
- the limited range of services available
- poor access to specialised or tertiary mental health services
- potential PIR clients unknown to existing services or common referral sources
- the small number of appropriately skilled staff available locally
- limited amount of public or social housing
- clients’ past experiences of exclusion from general practices or primary health care services.

In many rural and remote areas, contact with PIR was described as usually starting in regional towns or centres, often catalysed by an admission to an inpatient mental health unit. As such these mental health units are able to play a critical referral role for PIR clients who live in rural and remote areas. General practitioners were also identified as a critical referral pathway for PIR clients in rural and remote areas.
At the same time, as inpatient units tend to be located in regional centres, many potential PIR clients who are inpatients are far away from their homes, and when they are discharged they can be isolated from ongoing service provision. Staff in rural and remote areas described spending a sizeable proportion of their time on driving between different towns in the region and seeing clients who were often separated by considerable distances. In one interview, a Support Facilitator team leader said they were spending up to two days per week driving to meet with Support Facilitators based in different towns, though they anticipated this would lessen as staff became more established in their roles and the PIR Organisation moved beyond the implementation phase.

Many of the PIR Organisations in rural and remote areas were actively exploring ways of working more efficiently and effectively addressing client needs. Approaches being investigated include:

- outposting in a broad range of human service agencies, often as the only Support Facilitator in a large subregion
- strengthening relationships with police in rural areas, who were identified as a critical referral pathway and described as often being the main service in small communities
- identifying clients in rural and remote areas who aren’t known to services or local support networks
- seeing clients in or near regional inpatient units at discharge, but following them up locally when they return to their home
- identifying potential clients in rural and remote areas based on PIR staffs’ existing local knowledge and networks.

5.6.2 INDIGENOUS AUSTRALIANS

There were concerns expressed that Indigenous clients encounter a number of difficulties in accessing mainstream mental health services and that Indigenous PIR clients were likely to face these issues as well. There was a concern that Indigenous clients in remote areas in particular face dual barriers to access to services due to cultural barriers and distance from services.

A range of specific barriers and issues for Indigenous Australians were identified in the interviews, outlined below.

- Some of the assessment tools may not be culturally appropriate for use with Indigenous Australians, in particular the CANSAS.
- Indigenous consumers with severe and persistent mental illness can present with different symptoms and expressed issues compared with non-Indigenous Australians.
- The history of trauma amongst Indigenous Australians affects individuals’ mental health, social health and cultural wellbeing and needs to be considered in the assessment process.
- The history of removal and institutional abuse, in particular for members of the Stolen Generations, likewise needs to be considered in the assessment process.
- There is widespread mistrust of services among Aboriginal and Torres Strait Islander Australians.
- There is fatigue among potential clients and service providers with the new programmes and services seeking to address Indigenous Australians’ needs, which are described as often leading to limited practical benefits for Indigenous Australians.

A number of stakeholders also suggested that there may be a link between high rates of incarceration amongst Indigenous Australians and poor mental health. Engagement with criminal justice and prison systems was described as a significant stressor and a risk factor for poor mental health, affecting a disproportionately higher proportion of Indigenous Australians due to higher rates of incarceration. Interviewees suggested that referral and liaison between the justice system and PIR is important to ensure that the needs of Indigenous PIR clients are met.

*The majority of Aboriginal people that are incarcerated are between 25 to 35, but if there’s a link between mental health illnesses between 18 to 25, and they are*
reoffending and are going back into the system. We need to seriously look at what are the systemic problems that are not available for Aboriginal people with mental illnesses in that age bracket.

PIR Organisation staff

There was a recognised need for culturally sensitive Support Facilitators to work with Indigenous clients. In a small number of PIR Organisations this has led to the appointment of Indigenous Support Facilitators or Indigenous health managers or advisors. Many PIR Organisations had included cultural safety in their initial training for Support Facilitators. A number of PIR Organisations reported they were liaising with a range of Indigenous service providers in their regions in order to determine how to appropriately respond to the needs of Indigenous PIR clients. A network of PIR Organisations with specific interests in Indigenous and rural and remote client issues has been established, arising from interests expressed during the Capacity Building Project’s teleconferences.

5.6.3 CULTURALLY AND LINGUISTICALLY DIVERSE COMMUNITIES

There were differences in the level of engagement with the needs of culturally and linguistically diverse (CALD) communities among PIRs, primarily linked to the size of CALD communities within their regions. Two PIR Organisations described appointing specific staff to work with CALD communities. These workers were tasked with working with CALD communities to identify regional service gaps and barriers and to undertake system reform activities.

One of our [Support Facilitators] has had a background in community development so she’s been working with the multicultural association. There’s three or four agencies involved in that and they are wanting to work at how to support the needs of the CALD community better within the existing resources up in the region.

PIR Manager

Several barriers and issues for culturally and linguistically diverse groups were identified in the interviews:

- the cultural appropriateness and cultural safety of services
- language
- historical experiences with institutions and services
- availability of services specifically for CALD communities
- availability of services for survivors of torture and trauma.

The needs of refugees were noted as a separate, specific consideration. A large proportion of refugees are survivors of torture and trauma, and the impacts of torture and trauma are complex. A history of torture and trauma was also recognised as a significant complicating factor for both engagement and assessment processes, due to potential PIR clients past experiences of mental health services and government institutions.

5.6.4 LGBTI PEOPLE

Gaps in services for lesbian, gay, bisexual, transgender and intersex (LGBTI) people were identified in several interviews, as well as concerns that services may discriminate against LGBTI clients. A range of barriers and issues for LGBTI people were identified in the interviews:

- encountering stigma and discrimination from service providers
- services being reluctant or unwilling to recognise aspects of people’s LGBTI identity
- concerns that involvement in services could affect other personal and service relationships
- a lack, or total absence, of services specifically for LGBTI people within their region.
One PIR Organisation described a project that they had established to address the needs of LGBTI people experiencing severe and persistent mental illness in their region. This project involved consultation to identify regional service gaps and barriers, with the next step being system reform activities to enhance services for LGBTI PIR clients.

LGBTI, so looking at either consulting with or doing sector development around the needs of those communities and the mental health sector and how are they connecting in, or not, and how can we make the system work for those [communities].

PIR Organisation staff

5.7 SUMMARY

Most PIR Organisations started accepting referrals in November and December 2013, although some did not open their doors until 2014. There were only limited numbers of clients registered at the time of consultation, though the number of clients had expanded rapidly by the end of June 2014. Most PIR Organisations had focused on setting up processes for PIR client referral and assessment, with less activity focused on service coordination. The eligibility and assessment processes were structural and rigorous, though some concerns were raised about the suitability of some of the specific assessment tools.

The PIR Organisations that accepted client referrals earliest tended to have:

- a willingness to start accepting referrals before all systems, processes and protocols were in place
- no delays in staff recruitment or staff recruited from within a pool of existing employees
- consensus among the consortium about the employment and placement of Support Facilitators
- existing relationships and/or partnership arrangements
- a shared understanding of the purpose of PIR.
6 Profile of PIR Client Activity

6.1 INTRODUCTION

The following sections present data collected and reported for all 48 PIR Organisations for the period 1 July 2013 to 30 June 2014.

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

Due to the number and type of data items included in the subset of the MDS, some PIR Organisations have been unable to collect all of the data items for the 2013-14 period as they are still establishing the systems and processes required to collect this data. A total of six organisations have not provided any data for the 2013-14 period.

Please note, where data has not been collected this has been recorded as ‘not reported’ data. When a client should have been asked to provide data, but sufficient information has not been reported or recorded, this has been recorded as ‘not stated’ data.

6.2 DEMOGRAPHIC PROFILE

From 1 July 2013 to 30 June 2014 there were 5,235 clients registered to PIR organisations. Table 6 below provides summary data on the demographic and location profile of registered clients. This indicates that:

- more than half (54%) of all registered clients were female
- over one quarter (28%) were between the ages of 35-44 years, with a similar proportion (25%) aged between 45-54 years
- a total of 618 clients (12%) were of Aboriginal or Torres Strait Islander origin
- one third (34%) of clients were registered to organisations in QLD, with more than a quarter (28%) registered in NSW.

<table>
<thead>
<tr>
<th>TABLE 6 – CLIENT DEMOGRAPHIC DATA</th>
<th>REGISTERED CLIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
</tr>
<tr>
<td>GENDER</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2,410</td>
</tr>
<tr>
<td>Female</td>
<td>2,802</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
</tr>
<tr>
<td>Not stated</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>5,235</td>
</tr>
<tr>
<td>AGE</td>
<td></td>
</tr>
<tr>
<td>&lt;25 years</td>
<td>434</td>
</tr>
<tr>
<td>25–34 years</td>
<td>1,132</td>
</tr>
<tr>
<td>35–44 years</td>
<td>1,429</td>
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<tr>
<td>45–54 years</td>
<td>1,286</td>
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<tr>
<td>55–64 years</td>
<td>684</td>
</tr>
<tr>
<td>REGISTERED CLIENTS</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>65+ years</td>
<td>148</td>
</tr>
<tr>
<td>Not stated</td>
<td>122</td>
</tr>
<tr>
<td>Total</td>
<td>5,235</td>
</tr>
</tbody>
</table>

**ABORIGINAL AND TORRES STRAIT ISLANDER STATUS**

<table>
<thead>
<tr>
<th>Status</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander</td>
<td>618</td>
<td>12%</td>
</tr>
<tr>
<td>Neither Aboriginal nor Torres Strait Islander</td>
<td>3,687</td>
<td>70%</td>
</tr>
<tr>
<td>Not stated</td>
<td>930</td>
<td>18%</td>
</tr>
<tr>
<td>Total</td>
<td>5,235</td>
<td>100%</td>
</tr>
</tbody>
</table>

**LOCATION**

<table>
<thead>
<tr>
<th>Region</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>QLD</td>
<td>1,778</td>
<td>34%</td>
</tr>
<tr>
<td>NSW</td>
<td>1,460</td>
<td>28%</td>
</tr>
<tr>
<td>VIC</td>
<td>832</td>
<td>16%</td>
</tr>
<tr>
<td>WA</td>
<td>523</td>
<td>10%</td>
</tr>
<tr>
<td>SA</td>
<td>372</td>
<td>7%</td>
</tr>
<tr>
<td>TAS</td>
<td>145</td>
<td>3%</td>
</tr>
<tr>
<td>ACT</td>
<td>125</td>
<td>2%</td>
</tr>
<tr>
<td>NT</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>5,235</td>
<td>100%</td>
</tr>
</tbody>
</table>

Of the 618 Aboriginal and Torres Strait Islander clients, the majority were located in QLD (35%, equivalent to 218 people) followed by NSW (29%, equivalent to 181 people) and WA (21%, equivalent to 131 people).

Figure 5 presents a breakdown of client age by region. This indicates that ACT had the highest proportion of clients under the age of 34 years (42%) followed by SA (35%). TAS had the highest proportion of clients aged 55 years or more (19%), followed by QLD (17%) and NSW (17%).

**FIGURE 5 – CLIENT AGE BY LOCATION**
6.3 LIVING ARRANGEMENTS

As indicated in Figure 6, one third (32%) of clients lived in a lone person household, with one in seven living in ‘other family’ households (12%) or in a ‘one parent with child(ren)’ household (11%). Very few clients lived in a group household (6%) or as a couple with children (6%).

FIGURE 6 – CLIENT HOUSEHOLD TYPE

![Client Household Type Chart](chart)

With regard to accommodation type, half (50%) of all clients lived in a private residence, 15% did not state their current accommodation type, and accommodation type was not reported for 12% of clients. Only 4% were living in a boarding house or hostel, with 2% living in supported accommodation.

One quarter (24%) of clients had lived in their current accommodation for less than one year, with a similar proportion (26%) living in their accommodation for between 1-4 years. One third (32%) did not state how long they had resided in their current accommodation, and it was not reported for 18% of clients.

6.4 EMPLOYMENT AND INCOME

Figure 7 indicates that only one in twenty (6%) clients were employed, while over one third (37%) are not in the labour force and 29% are unemployed. Of those clients who are in employment, the majority (87%) work part-time, with only 65 (13%) working full-time.

FIGURE 7 – LABOUR FORCE STATUS

![Labour Force Status Chart](chart)
The ACT had the highest rate of employment among registered clients (14%) followed by WA (11%), VIC (7%) and NSW (7%).

As indicated in Table 7, with regard to income, close to half (47%) of registered clients receive income through the Disability Support Pension, with 20% receiving some other pension or benefit.

**TABLE 7 – SOURCE OF INCOME**

<table>
<thead>
<tr>
<th>SOURCE OF INCOME</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Support Pension</td>
<td>2,481</td>
<td>47%</td>
</tr>
<tr>
<td>Other pension or benefit (not superannuation)</td>
<td>1,043</td>
<td>20%</td>
</tr>
<tr>
<td>Not stated</td>
<td>661</td>
<td>13%</td>
</tr>
<tr>
<td>Not reported</td>
<td>629</td>
<td>12%</td>
</tr>
<tr>
<td>Paid employment</td>
<td>142</td>
<td>3%</td>
</tr>
<tr>
<td>Not known</td>
<td>109</td>
<td>2%</td>
</tr>
<tr>
<td>Nil income</td>
<td>85</td>
<td>2%</td>
</tr>
<tr>
<td>Other (e.g. superannuation, investments etc.)</td>
<td>50</td>
<td>1%</td>
</tr>
<tr>
<td>Compensation payments</td>
<td>35</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,235</td>
<td>100%</td>
</tr>
</tbody>
</table>
6.5 MENTAL HEALTH STATUS AND SUPPORT

Approximately one third of registered clients (32%, equivalent to 1,662 people) were reported as being diagnosed with a mood affective disorder, with around one quarter (23%) diagnosed with schizophrenia, schizotypal and delusional disorders, and over one in ten (12%) diagnosed with an unspecified mental disorder. Figure 8 presents the principal mental illness diagnoses for all clients.

FIGURE 8 – REPORTED PRINCIPAL MENTAL ILLNESS DIAGNOSES

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood [affective] disorders</td>
<td>1,662</td>
<td>32%</td>
</tr>
<tr>
<td>Schizophrenia, schizotypal and delusional disorders</td>
<td>1,191</td>
<td>23%</td>
</tr>
<tr>
<td>Unspecified mental disorder</td>
<td>645</td>
<td>12%</td>
</tr>
<tr>
<td>Disorders of adult personality and behaviour</td>
<td>319</td>
<td>6%</td>
</tr>
<tr>
<td>Neurotic, stress-related and somatoform disorders</td>
<td>305</td>
<td>6%</td>
</tr>
<tr>
<td>Mental and behavioural disorders due to psychoactive substance use</td>
<td>144</td>
<td>3%</td>
</tr>
<tr>
<td>Organic, including symptomatic, mental disorders</td>
<td>128</td>
<td>2%</td>
</tr>
<tr>
<td>Behavioural and emotional disorders with onset usually occurring</td>
<td>107</td>
<td>2%</td>
</tr>
<tr>
<td>Behavioural syndromes associated with physiological disturbances</td>
<td>82</td>
<td>2%</td>
</tr>
<tr>
<td>Disorders of psychological development</td>
<td>21</td>
<td>2%</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>13</td>
<td>2%</td>
</tr>
</tbody>
</table>

At a jurisdictional level, TAS had the highest proportion of clients reporting an unspecified mental disorder (56%) followed by ACT (21%) and NSW (15%). The ACT had the highest proportion of clients reporting mood disorders (58%) followed by WA (40%), VIC (35%) and QLD (34%). The most prominent disorders reported by clients in NSW were schizophrenia, schizotypal and delusional disorders, with one quarter (25%) of clients reporting such an illness.

During their period as a client with PIR, one in ten (8%) clients had been involuntarily treated under the relevant state mental health legislation, while over half (55%) of all clients had been treated voluntarily for mental health conditions. QLD had the highest proportion of clients who had been treated involuntarily (11%) followed by NSW (9%), while VIC (73%) and WA (58%) had the highest proportion of clients who had been treated voluntarily.

One third (33%) of registered clients are supported by public sector mental health services, 23% by a General Practitioner, and less than one in ten (7%) access a private psychiatrist as their principal clinical service provider.
Figure 9 indicates that half (50%) of the registered clients have no carer, 15% have an informal carer and only 7% having a formal carer. VIC (54%) and QLD (52%) had the highest proportion of clients with no carer.

**FIGURE 9 – CLIENT CARER ARRANGEMENTS**

6.6 REFERRALS

In 2013-2014 PIR Organisations received 7,913 referrals. Of these one fifth (20%) were made by public sector mental health service clinics with a further 16% provided by non-government community support and a similar proportion (16%) by other community or health care services. One in ten (10%) were also self-referrals to PIR. The site visits planned for 2014 will investigate further what self-referrals comprise, and assess any service involvement in these referrals.

In total, over three quarters (78%) of referrals were accepted, equivalent to 6,178 referrals, with one in eight (13%) refused, 4% withdrawn prior to assessment, and 4% with unknown outcomes to date. Figure 10 below presents the top ten sources of referrals to the PIR initiative and the outcomes for these referrals.
PIR Organisations in NSW (35%) and QLD (31%) received the most referrals, followed by VIC (14% of all referrals). Figure 11 below indicates that ACT had the highest proportion of referrals which were accepted (82%), followed by SA (81%) and QLD (80%). VIC had the highest proportion of referrals which were not accepted (18%).

**FIGURE 11 – RESULT OF REFERRAL BY REGION**

<table>
<thead>
<tr>
<th>Region</th>
<th>Accepted</th>
<th>Not accepted</th>
<th>Withdrawn</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT (n=152)</td>
<td>82%</td>
<td>13%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>SA (n=462)</td>
<td>81%</td>
<td>12%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>QLD (n=2,490)</td>
<td>80%</td>
<td>14%</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>NSW (n=2,742)</td>
<td>79%</td>
<td>12%</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>VIC (n=1,141)</td>
<td>76%</td>
<td>18%</td>
<td>5%</td>
<td>1%</td>
</tr>
<tr>
<td>WA (n=696)</td>
<td>75%</td>
<td>13%</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>TAS (n=227)</td>
<td>64%</td>
<td>9%</td>
<td>5%</td>
<td>22%</td>
</tr>
</tbody>
</table>

**6.7 CLIENT STATUS**

Figure 12 indicates that the majority of clients are active clients (60%, equivalent to 3,140 people). Around one in seven (15%, equivalent to 798 people) have exited the program. NSW had the largest number of active clients (953 people, equivalent to 65% of registered clients) while QLD had the largest number of clients who had exited the PIR initiative (386 people, equivalent to 22% of registered clients).
With regard to the reason for exit, one third (33%) of clients exited the PIR service as they no longer needed assistance. One quarter either could no longer be contacted (17%) or had left the area (7%). One in ten clients (11%) terminated the service themselves. The 2014 site visits will further explore reasons for exit.

6.8 NEEDS ASSESSMENT

In total 91% of clients, equivalent to 4,768 people, have undertaken a needs assessment. Of these, the majority (81%, equivalent to 4,232) have undertaken an intake assessment, with a small proportion having a review (7%) or exit (3%) assessment.

Table 8 below indicates that TAS has the smallest proportion of clients who have undertaken an intake needs assessment (21%) followed by SA (61%). Also, WA (14%) followed by SA (13%) had the highest proportion of clients undertaking a review needs assessment, while ACT (20%) had the highest proportion undertaking an exit assessment.

<table>
<thead>
<tr>
<th>JURISDICTION</th>
<th>TOTAL CLIENTS</th>
<th>PROPORTION WITH INTAKE NEEDS ASSESSMENT</th>
<th>PROPORTION WITH REVIEW NEEDS ASSESSMENT</th>
<th>PROPORTION WITH EXIT NEEDS ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>125</td>
<td>100%</td>
<td>2%</td>
<td>20%</td>
</tr>
<tr>
<td>NSW</td>
<td>1,460</td>
<td>86%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>QLD</td>
<td>1,778</td>
<td>80%</td>
<td>8%</td>
<td>3%</td>
</tr>
<tr>
<td>SA</td>
<td>372</td>
<td>61%</td>
<td>13%</td>
<td>4%</td>
</tr>
<tr>
<td>TAS</td>
<td>145</td>
<td>21%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>VIC</td>
<td>832</td>
<td>88%</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>WA</td>
<td>523</td>
<td>84%</td>
<td>14%</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>5,235</td>
<td>81%</td>
<td>7%</td>
<td>3%</td>
</tr>
</tbody>
</table>

In terms of the type of need, many clients had multiple unmet needs identified. Close to half (49%) of all clients had unmet needs for daytime activities, with 48% having unmet psychological distress needs, 45% unmet social life needs, 38% had unmet physical health needs and 35% unmet employment needs. This data is presented in Figure 13 below.
In total the PIR initiative aims to identify and support around a third (approximately 20,000) of the estimated national target population within the first three years of operation. Each PIR Organisation has specific target client numbers based on 40% of the estimated total potential client population in their regions.

In 2013-2014 PIR Organisations had 5,235 registered clients, which is equivalent to over half (54%) of the Year 1 target, and over one quarter (27%) of the Year 3 target. Table 9 provides data on the number of registered clients in each state/territory, and a comparison against Year 1 and Year 3 targets. This indicates that while no region has achieved its Year 1 target, PIR Organisations in QLD have achieved 81% of their Year 1 target and 42% of the Year 3 target. Also WA (75%), SA (56%), TAS (53%) and ACT (50%) have achieved over half of their Year 1 targets, and most jurisdictions have achieved over one fifth of their Year 3 targets.
### TABLE 9 – PIR CLIENT TARGETS

<table>
<thead>
<tr>
<th>STATE/TERRITORY</th>
<th>TOTAL REGISTERED CLIENTS YEAR 1</th>
<th>YEAR 1 TARGET</th>
<th>% OF YEAR 1 TARGET ACHIEVED</th>
<th>YEAR 3 TARGET</th>
<th>% OF YEAR 3 TARGET ACHIEVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>125</td>
<td>250</td>
<td>50%</td>
<td>436</td>
<td>29%</td>
</tr>
<tr>
<td>NSW</td>
<td>1,460</td>
<td>3,458</td>
<td>42%</td>
<td>6,979</td>
<td>21%</td>
</tr>
<tr>
<td>QLD</td>
<td>1,778</td>
<td>2,063</td>
<td>86%</td>
<td>4,267</td>
<td>42%</td>
</tr>
<tr>
<td>SA</td>
<td>372</td>
<td>670</td>
<td>56%</td>
<td>1,374</td>
<td>27%</td>
</tr>
<tr>
<td>TAS</td>
<td>145</td>
<td>276</td>
<td>53%</td>
<td>532</td>
<td>27%</td>
</tr>
<tr>
<td>VIC</td>
<td>832</td>
<td>1,955</td>
<td>43%</td>
<td>3,714</td>
<td>22%</td>
</tr>
<tr>
<td>WA</td>
<td>523</td>
<td>699</td>
<td>75%</td>
<td>1,962</td>
<td>27%</td>
</tr>
<tr>
<td>NT</td>
<td>-</td>
<td>258</td>
<td>-</td>
<td>258</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL</td>
<td>5,235</td>
<td>9,629</td>
<td>54%</td>
<td>19,522</td>
<td>27%</td>
</tr>
</tbody>
</table>
7 Partnerships

7.1 THE ROLE OF PARTNERSHIPS IN PIR

Partnerships are central to the design and intent of the PIR Initiative. Few mental health programmes have placed as strong an emphasis on widespread and effective partnerships between agencies to achieve better outcomes for consumers.

The nature, size and complexity of partnerships varies markedly across the PIR Initiative. The largest number of PIR consortium members within a PIR Organisation is 22 agencies in the Northern Sydney PIR. The smallest is two in the Central and North West Queensland PIR Organisation. Added to this variation there is the additional level of partnerships that sit outside the PIR Organisation in the form of the local PIR Networks (see Figure 14). There are often a wide array of stakeholders and sectors involved in PIR Organisations, and there are varying degrees of involvement.

FIGURE 14 - EXAMPLES OF COMMON ELEMENTS OF PIR IMPLEMENTATION MODEL

Source: (DOH, 2013)

Despite PIR’s clear focus on partnerships, different interpretations of the term ‘partnership’ have led to different approaches to building partnerships.

The development of partnerships within PIR has been strongly influenced by the personality and role of key people involved in the PIR and by the cultures of the organisations involved. The extent to which there were existing relationships between PIR Organisation agencies has also been an important factor in successfully navigating the tender and establishment phases, and working through any challenges and setbacks in the initial implementation phase.

There was a widespread recognition that whilst many initiatives involve partnerships, PIR requires higher-intensity partnerships that are critical in achieving the programme’s aims. In most cases, but not all, consultations revealed that the partnerships were working reasonably well.
7.2 KEY ELEMENTS OF SUCCESSFUL PARTNERSHIPS

In consultations, eight key elements were identified as important for the establishment of effective partnerships within the PIR context. These elements were not necessarily present or relevant in every PIR Organisation and Network, but at least two aspects were discussed in every interview that described partnerships.

In the small number of PIR Organisations where partnerships had not progressed or had deteriorated it was because one or more of these elements had not been addressed or were ignored.

<table>
<thead>
<tr>
<th>PARTNERSHIP ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Necessity</td>
<td>The need for the PIR partnership was recognised and understood.</td>
</tr>
<tr>
<td>Capacity</td>
<td>There were people and organisations involved in the PIR Organisation who had capacity and experience in working in partnership with other agencies, particularly intersectorally.</td>
</tr>
<tr>
<td>Relationships</td>
<td>The people involved in the PIR partnership had existing good working relationships or were able to forge new ones relatively quickly. Relationships with consumers and carers were described as part of this.</td>
</tr>
<tr>
<td>Leadership</td>
<td>Key senior staff with the PIR Organisations invested time and effort in the partnerships and prioritised them.</td>
</tr>
<tr>
<td>Time</td>
<td>There was sufficient time devoted to the development and maintenance of the partnerships. There was also a recognition that partnerships require time to mature.</td>
</tr>
<tr>
<td>Purpose</td>
<td>There was a shared understanding about the purpose of the partnership within the PIR Organisation.</td>
</tr>
<tr>
<td>Supportive arrangements</td>
<td>There were organisational arrangements in place that supported partnerships, such as memoranda of understanding and identified partnerships staff or service development staff.</td>
</tr>
<tr>
<td>Trust</td>
<td>There was trust between the individuals and agencies involved in the PIR partnership.</td>
</tr>
<tr>
<td>Common organisational goal</td>
<td>There was a clearly articulated, shared vision and strategy for the PIR partnership.</td>
</tr>
<tr>
<td>Senior decision-maker involvement</td>
<td>There were senior decision-makers actively involved in the PIR partnership with the authority to make or influence key decisions about PIR activities.</td>
</tr>
</tbody>
</table>

The site visits and stakeholder consultations consistently described an association between strong existing partnerships and shorter establishment periods that enabled PIR Organisations to start accepting client referrals sooner. This may be unsurprising given that organisations with existing partnerships had to invest less time in forming and resourcing their partnerships.

There was an expectation amongst most of those interviewed that even where there were existing partnerships, these are likely to change over the course of the PIR funding period. However, a few respondents felt that it was not realistic to expect significant changes in partnerships over a three year period.

There was a distinction made in the interviews between two forms of partnerships - partnerships within PIR Organisations and partnerships between PIR Organisations. The interviews highlighted several issues that PIR Organisations were collaborating on:

- identification and development of assessment tools and resources
- training and orientation for Support Facilitators
approaches to service coordination and system reform
development of clinical governance guidelines.

Several characteristics of successful and struggling partnerships, both within and between PIR Organisations, were identified through the interviews. These are described in Table 11.

TABLE 11 – CHARACTERISTICS OF SUCCESSFUL AND STRUGGLING PIR ORGANISATION PARTNERSHIPS

<table>
<thead>
<tr>
<th>SUCCESSFUL PARTNERSHIPS</th>
<th>STRUGGLING PARTNERSHIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared sense of purpose</td>
<td>Did not see the value of working in partnership</td>
</tr>
<tr>
<td>Consumer and carer involvement in PIR Organisation governance and decision-making</td>
<td>Disagreed about the purpose of their PIR Organisation</td>
</tr>
<tr>
<td>Invested in communication and partnership development</td>
<td>Regarded partnership processes as bureaucratic and/or too time-consuming</td>
</tr>
<tr>
<td>Built upon existing relationships and related partnerships</td>
<td>Described partnership in terms of contractual relationships</td>
</tr>
<tr>
<td>Developed organisational agreements</td>
<td>Did not regard all partner agencies as equal</td>
</tr>
<tr>
<td>Placed the interests of the partnership above their own agency’s</td>
<td></td>
</tr>
</tbody>
</table>

Some PIR Organisations took a practical, regional approach to developing partnerships. The case study overleaf highlights an example of a PIR Organisation that organised a regional conference attended by more than 100 PIR Organisation staff from across their region to share knowledge and ideas in the early implementation phase.
Nine PIR Organisations came together to attend a regional staff conference. These included System Coordinators, Service Support Facilitators, Support Facilitators and Programme Managers. Over 100 staff attended the conference held in December 2013.

The Conference originated from a regional meeting of PIR Managers where the need was identified to share information across the region and learn from one another at this important early stage in the development and implementation of PIR.

The objective of the conference was to create an opportunity for PIR Organisation staff to enjoy a supportive environment for sharing information and learnings, networking and cross-regional capacity-building by:

- building strong networks amongst PIR Organisations in the local region through establishing opportunities for face-to-face contact
- sharing information and resources on successful and innovative approaches to implementing PIR in their region
- enabling dialogue, trouble-shooting, information-exchange and dissemination, knowledge transfer and a way to keep individual PIR Organisations abreast of developments
- having a direct link to cross-regional peer supervision and support.

Throughout the day, the PIR Organisation staff engaged in structured discussions on a range of issues that aligned with the Flinders Capacity Building Project and also with the evaluation criteria included in the PIR Evaluation Framework.

Discussions were captured and recorded in a document that addressed issues and strategies to achieve:

**Ultimate outcomes**
- Improved clinical functioning
- Improved access to housing, education, employment and social activities
- Improved quality of life
- Consumer and carer satisfaction
- Effective coordination

**Immediate outcomes**
- Improving networks
- Training
- Care coordination and support
- Referral, intake and assessment
- Governance and management
- PIR Reporting
- Consortium and partnership functioning
- Following a Recovery-Based Model
- Cultural accessibility.

Most importantly, the discussions focussed on discussing and documenting potential strategies and solutions for addressing identified barriers or issues in their region.

Based on a survey afterwards, PIR staff reported the most useful aspects of the conference were problem-solving and sharing emerging learnings. While feedback also indicated a desire for a more structured programme which focussed on fewer issues, the conference resulted in some positive outcomes including the potential for shared planning, cost-sharing and practice development across PIR Organisations. The conference also resulted in a report that represented a first (and early) attempt to record issues about developing practice learnings within the region.
7.3 BARRIERS TO SUCCESSFUL PARTNERSHIPS

Several interviewees identified a tension between PIR’s clear emphasis on partnerships and the increasingly competitive nature of many of the involved service systems. This meant that PIR was not only trying to engage disparate agencies in partnerships, it was also often seeking to get agencies to work together who are competing in other settings. An example of this is agencies that are providing, or seeking to provide, services through the NDIS. This issue is described in greater detail in Section 9.

The fact that our population is smaller I think makes it more achievable. I listened in the training sessions… to what was happening in some of the bigger states and thought it would be much, much harder to get this off the ground… in somewhere like NSW where there’s a lot more competition anyway between organisations and a lot more things that would drive them apart rather than bring them together.

PIR Manager

Concerns about intellectual property issues within partnerships had arisen in a small number of PIR Organisations. These concerns related to whether organisations were in able to share service assessment tools with other agencies in the PIR Organisation when copyright was held by one agency, and whether it would be necessary to license their use. These issues were not regarded as insurmountable, though they were described as factors that had delayed the development of the partnerships. Several PIR Organisations have acted to address these issues through investing considerable time in building trusting relationships between participating agencies (within both PIR Organisations and Networks).

7.4 NATIONAL PARTNERSHIP SURVEY

A component of the evaluation involves a longitudinal survey of PIR Organisations to assess partnership functionality and effectiveness over time. The results of the first wave of the survey data, conducted in March-April 2014, are now presented. The survey will be repeated in 2016 and the results compared to those in 2014.

7.4.1 OVERVIEW

The survey was targeted at consortium members. The survey was not targeted at the broader PIR Network, i.e. contracted agencies not in a PIR Organisation. Only one response from each consortium member was permitted. Before responding to the questions, the respondent was encouraged to consult with others in their agency, to reflect an organisational view to the maximum extent possible.

The survey asked consortium members to rate their PIR Organisation partnership based on a Partnership Analysis Tool developed by John McLeod for VicHealth (VicHealth, 2011) for partners in health promotion, and adapted by Urbis to include a number of PIR-specific indicators. The Partnership Analysis Tool can also be used by organisations entering into or working within a partnership to assess, monitor and maximise their own effectiveness. The tool assesses the following four elements of partnerships:

- networking
- coordinating
- cooperating
- collaborating.

The survey was distributed via email to all PIR Lead Agencies, who were asked to forward it on to all consortium members. Two reminder emails were sent during the survey period, which ran for three weeks over March-April 2014.

7.4.2 RESPONDENTS

Almost all (96%) PIR Organisations responded to the survey, with an average of three responses received from each, totalling 155 completed responses. A good spread was achieved in relation to size and nature of consortium, region and role within the PIR Organisation (see Table 8 below).
7.4.3 SURVEY INSTRUMENTS

The survey included a series of questions asking respondents to rate various aspects of their partnership (consortium) arrangements and functionality. The word ‘partner’ is used throughout to refer to consortium members. Using a five point rating scale, respondents were shown a list of statements and asked to rate the extent to which they agreed (strongly agreed or agreed) or disagreed (strongly disagreed or disagreed) with each of the statements.

Two questions enabled respondents to provide open-ended responses concerning the key strengths of their partnership and the key challenges they face in the next 12 months.

Advanced statistical analyses were run to determine whether respondents’ attitudes were determined by any characteristics of their PIR Organisation. Chi Square tests were undertaken for all statements included in the questionnaire to test for any significant differences on the basis of any of the following variables: respondent type; Lead Agency within PIR Organisation; whether Lead Agency or not; number of consortium members in PIR Organisation; region; and whether or not accepting referrals.

All significant differences, that is, differences between respondent types agreeing or disagreeing with a statement that are not due to chance, are noted throughout the report where relevant.

7.4.4 KEY FINDINGS

Overall, the majority of PIR Organisation members responding to the survey were very positive about most aspects of their partnership arrangements within their PIR Organisation.

The areas of highest agreement (combined ‘strongly agree’ and ‘agree’) among respondents related to the following five areas:

- that there is a clear need and commitment to continuing the collaboration in the medium term
- partners have the task of communicating and promoting the coalition in their own agencies
- there is a perceived need for the partnership in terms of areas of common interest and complementary action
- there is a shared understanding about the purpose of PIR
- there is a shared understanding of the Recovery Model.

The top areas of agreement are detailed in Figure 15.

The areas where there was the highest level of disagreement (combined ‘strongly disagree’ and ‘disagree’) related to the following areas:

- carer representatives play a key role in decision-making
- processes that are common across agencies, such as referral protocols and service standards, have been standardised
- consumer representatives play a key role in decision-making
- the administration, communication and decision-making structure of the partnership is as simple as possible
- the roles, responsibilities and expectation of partners are clearly defined and understand by all other partners
- the lines of communication, roles and expectations of partners are clear.

The top areas of disagreement are detailed in Figure 16.

In the following sections, we further analyse the findings from the partnership survey, section by section. Additional figures setting out the level of agreement and disagreement in relation to each indicator are contained in Appendix D.

### 7.4.5 KEY ELEMENTS OF PIR

The first list of statements asked respondents to describe aspects of their partnership relating to key elements of the PIR programme. Results highlight that there was a very high level of agreement (ie ‘strongly agree’ amongst respondents or ‘agree’) that there is a shared understanding of both the purpose of PIR and the Recovery Model within their PIR Organisation (see Figure 17). This is a positive outcome and an important test of the fundamentals of the PIR Organisation.

Respondents were far less likely to agree, however, that consumer and carer representatives play a key role in decision-making within their PIR Organisation. This is significant as consumer and carer involvement in PIR is fundamental to the philosophy underpinning the programme. Furthermore, a large percentage (around a quarter) indicated they were not sure if carers or consumers played a key role, indicating a lack of communication or clarity on the issue.

While over half of respondents agreed that there is a clear approach to system reform activities within their PIR Organisation, one in ten disagreed and a third (32%) of respondents were unsure. This finding, too, is significant in that system reform is one of the two key aims of PIR. It strongly suggests that PIR Organisations have some way to go before their system reform focus and activities are developed.
FIGURE 15 – PIR PARTNERSHIP SURVEY: HIGHEST RATING INDICATORS

Figures represent net agreement with the statement (strongly agree and agree combined).

- There is a clear need and commitment to continuing the collaboration in the medium term: 92%
- Partners have the task of communicating and promoting the coalition in their own agencies: 92%
- There is a perceived need for the partnership in terms of areas of common interest and complementary capacity: 92%
- There is a shared understanding about the purpose of PIR: 92%
- There is a shared understanding of the Recovery Model: 90%
- The partners are willing to share some of their ideas, resources, influence and power to fulfil the goal: 89%
- There is a core group of skilled and committed (in terms of the partnership) staff that has continued over the life of the partnership: 88%
- The managers in each agency support the partnership: 88%
- There is a clear goal for the partnership: 87%
- There is an investment in the partnership of time, personnel, materials or facilities: 85%
- There is enough variety among members to have a comprehensive understanding of the issues being addressed: 85%
- All partners are involved in planning and setting priorities for collaborative action: 81%
There is a participatory decision making system that is accountable, responsive and inclusive.

There is a clear approach to system reform activities.

The partners share common ideologies, interests and approaches.

There are regular opportunities for informal and voluntary contact between staff from the different agencies and other members of the partnership.

There is a shared understanding of, and commitment to, determining the need for partnerships.

The administration, communication and decision-making structure of the partnership is as simple as possible.

The roles, responsibilities and expectation of partners are clearly defined and understood by all other partners.

The lines of communication, roles and expectations of partners are clear.

There are processes that are common across agencies, such as referral protocols, services standards have been standardised.

Consumer representatives play a key role in decision-making.

Carer representation play a key role in decision-making.

Figures represent net disagreement (strongly disagree and disagree combined)
There were some differences in these responses, depending upon the nature of the PIR Organisation.

- Respondents whose PIR Organisation was accepting referrals were significantly more likely to agree that there is a shared understanding about the purpose of PIR (97%) compared to those that had not started taking referrals (71%).

- Respondents from a Lead Agency were significantly more likely to agree that carer representatives play a key role in decision-making (82%) compared to other consortium members (61%).

- Respondents from a PIR Organisation with more than 10 consortium members were significantly more likely to agree that carer representatives play a key role in decision-making, compared to smaller partnerships.

- Respondents from NSW were significantly more likely to agree that carer representatives play a key role in decision-making (85%), compared to respondents from other regions (45% to 75%).

- Respondents from consortium members not from the Lead Agency were significantly more likely to disagree that there is a shared understanding about the purpose of PIR (8.4%) compared to nil (0%) respondents from a Lead Agency.

- Respondents whose Lead Agency is a Medicare Local were significantly more likely to disagree that consumer representatives play a key role in decision-making (39%) compared to other Lead Agencies (14%).

- Respondents from South Australia/Northern Territory were significantly more likely to disagree that consumer representatives play a key role in decision-making (57%), and participants from New South Wales/ACT were significantly more likely to agree with this statement (86%).

7.4.6 THE NEED FOR THE PARTNERSHIP

A list of statements was included in the survey to gauge the value attributed by respondents to the partnership. The results were generally very positive, with most respondents expressing high levels of agreement with the perceived need for the partnership (92%) (see Figure 18). Most respondents also agreed that their partners were willing to share ideas, resources, influence and power to fulfil the goal of the partnership (89%). There was strong, but somewhat lower, agreement that the perceived benefits of the partnership outweighed the costs (79%), and that there was a shared understanding of and commitment to the goal among all potential partners (79%).
Respondents from large PIR Organisations (consisting of fourteen or more members) were significantly more likely to disagree that there is a perceived need for the partnership in terms of areas of common interest and complementary capacity (13%) compared with other PIR Organisations (3%) or that there is a clear goal for the partnership (21%) compared with other PIR Organisations (0% to 5%) (see Appendix D).

A list of statements was included to better understand the relationships both between partners and within the consortium more broadly. Again, the results are generally positive, with highest agreement in relation to the variety of members enabling a comprehensive understanding of the issues being addressed (85%) (see Figure 19). There was also a high level of agreement around the consortium bringing added prestige to the partners individually as well as collectively (73%). The majority of respondents also agreed that the partners share common ideologies, interests and approaches (72%) and that there is a history of good relations between the partners (68%) although the scores were somewhat lower. This may be reflective of the diverse background of the partners and the newness of the PIR consortium arrangements, with many of the organisations not having worked together prior to PIR.

**FIGURE 18 - DETERMINING THE NEED FOR THE PARTNERSHIP**

- There is a perceived need for the partnership in terms of areas of common interest and complementary capacity: 92%
- The partners are willing to share some of their ideas, resources, influence and power to fulfill the goal: 89%
- There is a clear goal for the partnership: 87%
- The perceived benefits of the partnership outweigh the perceived costs: 79%
- There is a shared understanding of, and commitment to, this goal among all potential partners: 79%

**FIGURE 19 - CHOOSING PARTNERS**

- There is enough variety among members to have a comprehensive understanding of the issues being addressed: 85%
- The coalition brings added prestige to the partners individually as well as collectively: 73%
- The partners see their core business as partially interdependent: 73%
- The partners share common ideologies, interests and approaches: 72%
- There is a history of good relations between the partners: 68%
Respondents from South Australia/Northern Territory were significantly more likely than other jurisdictions to disagree that there is enough variety among members to have a comprehensive understanding of the issues being addressed (22%), which may reflect the smaller size of some of their consortia.

7.4.7 PLANNING AND IMPLEMENTATING COLLABORATIVE ACTION

A key objective of PIR is to strengthen partnerships and facilitate collaboration between partners resulting in the promotion and implementation of a community-based recovery model. Therefore, questions to assess the extent to which PIR was contributing to planning and implementing collaborative action between partners are important. The results are generally positive, as evident in Figure 20 and Figure 21.

In general, respondents agreed that there are processes in place to ensure collaborative action within their partnerships. The majority (92%) agreed that partners have the task of communicating and promoting the coalition in their own agencies, and four in five (81%) indicated that partners are involved in planning and setting priorities for collaborative action. Around three-quarters of respondents also agreed that within their PIR Organisation there are participatory decision-making systems that are accountable, responsive and inclusive (74%).

There was, however, somewhat less agreement that the lines of communication, roles and expectations of partners are clear (63%). There was also less agreement that some staff have roles that cross the traditional boundaries that exist between agencies in the partnership (61%).

Respondents whose PIR Organisation was currently accepting referrals were significantly more likely to agree that partners have the task of communicating and promoting the coalition in their own agencies (100%) than others who had not yet received referrals (85.7%).

There was high agreement among respondents that there is investment in the partnership of time, personnel, materials or facilities (85%). Three quarters (77%) also agreed that there is added value for the community, consumers or the agencies involved in the partnership.

However, there was some uncertainty as to whether collaborative action by staff was rewarded by management (40% of respondents were not sure). There was also a high level of disagreement that processes common across agencies had been standardised (24%, see figures in Appendix D).

Respondents with a mental health service provider as the Lead Agency within their PIR Organisation were significantly more likely to disagree that there is an investment in the partnership of time, personnel, materials or facilities (22%) compared with other respondents (0% to 6%).

FIGURE 20 - PLANNING COLLABORATIVE ACTION

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners have the task of communicating and promoting the coalition in their own agencies</td>
<td>92%</td>
</tr>
<tr>
<td>All partners are involved in planning and setting priorities for collaborative action</td>
<td>81%</td>
</tr>
<tr>
<td>There is a participatory decision-making system that is accountable, responsive and inclusive</td>
<td>74%</td>
</tr>
<tr>
<td>The lines of communication, roles and expectations of partners are clear</td>
<td>63%</td>
</tr>
<tr>
<td>Some staff have roles that cross the traditional boundaries that exist between agencies in the partnership</td>
<td>61%</td>
</tr>
</tbody>
</table>
7.4.8 BARRIERS AND STRATEGIES FOR EFFECTIVE PARTNERSHIPS

Understanding the perceived barriers and strategies currently partnerships can help to highlight those areas which would most benefit from improvement. Figure 22 highlights the processes or aspects in place to ensure effective partnerships. The highest area of agreement was in relation to the support managers in each agency provide to the partnership (88%), followed by partners having the necessary skills for collaborative action (79%). Areas where there was strong but somewhat less agreement was around the roles, responsibilities and expectations of partners being clearly defined and understood by all partners (65%) and that there are strategies to enhance the skills of the partnership (70%).

FIGURE 22 - MAKING SURE PARTNERSHIPS WORK

- The managers in each agency support the partnership (88%)
- Partners have the necessary skills for collaborative action (79%)
- The administrative, communication and decision-making structure of the partnership is as simple as possible (73%)
- There are strategies to enhance the skills of the partnership through activities to support the membership or workforce development (70%)
- The roles, responsibilities and expectations of partners are clearly defined and understood by all other partners (65%)

Figure 23 summarises further aspects of PIR which contribute to successful partnerships by minimising potential barriers. The area of highest agreement was that there is a core group of skilled and committed staff that has continued over the life of the partnership (88%). However one in five respondents did not agree that differences in organisational priorities, goals and tasks had been addressed (19%, see figures in Appendix D).
Respondents whose PIR Organisations were accepting referrals were significantly more likely to agree that there are strategies to ensure alternative views are expressed within the partnership (96%) compared with others who were not (80%).

**FIGURE 23 - MINIMISING THE BARRIERS TO PARTNERSHIPS**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a core group of skilled and committed (in terms of the partnership) staff that has continued over the life of the partnership</td>
<td>88%</td>
</tr>
<tr>
<td>There are strategies to ensure alternative views are expressed within the partnership</td>
<td>76%</td>
</tr>
<tr>
<td>There are informal ways of sharing information and resolving demarcation disputes</td>
<td>75%</td>
</tr>
<tr>
<td>There are formal structures for sharing information and resolving demarcation disputes</td>
<td>68%</td>
</tr>
<tr>
<td>Differences in organisational priorities, goals and tasks have been addressed</td>
<td>45%</td>
</tr>
</tbody>
</table>

To test the potential success or longevity of the PIR Organisation, the survey also includes a list of statements to examine the processes in place for reflecting on and continuing the partnership. There was a high level of agreement that there is a clear need and commitment to continuing the collaboration in the medium term (92%), and participants generally agree that there are sufficient resources and documentation to support the continued outcomes of the partnership (79%) (see Figure 24). However, there was less agreement in relation to recognising and celebrating collective achievements and/or individual contributions (54%) or reviewing the range of partners and bringing in new members or removing some (56%).

Respondents with fourteen or more consortium members in the PIR Organisation were significantly more likely to disagree that there is a clear need and commitment to continuing the collaboration in the medium term (14%) compared with other PIR Organisations (0% to 3%, see figures in Appendix D).

**FIGURE 24 - REFLECTING ON AND CONTINUING THE PARTNERSHIP**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a clear need and commitment to continuing the collaboration in the medium term</td>
<td>92%</td>
</tr>
<tr>
<td>There are resources available from either internal or external sources to continue the partnership</td>
<td>79%</td>
</tr>
<tr>
<td>The partnership can demonstrate or document the outcomes of its collective work</td>
<td>77%</td>
</tr>
<tr>
<td>There is a way of reviewing the range of partners and bringing in new members or removing some</td>
<td>56%</td>
</tr>
<tr>
<td>There are processes for recognising and celebrating collective achievements and/or individual contributions</td>
<td>54%</td>
</tr>
</tbody>
</table>
7.4.9 KEY STRENGTHS OF THE PARTNERSHIP/CONSORTIUM TO DATE

A two-part question was included in the online survey to allow participants to indicate what they perceived to be the key strengths of their PIR Organisations and the key challenges it faces in the next 12 months. Of the 155 respondents to the survey, 143 commented on the strengths of the partnership and 138 commented on the challenges.

Key strengths of the partnership emerging from a thematic analysis of the responses included:

- vision and values
- collaboration
- diversity of membership
- commitment, drive and enthusiasm
- strong leadership
- communication
- existing strong partnership/relationships and networks.

VISION AND VALUES

A particular strength of their partnership, according to many respondents, was the shared vision and values among consortium members. The commitment to these shared values enabled consortium members to work together towards a shared goal. In some cases, a consortia had developed their model, credo and practice principles together, enabling them to achieve a shared understanding of their purpose and goals and strategy. Many respondents believed there was a shared belief among their consortium members that change is needed.

Sharing vision and values.

The values and service orientation of consortium members.

Achieving a shared understanding of what it means to implement a partnership-based programme.

COLLABORATION

Respondents indicated that a key strength of their partnership was consortium members’ willingness to collaborate and engage with one another in a meaningful way. Several mentioned the inclusive approach of their partners and people’s willingness to share information, knowledge and resources with one another. Some respondents commented on partners’ willingness to share equal responsibility for financial management decisions. Supporting the strong theme of collaboration were responses that indicated a high degree of goodwill between partners and strong relationships of trust.

We are very collaborative. There is a high level of trust and a demonstrated commitment to both the clients and to systemic change.

This has been a collaborative effort to commit to system reform for positive outcomes for the PIR target group, sharing of resources and strengthening partnerships.

The consortium continues to act in a collaborative and respectful manner with each other.

DIVERSITY OF MEMBERSHIP

A number of respondents mentioned the diverse skill sets and experience of their members as a key strength of their PIR Organisation. Respondents mentioned that their partners provided a good representation of all the sectors, and a good balance of professions and services. In many cases, the different experiences and backgrounds complemented one another and created a balanced and powerful
team. The collective wisdom of the different partnership organisations was also identified as a key strength.

Diversity, providing a very good representation of all the sectors.

The diversity of the membership and different approaches from having joint lead.

Bringing together professionals from a broad range of backgrounds, professions and organisations.

COMMITMENT, DRIVE AND ENTHUSIASM

The commitment of each of the partners and their determination to see the programme succeed was a commonly mentioned strength of the programme. A number of respondents also identified the strong drive and enthusiasm of their partners and their ongoing commitment to the programme as key strengths.

The commitment of all partners from point of inception through to programme development, implementation and further development. This commitment and partnership has been respected by all parties throughout the process.

A strong commitment to encouraging and fostering recovery for long-term consumers and improving their quality of life.

STRONG LEADERSHIP

Strong leadership was a key strength of many partnerships. Respondents also mentioned that good governance structures and clear direction and leadership by the Lead Agency were important success factors. Leadership that was solutions-focused, impartial and consistent was highly valued.

Good leadership that focuses on collaborative partnership and respectful involvement of potential clients, carers and Aboriginal people.

Skilled leadership from the Lead Agency.

GOOD COMMUNICATION

Good internal and external communication contributes to the success of partnerships. A number of respondents mentioned that all partners have the opportunity to have input into decision-making and there were regular opportunities for them to meet. Respondents also mentioned people’s willingness to engage in robust conversations and the openness and transparency of their relationships as key strengths.

General willingness to have robust conversations that contribute to our growth development and understanding.

Openness and communication. The profile of the partnership has been raised through multiple and diverse forums and events.

EXISTING STRONG PARTNERSHIPS/RELATIONSHIPS/NETWORKS

A number of respondents mentioned that a key strength of their partnership was the shared history and previous positive experiences of working together. This meant that strong relationships of trust had already been developed between some partners. Existing networks and partnerships with the broader service sector was also identified as a key strength.

Goodwill and previous relationships based on joint collaboration and mutual respect. Positive previous experiences of achieving things together.

Previous partnerships and working together allowed services to have a strong relationship of trust prior to PIR.

The historical partnerships that existed before PIR.
7.4.10 CHALLENGES FOR PIR ORGANISATIONS OVER THE NEXT 12 MONTHS

The key challenges identified in the survey focussed on:

- sector and system reform
- staff recruitment and retention
- cost/funding issues
- maintenance of diverse partnerships (culture, relationships)
- communications (including promotion of PIR)
- governance and leadership
- maintaining momentum and enthusiasm for PIR from all parties.

SECTOR AND SYSTEM REFORM

Respondents identified the sector and system reforms occurring both nationally and in different jurisdictions as key challenges that they expect to face in the next 12 months. In particular, the recommissioning of the community-managed mental health sector, pending changes to the Medical Locals, and the impact of the NDIS were commonly mentioned concerns. Some respondents also highlighted that it was challenging to work collaboratively in the competitive environment of the mental health and broader service sector.

The competitive nature of the environment we are expected to work collaboratively in, the value systems that determine future directions, the changing politics that govern future possibilities.

Understanding the impact of NDIS on PIR and how PIR will integrate into the NDIS landscape, in regards to other mental health programmes.

Concerns re our agency’s viability given the various sector reforms that are about to happen e.g. MHCSS, AOD, aged care, disability (NDIS).

STAFF RECRUITMENT AND RETENTION

Staff retention and the ability to recruit experienced Support Facilitators were key challenges that some PIR Organisations report facing in the next 12 months. Some respondents had experienced high staff turnover and changes of role within agencies, which were having an impact on their PIR Organisation.

Being able to successfully recruit and retain PIR Support Facilitators.

Staff turnover/changes of roles within their agencies.

COST/FUNDING ISSUES

A number of respondents expressed concern about the uncertainty of ongoing funding. Others were concerned that resources are being used appropriately, and/or that flexible funding had the potential to be divisive if not managed well. Some respondents felt that the work required to implement PIR exceeded the funding provided to them by their Lead Agency and that they were providing services without sufficient resources. A few respondents were also concerned about the lack of funding available for carers of people with mental illness and that a number of community services had lost funding, which could limit referral options in the future. There was also concern about the potential for PIR clients to fall through the gaps due to lack of funding in the service sector.

From the ITA to implementation agencies have had to commit significant human/financial resources which cannot be compensated fully from the PIR financial allocations. If agencies experience reduction in funding in other service areas either State or Federal funding this commitment and contribution will become a greater impost and potentially reduce engagement in PIR.
The way in which its flexible funding is being managed has the potential to be divisive.

MAINTENANCE OF DIVERSE PARTNERSHIPS
Maintaining the diverse partnerships can be challenging, particularly when there are philosophical differences and a clash of cultures. In some cases the geographic spread of consortium members was limiting contact and/or communication with one another. Dealing with conflicts, and different expectations of the various members were also seen as ongoing issues by some respondents.

Conflicts and different expectations/understandings about roles and responsibilities.

Challenges of managing the PIR programme over the large area covered. Being able to bring consortium members together to meet face to face at least once which has not happened yet and there has been reluctance on some consortium organisations part to travel for this to occur.

COMMUNICATIONS
Developing a clear and concise understanding of the value of the PIR community was identified challenge, as was getting ‘buy in’ from the broader service system. Some respondents indicated that there is a need for better information dissemination and more effective communication pathways, particularly when it came to connecting and engaging with consumers.

There is a need for better collaboration and information dissemination across the community sector.

Developing a clear and concise understanding of the value added by the partnership in the local community.

GOVERNANCE AND LEADERSHIP
Poor governance practices were identified as particular challenges in some cases – in particular the lack of policies, processes and procedures within their PIR Organisation. Some respondents also commented on the inconsistency of management practices, micro management by their Lead Agency, and/or the view that some of the larger organisations were trying to control ‘the agenda.’ A few identified the need for greater involvement by carer and consumer organisations in the leadership and governance arrangements of their PIR Organisation.

The Partnership is overly complicated in its governance, administration and communication. Day-to-day leadership of the partnership is unpredictable.

Poor governance practices associated with the PIRO - lack of policies/processes and procedures relating to how the PIRO seemingly has delegation over partners. No consideration given to organisational autonomy. What small consideration there has been for governance has been applied in a largely inconsistent and non-transparent way.

MAINTAINING MOMENTUM AND ENTHUSIASM FROM ALL PARTIES
Remaining enthusiastic and committed, particularly when consortium members had conflicting demands, was identified as a key challenge by some respondents. The ability to maintain momentum and continue to significantly invest in the programme was open to question, in a few cases. Some respondents mentioned flagging interest by consortium members that had not been selected to provide services, and the potential difficulty in keeping all partners involved in the process over the longer term.

Maintaining momentum in articulating and actualising sector change initiatives and approaches.

Time and energy to maintain the level of engagement from senior staff, which is essential for strategic development and to break down barriers.
7.5 SUMMARY

The results from both the stakeholder consultations and the first national partnership survey show that partnerships in most PIR Organisations are functioning reasonably well to date. A minority of PIR Organisations are struggling to establish effective partnerships. Of the 48 PIR Organisations that have been funded only one PIR Organisation has failed to establish partnership arrangements. This PIR Organisation’s Lead Agency has adopted a purchaser-provider approach to PIR in response to a number of organisational and contextual difficulties.

There were differing levels of performance across PIR Organisations. The most successful PIR Organisation partnerships had:

- developed a shared sense of purpose
- involved consumers and carers in governance and decision-making
- invested in communication and partnership development
- built upon existing relationships and related partnerships
- developed organisational agreements, including memoranda of understanding and service-level agreements
- placed the interests of the partnership above their own agency’s interests.

The partnerships that were progressing less well generally lacked these characteristics but also did not recognise the importance of partnerships in achieving the aims of PIR. They had much lower levels of agreement about the purpose of their PIR Organisation and what they were collectively trying to achieve. They also generally saw the PIR Organisation as operating as a series of contractual relationships.

The first of two partnership surveys of PIR consortium members reveals, overall, positive signs about the partnership operations of the PIR Organisations. The fact that responses were received from 96% of the PIR Organisations means there can be a high level of confidence in these findings. Importantly, the highest rated partnership indicators related to the need for, and commitment to the partnership, and a shared understanding about the purpose of PIR and of the Recovery Model underpinning it.

Consortium members who took part in the survey are generally of the view that their PIR Organisation is sharing ideas, resources, personnel, facilities and that they have a good combination of skills both for collective and collaborative action and also for understanding and responding to issues as they arise. Importantly, three-quarters of the consortium members report there are strategies in place to ensure that alternative views are expressed within the partnership.

The aspects of PIR or the partnership arrangements that are rated most poorly (by close to one in four respondents) relate to consumer and carer participation in decision-making within the PIR. This is somewhat disappointing in light of the aspirations of PIR to involve consumers and carers in a meaningful way within the governance structure of PIR Organisations. It does, however, confirm feedback from consultations which indicates that there is variation across PIR Organisations in the level and nature of consumer and carer involvement in the governance and design of the PIR approach.

While it is positive that over half (58%) of consortium members were of the view that there was a clear approach to system reform activities, two out of five do not think this is the case (or are unsure). Either way, there is clearly room for improvement on this important aspect of PIR.

A minority of consortium members have concerns about the nature of participatory decision-making; the degree to which there is a shared ideology, interest and approach; the degree of clarity around roles, responsibilities, expectations, and decision-making structures; and the level of communication in their PIR. While these are in the minority at this time, these findings provide a key benchmark against which to measure partnership progress after a further two years of PIR operations.
8 System reform elements of PIR

8.1 APPROACHES TO SYSTEM REFORM

At the time of the consultations, there had been limited tangible activity in relation to system reform across PIR Organisations. PIR Organisations were primarily concerned with establishment activities. Just over half the PIR Organisation consortium members surveyed had developed an approach to system reform activities, however there was not much tangible evidence of activity on the ground in PIR Organisations at the time the data for this report were collected.

There was a lack of consensus across the PIR Organisations about what system reform activities should look like, and what the key focus should be. The consistent message across all consultations was that system reform is perceived as an important goal of PIR in order to achieve the objectives of better integration, coordination and access to services for the client group. There was far more limited agreement about the form it should take and how those goals can be achieved. As such, there was widespread enthusiasm for system reform but not much clarity about what it is in practice.

PIR Organisations, however, described the importance and value of system reform being undertaken and modelled by the PIR Organisations and PIR Networks in the first instance. This was being done through information-sharing, developing shared protocols for working with PIR clients, joint training and funding bids.

An important area of difference between the PIR Organisations is the extent to which system reform is regarded as being part of the Support Facilitator role. In a significant number of PIR Organisations, positions devoted specifically to system reform have been created. These workers have responsibility for identifying and undertaking system reform activities. In other PIR Organisations system reform was regarded as an intrinsic part of all Support Facilitator roles. It is too early to determine the differences between these approaches in practice, or their benefits, due to the relatively early stage of implementation.

Many PIR Organisations have sought to embed aspects of system reform into their governance structures through having a diverse and intersectoral membership on their consortia and advisory groups. These were regarded as important avenues to change service systems and to act collectively in the interests of PIR clients. An example of this is those PIR Organisations that have invited diverse government-funded agencies, such as social housing or employment agencies, onto their consortia. Although this approach was regarded as showing considerable promise, it had yet to show much practical progress at the time of the consultations. In another case, the PIR had created a leadership panel which brought together particular agencies that are felt to have an influential role for any potential system reform.

One PIR Organisation was particularly advanced in its thinking about the internal structures required within organisations to identify and prioritise system reform, and clear processes for progressing key initiatives. More details are provided in Case Study 6 overleaf.

The extent to which service coordination can or should guide system reform activities was an issue raised repeatedly in consultations. At the time of the consultations, most PIR Organisations had focused on service coordination activities rather than system reform. This was because much of the early focus for PIR was on staff recruitment, client systems and referral pathways. These activities were described as resulting in the identification of a number of service gaps that could usefully inform system reform efforts.
CASE STUDY 6 – STRUCTURING PIR FOR SYSTEM REFORM

STRUCTURING PIR FOR SYSTEM REFORM

One PIR Organisation has put in place clear structures and mechanisms for identifying and progressing priority system reform activities. The key elements of this include:

- the creation of a position with major responsibility for leading and driving system reform initiatives within the PIR
- a clear articulation of the respective roles and responsibilities of various PIR personnel in relation to system reform
- the establishment of a System Reform Register
- a highly consultative approach to identifying system reform priorities in the region
- the use of the flexible funding pool to encourage organisations to work together on projects addressing these priorities, with clear system reform outcomes.

The PIR Organisation has clearly defined system reform as:

- working on those factors that influence a population’s health and their ability to control their health: the social determinants of health
- working across and with various levels or layers of influence – individual, family, community, sector/system and society.

The PIR Organisation took the view that while all PIR staff have a role to play in system reform, a lead position was required to identify, progress, monitor and evaluate system reform within the organisation. It was also recognised that such a role requires specific skills and experience to maximise impact and effectiveness.

The System Reform Register was compiled to ensure a consistent approach across the PIR Organisation to capture, prioritise and act on system reform issues, arising out of the work of the Support Facilitators. Through their work with individual consumers, Support Facilitators may identify issues that will affect more than one client, and where the resolution to the issue is likely to take some time and involve working with others to effect change. Such issues are recorded on a computerised register.

Identified system reform issues are discussed monthly involving a range of PIR staff and an advisory body to determine priorities, allocate lead responsibility for actioning and developing a Reform Plan.

In addition to this internal process, this PIR Organisation has engaged in extensive external consultation (through a Regional Forum) to identify and prioritise system reform issues, which may be progressed through the PIR Organisation or through a contracted organisation.

A Report on the Forum (which will be held every year) was available both in written and digital form to increase accessibility and build awareness.
8.2 CONCEPTUALISING SYSTEM REFORM

The data from the consultations were coded to identify levels of activity, areas of activity and the desired outcomes in relation to system reform. Activity described as system reform potentially may occur at all levels, ranging from within PIR Organisations through to jurisdictional and even national service systems. It should be noted however that most of the discussion was about the need for system reform activity at those levels, rather than describing any concrete activities.

Most of the system reform activities being pursued were described as occurring at the PIR Organisation or Network level. A number of the areas of activity described as system reform overlap with a number of service coordination and governance activities, such as workforce development and communications and promotion. The desired outcomes described were similarly diverse.

A conceptual framework has been developed by Urbis based on these factors and informed by other related conceptual frameworks (NSW Health, 2001; Bush, Dower, & Mutch, 2002; Bowen & Zwi, 2005); this is illustrated in Figure 25. This conceptual framework may assist in describing the range and complexity of system reform activity at future stages in the Evaluation and Monitoring Project. At the time of the site visits and telephone consultations the bulk of the system reform activity across the PIR Initiative nationally was described as occurring:

- at the PIR Organisation or PIR Network level
- on organisational development and the development of information and tools
- with the goal of improving service systems.

The character of system reform activities is likely to change over the coming year, as all PIR Organisations move beyond the implementation phase.

There was a view expressed in many of the interviews that system reform activities should be regarded as outward-facing, involving agencies beyond the PIR Organisation and in many cases outside the PIR Network.

Several of the sites visited expressed concern about whether they were doing enough in relation to system reform. They described the need for system reform requiring a different range of activities from their current efforts, but there was no clarity about what this should look like. As such there was an eagerness to act on system reform but a lack of detailed planning.

Several stakeholder consultations described the need for PIR Organisations to be realistic about the extent of system reform feasible within the PIR funding period. Change was regarded as possible at the level of PIR Networks but many key aspects of the broader mental health and social service system are controlled at the jurisdictional and national levels. Several people who were interviewed suggested that whilst PIR’s regional approach allowed it to be practically oriented, this local focus would limit the extent to which it can influence broader resource allocation. On the other hand, some articulated a contrary view, stating that PIR Organisations were more likely to be able to influence internal allocation of resources and staff within PIR Organisation member agencies, for example the distribution and allocation of state mental health resources within a region.
### Figure 25 – Conceptual Framework for System Reform within Partners in Recovery

<table>
<thead>
<tr>
<th>National/jurisdictional service systems</th>
<th>Organisational development</th>
<th>Workforce development</th>
<th>Resourcing</th>
<th>Information and tools</th>
<th>Interagency agreements and partnerships</th>
<th>Leadership and culture</th>
<th>Regulations, policies and practices</th>
<th>Outcomes</th>
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<td>Regional service systems</td>
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- **Outcomes**:
  - Improved quality of life
  - Improved social inclusion
  - Improved clinical functioning
  - Improved service system
8.3 SERVICE MAPPING

Several PIR Organisations had undertaken service mapping activities of varying complexity, as the first step in planning their system reform activities. Over half of all PIR Organisations described it as a current or planned activity.

"You need to do some mapping of services and programmes [in your PIR Organisation] because there’s, it’s such a mishmash… As well there’s duplications of programmes and service delivery."

NGO stakeholder

This mapping activity was described as useful and formed the basis for community service directories and community asset maps in most cases. This activity was also used to identify key agencies with which to develop new partnerships.

"I think from the [service] mapping, the need for people to be able to sit and better coordinate and collaborate, and try to remember that ‘yes, today we are competing on a contract but tomorrow we will have to work together’.

PIR Organisation consortium member

One PIR Organisation took a particularly sophisticated approach to service mapping, which is profiled in Case Study 7 overleaf.

8.4 WORKFORCE DEVELOPMENT

One idea identified in a number of the telephone consultations is that PIR is contributing to system reform by improving the skills of the mental health workforce. It is hoped that this will bring about a change in orientation towards a recovery approach.

"PIR had the potential, and still has the potential, to shift that generation of support workers to think differently, and these people will be the leaders of the future I believe in our sector, and will probably be required very, very soon with the introduction of NDIS. So PIR has the potential to develop the workforce skills not just of the workers who are delivering services, but as they become managers and leaders and board members and involved in governance, their expectations will change… That’s why I call it once in a career [opportunity that] can make a significant difference to future leadership in our sector."

Government stakeholder

"PIR has the potential to develop the workforce skills not just of the workers who are delivering services, but as they become managers and leaders and board members and involved in governance their expectations will change. So my vision, which is shared by many, is that with the change to approach, that it isn’t just about helping John or Mary on this day it’s about how might we assist Johns and Marys for all days."

Consumer representative

It is worth noting that this issue was raised by stakeholders rather than PIR Organisations themselves. A challenge is that the workforce is not evenly distributed throughout Australia. Regional and rural PIR Organisations have faced considerable challenges in recruiting Support Facilitators with the wide range of skills that a recovery approach requires.

"Organisations have had to recruit from outside the area, and have had to recruit from outside of what has been local service delivery. So we’re bringing new people in to a new region, new organisations, a new initiative and the people that are there to deliver it will need a good twelve months of development to get to the point where they can really look at system reform."

PIR Manager
A number of PIR Organisations undertook service mapping and gap analysis early in the implementation phase. One large PIR Organisation undertook a very comprehensive, mixed method approach to this task to ensure its model and approach were focused on priority issues and needs.

The process led to a greater understanding of the specific needs of the client group and gaps in service delivery in the very large and diverse region covered by the PIR Organisation. It also helped to strengthen relationships between key groups and stakeholder in order to successfully deliver the program.

The extensive data gathering and consultations undertaken included the following:

- analysis of statistical data from the ABS, the Health Department and patient information systems
- the analysis of utilisation data on mental health and psychiatric services and facilities
- a client audit that profiled over 100 people from twelve local non-government organisations who were potentially eligible for PIR to identify demographic information, as well as social measures, physical health issues, met and unmet needs of the clients
- consultations with a broad range of service providers including GPs, mental health services, government agencies, non-government agencies represented on the consortium, local Aboriginal services and housing services
- focus groups with consumers
- focus groups with carers
- service mapping to develop a greater understanding of gaps in provision of services locally
- a literature review on relevant policy and research.

The extensive report compiled after this brought together these data in a single document. It reported on needs, gaps and strategies as identified by local consumers with complex mental health and other support needs, carers, primary health care practitioners, mental health services, a range of non-government service providers, housing and police.

It included a detailed service mapping of each LGA within the PIR Organisation Region – including government agencies, primary health care providers, mental health services (private and public), family and carer support programs, rehabilitation and supported accommodation services, counselling and social support services, housing, police and Centrelink.

The report included strategies developed through consultations with stakeholders, which will inform the work of the PIR System Reform Officer, PIR Support Facilitators and the PIR consortium. It also included a list of indicators that will be used to help the PIR Organisation assess the extent to which it has been successful in relation to each of its seven focus areas. The key focus areas identified included:

- recovery focus of services
- carers and family
- coordination and communication
- housing
- physical health and commodities
- CALD communities and refugee and humanitarian entrants
- Aboriginal and Torres Strait Islander communities.
9 The PIR-NDIS interface

9.1 OVERVIEW

The interface between the National Disability Insurance Scheme (NDIS) and PIR is still in early stages. The NDIS is being progressively rolled out across Australia, following different schedules in each state and territory and targeting different population sub-groups, at least initially. There was only one operating interface between PIR and the NDIS at the time of the fieldwork, in the Hunter region of NSW. (The Barwon region in Victoria has also established the NDIS but it is one of the thirteen regions in which a PIR Organisation has not currently been appointed.)

The next three years are going to be a period of significant expansion for the NDIS (see Figure 26) and the interface with PIR will become important in almost all regions during this time. New PIR-NDIS interfaces are expected to expand over the next twelve months to include the ACT, the Barkly region in the Northern Territory (though this will only affect a small number of PIR clients due to the small projected potential client population), and three regions in Western Australia².

FIGURE 26 – ESTIMATED NUMBERS OF NATIONAL DISABILITY INSURANCE SCHEME PARTICIPANTS 2013-2020

Source: (Whalan, Acton, & Harmer, 2014)

There was considerable uncertainty expressed in consultations about the implications of the NDIS for clients, carers and PIR Organisations. Communication with the NDIA was described as being productive and valuable by all PIR Organisations that have engaged with the agency and NDIA staff were regarded as committed to the successful implementation of the NDIS. However, a high level of staff turnover during the early stages of planning and rollout has reportedly been a challenge to sustaining communication between the NDIA and the PIR Organisations.

9.2 ELIGIBILITY

A significant concern raised during site visits and telephone consultations was the different criteria for eligibility for the NDIS compared with PIR. The NDIS has a requirement that participants have a permanent disability, though what constitutes a permanent psychosocial disability is unclear. The

² The Western Australian Government is trialling its own NDIS model in the Lower South West region from 1 July 2014 and in the Cockburn-Kwinana region from 1 July 2015. The Australian Government’s model will be run by the NDIA in the Perth Hills region.
elibility for PIR emphasises severe and persistent mental illness, though there are no specific requirements in relation to permanence.

The problem for us [in the NDIA], is the second criterion [for eligibility] is permanence... It is quite difficult for people to say a psychiatric illness is permanent. The third criterion is it that has to be the right agency to provide the supports for a lifetime and the fourth one is they have to have a substantially reduced functional capacity. So in terms of meeting the permanence criteria, that one is quite hard because you know most doctors aren’t saying [a psychosocial disability] is permanent and it’s not like a head injury where you’ve had neural damage or a congenital condition you’re born with.

Government stakeholder

The idea of permanence in relation to psychosocial disability was regarded as being at odds with recovery principles, which emphasise that supportive services and relationships can lead to client empowerment, social inclusion and changed lives. Many stakeholders also highlighted concerns that NDIS participants need a degree of motivation and self-efficacy. Specific concerns were raised about how the NDIS would respond to the needs of clients with severe mental illnesses who fail to maintain contact with them. PIR clients were described as being much harder to engage than other clients with mental illness and several interviewees expressed concerns that they could effectively fall through the gaps.

Government stakeholder

Eligibility issues are being identified as they emerge at the new NDIS sites. The NDIA staff were described by PIR stakeholders as being open to collaboration and learning about new and emerging eligibility issues, but they face a number of challenges in dealing with the establishment of the NDIA and the rollout of a major national scheme.

9.3 ASPECTS OF PIR THAT MAY BE IN-SCOPE

The number of PIR clients who will be eligible to participate in the NDIS is unclear, as is the extent to which services currently coordinated and supported through PIR will be regarded as ‘in scope’ under the NDIS. Several interviewees indicated that they believe at this point, 70% of PIR clients would be eligible to participate in the NDIS. Other stakeholders described this 70% figure as relating to a budgeted amount for in-kind transfer of funding between Australian Government agencies. A small number of interviewees went so far as to suggest that they saw little point in participating in PIR given the likely impact of the NDIS.

NDIA are using some documentation that says that PIR – 70% of PIR clients should be NDIS, with no rationale where that’s from.

PIR Organisation consortium member

PIR is 70% in scope with NDIS. We don’t know where that 70% came from. One speculation is there is unofficially an estimate of 35,000 people who will be eligible for a funded package under the NDIS who will have a psychosocial disability associated with mental illness and 70% of that is 24,000 which is the target number for PIR. That’s one speculation, not in any way official. We don’t understand how they came up with the 70%. We’ve heard conflicting stories about what that means. One version is that 70% of services delivered through PIR will be non-clinical and therefore in-scopes for the NDIS and … clinical [services] are therefore the responsibility of the health system not the NDIS. That’s one explanation. Another explanation is that 70% of people referred to the NDIS from PIR will be eligible for the NDIS.

NGO stakeholder

There have been indications in advice provided by the NDIA to other agencies that at the Commonwealth level 100% cent of the Personal Helpers and Mentors programme (PHaMS), 70% of Partners in Recovery
(PIR) and 50% of Mental Health Respite for Carers and 35% of Support for Day to Day Living in the Community are in-scope for the NDIS (MHCA, 2013). The precise nature and extent of the overlap between PIR and the NDIS will be further determined over the coming year, however there is little doubt that psychosocial disabilities will account for a significant proportion of all NDIS participants.

And we’re doing a lot of work for the NDIS to roll out… In relation to PIR the conversation that has come up is will PIR be defunct? Will we really need that service, or will that be an NDIS planner doing that work?… We had the enhanced service offer grants that just went out to get the community ready for NDIS next year… Out of the 1,500 applications there were 350 applicants for psychosocial disability so there’s definitely a lot of promotion out there for our [mental health] clientele.

Government stakeholder

A number of interviewees stated that they were concerned that if the proportion of PIR clients in-scope for the NDIS is quite high, there is likely to be a reduction in the range and availability of services for people who have serious mental illnesses but who may be ineligible for participation in the NDIS. Several interviewees expressed the related concern that due to the existing high levels of unmet need amongst the intended PIR client group, the NDIS may exacerbate problems that people with severe and persistent mental illnesses experience in accessing services, rather than reducing them.

9.4 DIFFERENCES IN APPROACH

The NDIS relies on a purchaser-provider model for the provision of services included in participants’ plans. This means that service providers are often in competition to provide services. This is in contrast to the approach taken with PIR, which emphasises partnerships and system development at a regional level. As a consequence, several agencies involved in PIR Organisations have indicated that they anticipate being in direct competition with one another for the provision of services under the NDIS. Many non-government organisations in the mental health sector are positioning on a competitive footing for the NDIS and other reforms. Several interviewees reported that there have been tensions within PIR Organisations and PIR Networks about the extent to which collaboration and resource-sharing might be possible in the future.

In terms of the PIR Organisation I hear everyone say it’s great. It’s a great collaboration we’re all best friends. Realistically you have challenges and you have uncomfortable conversations with people because there are people on our PIR at the same time we’re sitting on the PIR Organisation working together. The next week we might be putting in tenders competing against each other on another programme. So we still live in a competitive environment and working through that tension has been one thing.

PIR Organisation consortium member

Several stakeholders expressed the view that Medicare Local-led PIR Organisations may not be as well-placed to deal with PIR-NDIS interface issues. This is because they were not regarded as being focused on disability services. As such Medicare Locals were not considered to be as directly affected by the rollout of the NDIS when compared with other NGO stakeholders. Because of this many stakeholders thought the NDIS would not be regarded as a priority by Medicare Locals. It was also suggested that as Medicare Locals may be constrained by operating within particular regions. Because of this regional focus they may not be able to take advantage of the economies of scale that are possible for other agencies in relation to the provision of NDIS services.

There was a view expressed by a small number of people that the NDIS could provide an opportunity for agencies within PIR Organisations to explore new and innovative approaches to service delivery. For example, several suggested that whilst the NDIS does not fund case management, participants may receive funding for the coordination of complex supports. This is similar to the distinction that PIR has made between case management and service coordination. It was suggested that this may allow agencies employing Support Facilitators to offer service coordination services for NDIS participants with psychosocial disabilities.
9.5 OTHER REFORMS

Several states and territories are undertaking reviews of human services funding and delivery arrangements, largely in response to the rollout of the NDIS. The introduction of the NDIS has provided opportunities for governments to reassess a broad range of disability and social service arrangements. The implications of these reviews will vary across jurisdictions and none had been finalised at the time of the consultations:

[State or Territory] government has been through its own [review process], looking at the contracts and services it provides, has been through a process of mapping out its services and determining what it will cash out NDIS… We don’t know what the future state will be.

PIR Organisation consortium member

Several stakeholders noted that the forthcoming Review of Mental Health Services and Programmes by the National Mental Health Commission (National Mental Health Commission, 2014) is also likely to have an impact on PIR and in the mental health sector in general, though it is not possible to foresee what these impacts might be. There was a view expressed that the review has potential to streamline and rationalise Australian Government-funded mental health programmes, though this will depend on its recommendations.

The Review of Medicare Locals was mentioned by a small number of interviewees during the stakeholder consultations. Since the consultations, the Review has been released (Horvath, 2014) and it may have a number of indirect impacts on PIR due to the recommended changes to Medicare Locals. These impacts are likely to be more pronounced in the PIR Organisations that have Medicare Locals as their Lead Agencies. The nature of these impacts will become clearer in the next six months as the recommendations are implemented.

9.6 SUMMARY

At the time of the site visits only one PIR-NDIS interface was operating, in the Hunter region of NSW. This will expand to four new regions over the next twelve months. Presently there is little clarity and considerable uncertainty about how the interface will operate. There has been dialogue and considerable goodwill between PIR and the NDIA in the Hunter.

There continues to be lack of clarity about what constitutes permanence in relation to psychosocial disability, which is a requirement to participate in the NDIS. There has also been considerable misinformation about what aspects of PIR are in-scope for the NDIS, what the implications of this are, and how these interface issues will be managed. The next two years will be a critical period in determining how the PIR-NDIS interface will function.
10 Conclusions

This section presents an overview of key findings, a description of opportunities and challenges facing PIR and provides a list of recommendations to enhance and inform the delivery of the PIR Initiative.

10.1 KEY FINDINGS

- **PIR is a complex initiative that has been successfully established.**
  The PIR Initiative programme infrastructure represents best practice in implementing a complex national programme. The Capacity Building Project, Resource Development Project and Department of Health have all contributed to the successful establishment of PIR.

- **The majority of PIR Organisations have progressed well through establishment and implementation phases.**
  There has been a large amount of activity including staff recruitment and training; development of systems, policies and procedures; promotion of PIR; and extensive sector and community engagement. PIR Organisations are now shifting their focus to ongoing operation with a focus on enhancing PIR client outcomes.

- **All but one PIR Organisation are currently accepting referrals.**
  PIR Organisations have made substantial progress in developing the systems, forms and procedures required to operate. PIR Organisations have also devoted considerable effort to developing referral pathways and promoting PIR. To date, 7,913 referrals have been received, with 5,235 clients proceeding to registration. The PIR Organisation that has not started accepting referrals has faced a number of challenges, including the disbanding of its consortium.

- **Partnerships have been a critical mechanism for PIR Organisations and have generally been well developed.**
  The national partnership survey found that partnerships are generally functioning well. There were generally high levels of commitment to the partnerships and to a recovery approach. Partnerships could be enhanced through more attention to developing shared understanding about the purpose of the partnership, participatory decision-making and communication mechanisms. Effective partnerships will increase the likelihood of PIR’s impacts being sustained in the medium- and long-term.

- **There is scope to enhance consumer and carer involvement.**
  All PIR Organisations reported some level of consumer and carer involvement. The nature of this varied considerably, from consumers and carers sitting on the consortium or governing body through to carer and consumer involvement in training and recruitment. There was scope for the extent of consumer and carer involvement to be expanded in most PIR Organisations, though all described a commitment to working with consumers and carers. An area that requires investigation is the extent to which PIR Organisations intend to engage directly with carers and provide services to them.

- **The flexible funding pool needs to be used.**
  Very few PIR Organisations had spent any of their flexible funding at the time of consultation. Many had identified situations where it may have been possible to use the flexible funding, but were able to resolve the issues through alternate means. The reluctance to use the flexible funding reflects uncertainty in many PIR Organisations about the circumstances in which it is appropriate for it to be used.

- **The next twelve months will be a critical period.**
  PIR Organisations are moving beyond establishment and implementation phases into ongoing operation, with a greater emphasis on PIR client outcomes.
10.2 OPPORTUNITIES AND CHALLENGES

Table 13 provides an overview of the key opportunities and challenges for PIR.

**Table 13 – Overview of Risks and Opportunities**

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<thead>
<tr>
<th>OPPORTUNITIES</th>
<th>CHALLENGES</th>
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<tr>
<td>Diverse partnerships</td>
<td>Reviews and system reform</td>
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<tr>
<td>Current enthusiasm</td>
<td>Maintaining momentum and enthusiasm for PIR</td>
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<tr>
<td>Enhancing the recovery focus of mental health and other services</td>
<td>Unrealistic expectations about the extent of system reform that is possible</td>
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<td>Innovative and flexible practices</td>
<td>Staff retention</td>
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<td>Lead Agencies taking responsibility</td>
<td>Not reaching the consumers with greatest needs</td>
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10.2.1 OPPORTUNITIES

PIR Organisations are generally collaborating well for collective impact, informed by the real practice of case coordination and the real issues clients are encountering. They have diverse membership overall and many have been successful in engaging agencies that have traditionally had limited collaboration and direct involvement with the mental health sector, such as a range of employment and material assistance agencies.

*So we’ve got meetings set up with police, community mental health, with agencies, the prison sector, with employment so I think we’ll actually have those relationships going and I think that’s going to be working; facilitating the relationship between participants and those agencies much better and, hopefully we’ll be seeing outcomes there.*

**PIR Manager**

There is widespread enthusiasm for PIR and its goals, though this is tempered by uncertainty about the impact of the NDIS and changes to mental health and primary health care services. The site visits emphasised the opportunity and also the need for this enthusiasm to be maintained if PIR is to be successful and maintain momentum.

*When you start something new, in my experience, the people employed in that programme generally have a lot of enthusiasm and energy to give, but you come up against a system that’s just been there for years and years. Really a system is just a group of people, they’re changed, they’re fatigued… How do you sustain that energy and motivation and bring people with you [and not end up as] another client service provider with some lobbying money?*

**Government stakeholder**

This enthusiasm for PIR is driven in part by the idea that it represents a “once in a career” opportunity to change the way services work together to meet the needs of clients with severe and persistent mental illnesses.

*What I would hope would happen out of all of this is that the system itself will change so that people actually work differently. It’s an opportunity for change, it’s not just about this programme it’s about changing the way within the sector.*

**Consumer representative**

PIR was regarded as an important part of the development of Australia’s future mental health workforce, and ensuring the workforce and system is focused on recovery.

*PIR had the potential, and still has the potential, to shift that generation of support workers to think differently and these people will be the leaders of the future, I believe, in our sector and will probably be required very, very soon with the introduction of NDIS.*

**NGO stakeholder**
The diversity of agencies involved in PIR Organisations presents an opportunity to take creative approaches to system reform and case coordination. In many of the PIR Organisations visited and consulted this has been pursued by:

- outposting staff to other agencies on a permanent or rotating basis
- formal interagency agreements in the form of memoranda of understanding or guarantees of service
- creative use of technology to share information within PIR Organisations about agencies and activities that may lead to referrals, case coordination and system reform activities.

There are opportunities for these approaches to be strengthened and become more widespread over the next twelve months. Many of the PIR Organisations have made considerable investment in communication and marketing, though most of this activity has been targeted at the mental health sector thus far. There is an opportunity for PIR Organisations to extent the scope of the communication activities and to focus on:

- enhancing the awareness of PIR amongst agencies outside PIR Networks and the mental health sector
- increasing the recognition of PIR Support Facilitators, their roles and achievements
- diffusing innovative practices.

Perhaps the greatest strength of PIR is that in all cases responsibility has been taken by a Lead Agency (or joint Lead Agencies in a small number of cases), meaning that even though PIR takes a partnership approach it also ‘belongs’ to a specific agency. This suggests that even though there are many changes underway across the mental health and social services sectors, there will continue to be a clear contact agency within each PIR Organisation. There are designated PIR staff and these workers continue to play an organising and catalysing role at local and regional levels.

10.2.2 CHALLENGES

There are a number of changes occurring or foreshadowed across the mental health, primary care and human services sectors. These include the continuing rollout of the NDIS, the disbanding of Medicare Locals, and the National Mental Health Commission’s review of mental health services and programmes. A number of reviews and reforms are also underway in states and territories. These changes all have the potential to overwhelm the impact of PIR, particularly in relation to system reform activities.

*The other risk I think to PIR… is about transition to NDIS… at the moment we’re running nearly all the state-funded and commonwealth-funded mental health services so two thirds of our business will be rolled into NDIS and we’ll be a major NDIS player.*

PIR Organisation consortium member

…it’s a crowded market here, it’s been really interesting, the government’s rolled out quite a number of programmes in the last 12 months in this field.

PIR Organisation consortium member

*I think the biggest challenge facing PIR is uncertainty over reforms to the mental health sector; the NDIS, I’ve heard multiple times that 70% of PIR funding is set to be rolled into the National Disability Insurance Scheme that means that this huge uncertainty around PIR and what its future might be so that’s big.*

Government stakeholder

A related risk is that PIRs will face difficulties in maintaining momentum and enthusiasm from all parties in the context of this broader system reform. A number of people and agencies involved in their PIR Organisations were already devoting considerable time to thinking about how reforms might affect their agencies and their involvement in PIR.
Several interviewees noted that there are fewer advocates or interest groups for PIR when compared with some other reforms or national initiatives. Several suggested that because PIR seeks to meet the needs of a substantial but often forgotten group, there is limited public awareness about PIR.

*From a political point of view PIR has no power base. So if you compare it to a large programme where, say, the medical profession is at the heart of it, they’ll have strong advocates to defend it… The PIR initiative by design is so diffuse, it devolves power to such a local level that even if there’s some really valuable work that’s going on, there’s no one who will come to its aid and advocate to retain it.*

*NGO stakeholder*

There is a need to be realistic about the scale and nature of system reform that is possible during the funded timeframe. PIR has generally taken a local and regional approach to system reform, which is likely to ensure that gains in this area, whilst modest, are likely to be visible and practical. It also means that some stakeholders’ expectations that PIR will change significant portions of the mental health and social services systems are not likely to be met.

Several challenges will be faced by PIR Organisations that do not relate to external factors. The greatest may be staff retention. As the funding period for PIR draws closer it will become more difficult for PIR Organisations to replace staff. It will be difficult to recruit staff to short-term positions. This could have a marked impact on PIR Organisations’ capacity and morale. PIR Organisations with high rates of staff turnover are likely to experience:

- loss of organisational knowledge
- reduced continuity of contact within partnerships
- instability within PIR Organisations.

*I know our providers have had their own issues around recruitment and retention, based on the level of reform they are going through... We’re under review so every aspect of this is in a state of flux, it makes it much more difficult at the moment, a difficult environment.*

*PIR Manager*

Another risk that PIR Organisations face is that they may not be able to reach the consumers with the greatest needs. By focusing on clients who are known to existing services there is a risk that the consumers with the greatest needs, those who have been lost from the service sector, could be excluded from PIR. PIR Organisations have taken varied approaches to address this issue. To successfully address this will require regular review of PIR client identification, referral, service coordination and system reform activities. The next year will be a critical period because PIR Organisations are shifting from establishment to ongoing operation. If PIR Organisations are to achieve their intended goals they will need to ensure continuity of staff and make sure they reach the intended clients of PIR.
10.3 SUGGESTIONS TO STRENGTHEN PIR

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

TABLE 14 – SUGGESTIONS TO STRENGTHEN THE PIR INITIATIVE

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<tr>
<th>AGENCY</th>
<th>SUGGESTIONS FOR STRENGTHENING</th>
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<td>PIR Organisations</td>
<td>1. Avenues for enhancing the involvement of consumers and carers in the governance and decision-making of PIR Organisations should be investigated.</td>
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<td>2. The scope, nature and desired outcomes of system reform and service coordination activities should be defined within each PIR Organisation.</td>
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<td>3. Policies and procedures for spending their flexible funding pool should be clarified as a matter of priority.</td>
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<td>4. Information on creative and effective ways of using the flexible funding pool should be disseminated across PIR Organisations.</td>
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<td>5. PIR Organisations should share strategies/approaches to targeting and assisting PIR clients who are Indigenous, CALD/refugee or LGBTI.</td>
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<td>6. More training and/or a clearer articulation of how a recovery-based approach can be translated into practice should be undertaken.</td>
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<td>7. Partnership development activities should focus on:</td>
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<td>a. developing participatory decision-making processes</td>
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<td>b. developing communication mechanism and processes</td>
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<td>c. developing procedures for identifying new partners and bringing them into the PIR Organisation or Network.</td>
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<td>Capacity Building Project</td>
<td>8. The Capacity Building Project should take a more strategic thought-leadership approach.</td>
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<td>9. Greater emphasis should be placed on highlighting and disseminating good practices and innovation.</td>
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<td>10. More emphasis should be placed on building capacity for partnership development and partnership strengthening.</td>
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<td>11. The PIR Initiative website should be reviewed to enhance navigability and searchability. The online forums should be changed to allow more unmediated communication between PIR Organisations.</td>
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<td>12. The operation of teleconferences with PIR Organisations should be reviewed to include clearer agendas and chairing procedures.</td>
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<td>13. Avenues should be explored for creating awards recognising achievement and innovation among PIR Organisations, possibly in collaboration with sector and/or consumer and carer peak bodies.</td>
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<td>Department of Health/Government</td>
<td>14. PIR Organisations require information and guidance about the PIR-NDIS interface and NDIS eligibility for PIR clients.</td>
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<td>15. Assistance and guidance is needed for PIR Organisations to guide their own evaluations to complement the national evaluation.</td>
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<td>16. A mechanism should be established to conduct a meta-synthesis of the individual evaluations being conducted by PIR Organisations.</td>
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11 Next steps for the PIR Evaluation Project

11.1 OVERVIEW

There has been very enthusiastic participation in PIR evaluation activities to date by PIR Organisations and stakeholders. Many stakeholders are very keen to participate in the national evaluation and to ensure that a robust approach is being adopted. Many PIR Organisations are conducting evaluations of their own operations.

The recommendations of the National Mental Health Commission’s Review of Mental Health Services and Programmes and the actions arising from the Medicare Local Review will have an impact on PIR. The ways in which PIR Organisations respond to these environmental challenges will be an added focus of 2014 national fieldwork. Similarly, the nature and extent of the NDIS interface will expand significantly over the next twelve months and will be a focus of the next round of fieldwork and telephone consultations in those locations with an NDIS interface.

Many of the issues identified in this report reflect the timing of the fieldwork, which was in the first six to eight months of the implementation stages of PIR between November 2013 and January 2014 in the case of the site visits and between January and April 2014 in the case of the telephone consultations. Some of the later phone consultations indicated that some of the issues discussed here were in the process of being resolved, as have discussions at PIR conferences and workshops since then. Some of the challenges encountered during implementation may now reflect historical rather than contemporary concerns for PIR Organisations.

Additionally, as part of the site visits, the evaluation team sought feedback on the feasibility of four potential evaluation activities (see Appendix A for the specific research instrument):

- conducting a survey of PIR clients and carers about their satisfaction and experiences of PIR
- in-depth interviews with PIR clients and carers as part of the site visits
- the use of a consumer self-reported quality of life measure
- the use of a carer needs assessment tool (e.g. the Carer Eligibility and Needs Assessment [CENA]).

Comments on the feasibility and appropriateness were sought in particular from PIR Managers, as they had the most direct involvement with all aspects of PIR within a region. A number of logistical issues and practical considerations were identified in relation to each activity, which are outlined below.

11.2 PIR CLIENT AND CARER SATISFACTION SURVEY

The idea of a survey of PIR clients and carers was well-received and there was general agreement that PIR Organisations and Support Facilitators would be willing to assist in publicising and assisting with survey recruitment. It was recognised that alternate mechanisms for contacting consumers directly, such as letters or emails, were unlikely to be effective in gaining responses from most of the PIR client group. When prompted to discuss survey methodology, participants advised that an online-only or paper-only survey was unlikely to meet the needs of all PIR clients and carers, and that a mixed approach to recruitment would be required. The preferred methodology that emerged was for a printed information flyer for the survey that could be circulated by Support Facilitators, offering three options for participation:

- a link to an online survey
- a phone line that could be manned for a one or two week period so that consumers and carers could complete the survey over the phone
- a phone number and email address to contact to request a paper-based version of the survey.

It was anticipated that Support Facilitators would play an active role in encouraging PIR clients and carers to participate in the survey but that it would not be appropriate for them to assist PIR clients or carers...
directly to complete the survey. It was unclear whether it would be feasible to recruit PIR clients who had been discharged for the survey, though most interviewees said that it would be feasible to send the survey information to former PIR clients even if they no longer had direct contact with PIR.

When asked if a survey was preferable to alternate methodologies, such as telephone interviews with consumers and carers, most interviewees reported that a survey was likely to reach a wider group of consumers and carers. It was suggested that telephone interviews were likely to only be conducted with those consumers and carers who were most engaged with PIR.

11.3 IN-DEPTH INTERVIEWS WITH PIR CLIENTS AND CARERS

There was consensus that it was appropriate and desirable for the PIR Evaluation and Monitoring Project to interview PIR clients and carers directly as part of the site visits. Since the Round 1 site visits were completed the Evaluation and Monitoring Project has received ethics approval from the Department of Health’s Human Research Ethics Committee to interview PIR clients and carers as part of the Round 2 and Round 3 site visits. These interviews will form an additional component of the fieldwork to commence in late 2014.

11.4 CLIENT SELF-REPORTED QUALITY OF LIFE MEASURES

There was recognition that it would be valuable to capture PIR client self-reported quality of life as part of the evaluation of PIR. All PIR Organisations are using the CANSAS. The CANSAS ratings are incorporated into their client activity reporting systems as set out in the MDS. Though the CANSAS includes PIR client ratings, these were not included in the original MDS specifications. That was due to recognition of the difficulties that Support Facilitators can encounter during the assessment process in establishing rapport with consumers, explaining detailed assessment processes and ensuring timely completion.

Since the Round 1 site visits, the Department of Health has issued a revision to the MDS to allow voluntary reporting of the PIR client CANSAS ratings in addition to the CANSAS ratings. This means that there will be more data on client self-reported quality of life available to the evaluation through the routine client activity reporting data.

Several of the longitudinal sites visited reported that in addition to the CANSAS they also collected data using recovery oriented scales, such as the Mental Health Recovery Star (MHRS) or the Recovery Assessment Scale (RAS). They reported that they used these scales because they were regarded as:

- comprehensible to consumers and carers
- more meaningful in a recovery setting than other scales
- useful in identifying areas of need and establishing goals in conjunction with consumers and carers.

All the longitudinal sites using these recovery measures reported that they thought it would be feasible and desirable to share de-identified data from these tools with the evaluators. This will supplement the PIR client self-reported scales within the CANSAS that are now being voluntarily reported by PIR Organisations nationally.

11.5 CARER INPUT TO THE EVALUATION

There was widespread recognition that the needs of carers are substantial, often unmet and can vary substantially. None of the sites reported that they currently used a carer assessment tool, nor did they have immediate plans to introduce the use of one. This reflects the primary orientation of PIR Organisations towards assessing the needs of PIR clients. It is therefore proposed that feedback from carers will primarily be collected via interviews conducted during 12 site visits each year, and from responses to the consumer and carer satisfaction survey conducted in 2016. Several sites reported that they would be reluctant to routinely or episodically collect data on carers, as distinct from consumers, because it might not be appropriate or feasible in all cases. Concerns were also expressed that any additional data collection on carers could be burdensome and might not meaningfully assist practical activities with individual PIR clients.
11.6 TIMING OF EVALUATION ACTIVITIES

The policy and programme landscape is moving very fast, and Urbis sees potential benefit in bringing forward the consultation and site visit schedule, to ensure that the Department is receiving up to date information on PIR Organisation operations in line with developments in the sector.

The next phase of the evaluation will be particularly critical in that:

- the interface with the NDIS should become clearer as the scheme matures and is rolled out to more regions
- the field will be developing more practice learnings as they intake larger numbers of PIR clients
- it will become possible to analyse the early outcomes of client and carer contact with PIR through interviews and data
- more developments will have occurred in relations to the system reform elements of PIR, increasing the possibility of documenting some outcomes.

11.7 EVALUATION ISSUES FOR DISCUSSION

Urbis recommends the following issues be discussed in relation to the evaluation in the near future:

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>ISSUE</th>
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<tbody>
<tr>
<td>Fieldwork and consultations in 2014-2015</td>
<td>Timing of consultations and site visits&lt;br&gt;Selection of six new sites to be visited in 2014-15&lt;br&gt;Approach to identify and engaging consumers and carers in interviews in site visit locations&lt;br&gt;Timing of reporting on consultations and fieldwork</td>
</tr>
<tr>
<td>Regional evaluation workshops COMPLETED</td>
<td>Finalising schedule of workshops&lt;br&gt;Agreeing key focus and purpose of workshops&lt;br&gt;Logistical arrangements&lt;br&gt;Design and delivery of workshops</td>
</tr>
<tr>
<td>Linked data sets ON HOLD PENDING OUTCOME OF NHMC REVIEW</td>
<td>Communication with jurisdictions to test their interest in linking PIR data to state/territory data sets&lt;br&gt;Investigation of value, technical and cost feasibility should interest be expressed by particular jurisdictions&lt;br&gt;Seeking ethics approval, if required</td>
</tr>
<tr>
<td>Outcome data from longitudinal sites</td>
<td>Discussion of agreements with longitudinal sites regarding access to more data on consumers via use of recovery assessment tools&lt;br&gt;Information on period and timing of data extraction</td>
</tr>
<tr>
<td>MDS Data COMPLETED AND INCLUDED IN THIS REPORT</td>
<td>Analysis of first year’s data once provided by the Department&lt;br&gt;Discussion of timing/method of extraction of MDS data in the future</td>
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References


Disclaimer

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

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**Introduction**

My name is XXX and I work for social research consulting firm Urbis. As you are aware, Urbis has been commissioned by the Australian Government Department of Health to conduct an evaluation of PIR from 2013 to 2016. The primary focus at this stage of the evaluation is *implementation issues and challenges* although we are of course interested to discuss any outcomes and achievements to date.

This visit is one of twelve site visits that we will be conducting this year, with a further 24 site visits to be conducted over the next two years to a selection of PIR Organisations. In selecting sites for visits, we have been keen to achieve a variety in terms of Lead agency type (Medicare Local, NGO), geographic location (States/Territories and urban, regional and remote localities), size of target population, population demographics (including PIRs servicing high proportion of Aboriginal or CALD clients) and PIR service model.

Six of the twelve sites we visit this year will be revisited over the next two years – this will enable us to track and report on issues, challenges and outcomes for these PIRs, their service systems, clients and carers over a three year period from a longitudinal perspective.

All other PIRs (not visited) are being consulted by telephone.

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

Have you any questions to ask before we start?

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

**(A) PIR background**

Please describe your PIR

1. Can we start with you outlining the nature of your PIR model – lead agency and number and type of consortium members?
2. How would you describe the key characteristics of your service model or approach? To what extent is this similar or different to PIR models in other regions, to your knowledge?
3. What is the size and nature of your target population? Are there particular characteristics they have or issues that they face in comparison to the broader PIR target group?

**(B) Implementation progress and challenges**

What implementation issues have you encountered?

4. Overall, how satisfied have you been with the progress of the implementation of PIR in this establishment phase? Why is that?
5. What things have progressed well? What factors have assisted with this?
6. What, if any, aspects of implementation have taken/are taking longer than expected? What have been the major challenges or obstacles? How are you addressing these issues currently?
(C) Specific implementation issues

The Consortium

How is your Consortium going?

7. How satisfied are you with the way the Consortium is working to establish and implement PIR? (Probe commitment, communication, information-sharing, collaboration and capacity)

8. What is working well? What have been the critical factors in this?

9. What is working less well and why? How can this be improved?

Partnerships

How are partnerships within your Consortium going?

10. How would you describe your partnership development strategy?

11. How do you facilitate the engagement of cross-sectoral partners beyond the consortium?

12. What is working well? What have been the critical factors in this?

What is working less well and why? How can this be improved?

Governance and management

What are the governance and management arrangements in place for your Consortium?

13. What governance and management structures have been put in place for your consortium?

14. How well are these working to date?

15. How are partners beyond the consortium engaged in governance and management?

16. What, if any, mechanisms do you have for engaging consumers in the development/design of your PIR model?

PIR Organisation staffing

What staffing issues have you encountered?

17. To what extent have PIR Organisation staff been recruited in line with your plan and service model?

18. If not, how has your approach differed?

19. To what extent have they been trained as needed and planned?

20. Are there any staffing issues that have gone particularly well or proved challenging?

Care coordination and support model

What is your PIR model, and how does it relate to the recovery model?

21. What is your approach to the recovery model?

22. What types of care coordination and support models have been or are being put in place? How are these built on the recovery model underpinning PIR?

23. What are the key features of your model?

24. What were the processes and the rationale for the development of this particular model or approach in this region or service context?

25. To date, how well do these seem to be working do you think?

Referral, intake and assessment processes
How are your referral, intake and assessment processes going?

26. What referral, intake and assessment processes are in place?
27. How well are these working to date?
28. What steps have you taken to communicate the referral process across the region?

Data collection

What data do you think will be important for the evaluation?

29. Have you any comments to make on the MDS and the extent to which you think it will be useful for your organisation and agency?
30. Apart from the MDS, is there other data that you are collecting or needing that may be useful for management or evaluation purposes?

(D) Clients and carers

What issues have you encountered identifying and engaging the target group?

31. What challenges do you anticipate in identifying and engaging the target group? What strategies do you have in place to address these?
32. When did you first open your doors to clients? Approximately how many have been accepted onto PIR to date? How many have been referred on elsewhere?
33. How well have the programme inclusion guidelines been working? Are you exercising discretion in cases to accept people who don’t meet all the inclusion criteria? If so, why is that?
34. Where have most referrals been coming from? Are the right clients being referred to PIR?
35. Have the client numbers been more or less than you had expected at this point? Why is that? If less than expected, what strategies are you putting in place to increase client referrals?
36. What have been the key needs that they have presented with?
37. And what about carers - how are they interacting with PIR and what support are they receiving? What in your view is the main role of PIR in supporting or assisting carers?

(E) The service system and network

How is PIR fitting into and/or changing the broader service system?

38. A key aim of PIR is to improve the service system for PIR clients. This will take time – but what steps, if any, have been taken towards this end thus far?
39. What are the key challenges you face in achieving this aim? What are the best opportunities that you think present themselves?
40. How would you describe the mental health service system in your PIR that is available/potentially available to support PIR clients and carers? What are its key strengths? What are the key gaps or problem areas?
41. What about the broader service network – strengths and gaps/problem areas? Who do you anticipate will be the most critical services to engage with and why?
42. What engagement has there been with these agencies and services to date and to what effect? What has been their response to PIR?
43. What are your plans for the next six months in relation to the service system and network?
(F) Programme management, capacity-building and learnings

Do you have any comments on the broader PIR Initiative’s programme management, capacity building and/or learnings?

44. How satisfied have you been with the support provided by Flinders University (websites, forums, conferences, resources etc) in the roll out and ongoing implementation of PIR? What has been most useful and why? Is there any support that you have needed that you haven’t been able to access?

45. How satisfied have you been with the tools and resources (provided by Siggins Miller) to assist with PIR implementation? Which of these are proving most useful to date and why?

46. How satisfied have you been with your dealings with the Department?

47. Have you any ideas about how PIR management, capacity-building or implementation could be strengthened in the next year or so?

48. Are there any other comments that you would like to make that are relevant to the evaluation?

(G) Feasibility of Evaluation Project

49. See separate document on feasibility issues, of particular relevance for PIR Managers/PIR Managers.

THANKYOU FOR YOUR PARTICIPATION
Evaluation of Partners in Recovery (PIR)
Questions for PIR Organisations about the Feasibility of some Proposed Evaluation Activities in 2014 - 2016

Introduction

In the PIR Evaluation Framework, Urbis has proposed a number of potential evaluation activities to be conducted from next year 2014. However, we need to check with PIR Organisations whether these are feasible and practical, and if so, what would be the logistics involved. We are also planning on talking with clients and carers in the next round of visits and are keen to talk with you about how we best identify, recruit and engage with PIR clients and carers for the purpose of the evaluation.

<table>
<thead>
<tr>
<th>PLANNED ACTIVITY</th>
<th>WHAT WE’D LIKE TO DO</th>
<th>KEY QUESTIONS</th>
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</table>
| Client and carer satisfaction survey | ▪ Conduct a survey of clients and carers in 2016  
▪ Idea is that this is a ‘census’ of all clients/carers who have been engaged with PIR to obtain feedback on their experiences of PIR  
▪ Will be a very short, simple survey – mainly ‘tick a box’ – but with one or two open-ended questions                                                                 | ▪ We need to consider whether this will be an online or paper-based survey or a mixture of both. Do you have online/SMS contact for all/most clients and carers who you assist?  
▪ Would you be willing/able to distribute a survey on our behalf (eg via email or paper-based) to clients/carers to fill in?  
▪ What if any challenges do you see in conducting the survey?  
▪ What would be your advice as to how best to address these?  
▪ What would be good questions to ask carers/clients?                                                                 |

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<tr>
<th>PLANNED ACTIVITY</th>
<th>WHAT WE’D LIKE TO DO</th>
<th>KEY QUESTIONS</th>
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| Client and carer in-depth one-on-one interviews | ▪ Conduct up to six one-on-one in-depth interviews with PIR clients/carers on each site visit (24 site visits over 3 years)  
▪ These interviews may be face-to-face, or by telephone if preferred  
▪ We would like to speak to a ‘mix’ of clients eg in terms of age, gender, cultural background, experiences, needs  
▪ We will obtain formal ethics clearance for these interviews prior to the visit  
▪ We will consult with you about the duty of care issues for clients, staff and the evaluator  
▪ We will consult with PIR Organisations regarding recruitment, interview venue etc                                                                 | ▪ Will you be able/willing to assist with ‘recruiting’ clients/carers to speak with us?  
▪ What challenges do you foresee in doing this?  
▪ What sort of contact methods would be best with clients – telephone, email, text etc?  
▪ What opportunities are there to build in some ‘random’ sampling methods?  
▪ What would be good questions to ask clients? Carers?  
▪ What privacy/consent/ethical issues need to be considered?                                                                 |
<table>
<thead>
<tr>
<th>PLANNED ACTIVITY (LONGITUDIAL SITES ONLY)</th>
<th>WHAT WE’D LIKE TO DO</th>
<th>KEY QUESTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of a client self-report ‘quality of life’ or other tool</td>
<td>Utilise a quality of life tool twice – at two yet to be determined points (eg at entry to PIR and a year or 18 months later)</td>
<td>What practical/logistical or other issues will we need to consider in doing this? Could it be ‘built in’ in some way to your PIR operations? Would it be best to focus on a sample – eg those interviewed for the evaluation? How would it best be administered? What privacy/consent/ethical issues need to be considered?</td>
</tr>
<tr>
<td>Purpose to obtain a ‘pre and post’ assessment of quality of life based on clients perceptions</td>
<td>Suggest a sample of clients only Possibly only used with clients who are interviewed by the evaluation team Could be administered by Urbis or by PIR personnel</td>
<td></td>
</tr>
<tr>
<td>PLANNED ACTIVITY (LONGITUDIAL SITES ONLY)</td>
<td>WHAT WE’D LIKE TO DO</td>
<td>KEY QUESTIONS</td>
</tr>
<tr>
<td>Use of carer needs assessment tool (eg CENA) to measure and track changes in carers’ needs over time (as a measure of improvement)</td>
<td>Administer the CENA (or other carer assessment tool) with a sample of carers Administered twice – eg early contact with PIR and at a later stage</td>
<td>What level and type of contact is expected with carers? Is a carer assessment tool being used at all in this process? Is there merit in this proposal? How feasible is it – what mechanisms could be put in place for it to happen? How would it best be administered? What privacy/consent/ethical issues need to be considered?</td>
</tr>
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</table>
Appendix B  Telephone Consultation Discussion Guides
Evaluation of Partners in Recovery
Interview Guide for 2013-2014 Telephone Consultations
PIR Organisations and Consortium Members

Introduction

My name is XXX and I work for social research consulting firm Urbis. As you are aware, Urbis has been commissioned by the Department of Health to conduct an evaluation of PIR over the next three years. The primary focus at this stage of the evaluation is implementation issues and challenges although we are of course interested to discuss any outcomes and achievements to date. We are conducting a series of telephone consultations with PIR Organisations and Consortium members and we have also conducted visits to 12 PIR Organisations over recent months.

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

Have you any questions to ask before we start?

PIR background

1. Can we start with you outlining the nature of your PIR – lead agency and number and type of consortium members?
2. What is the size and nature of your target population? Are there particular characteristics they have or issues that they face in comparison to the broader PIR target group?

Implementation progress and challenges

3. Overall, how satisfied have you been with the progress of the implementation of PIR in this establishment phase? Why is that?
4. What things have progressed well? What factors have assisted with this?
5. What, if any, aspects of implementation have taken/are taking longer than expected? What have been the major challenges or obstacles? How are you addressing these issues currently?

Probe:
- The Consortium arrangements
- Contracting arrangements
- Governance and management (including the involvement of consumers in design/development)
- PIR Organisation staffing
- Care coordination and support model
- Referral, intake and assessment processes

Clients and carers

6. What challenges do you anticipate in identifying and engaging with the target group? What strategies do you have in place to address these?
7. When did you first open your doors to clients? Approximately how many have been accepted onto PIR to date? How many have been referred on elsewhere?
8. How well have the programme inclusion and exclusion guidelines been working? Are you exercising discretion in many cases to accept people who don't meet all the inclusion criteria? If so, why is that?

9. Have the client numbers been more or less than you had expected at this point? Why is that? If less than expected, what strategies are you putting in place to increase client referrals?

10. What has been the response of clients to PIR up until now? What do they like/value about it or is it too early to say? Is there anything that they are finding difficult or confusing?

11. And what about carers - how are they interacting with PIR and what support are they receiving? What in your view is the main role of PIR in supporting or assisting carers?

**Flexible funding pool**

12. What policies and protocols have been put in place regarding the flexible funding pool?

13. Are these working well to date?

14. What sorts of things is the funding pool being used for mainly?

**The service system and network**

15. A key aim of PIR is to improve the service system for PIR clients. This will take time – but what steps, if any, have been taken towards this end thus far?

16. What are the key challenges you face in achieving this aim? What are the best opportunities that you think present themselves?

17. What are your plans for the next six months in relation to the service system and network?

18. Have you any comments to make on the MDS and the extent to which you think it will be useful for your organisation and agency?

19. Apart from the MDS, is there other data that you are collecting or needing that may be useful for management or evaluation purposes?

**Programme management, capacity-building and learnings**

20. How satisfied have you been with the support provided by Flinders University (websites, forums, conferences, resources etc) in the roll out and ongoing implementation of PIR? What has been most useful and why? Is there any support that you have needed but haven’t been able to access?

21. How satisfied have you been with the tools and resources (provided by Siggins Miller) to assist with PIR implementation? Which of these are proving most useful to date and why?

22. How satisfied have you been with your dealings with the Department?

23. Have you any ideas about how PIR management, capacity-building or implementation could be strengthened in the next year or so?

24. Are there any other comments that you would like to make that are relevant to the evaluation?

THANKYOU FOR YOUR PARTICIPATION
Interview Guide for 2013-2014 Telephone Consultations
National and State/Territory Stakeholders

My name is XXX and I work for social research consulting firm Urbis. Urbis has been commissioned by the Department of Health to conduct an evaluation of PIR over the next three years. The main aim of the evaluation is to examine the implementation and delivery of PIR; assess the impact of PIR on clients, carers, PIR organisations, other service providers, and the wider health service delivery system; evaluate PIR’s effectiveness in improving the system of care available to people with severe and persistent mental illness that have complex multi-agency needs and identify implications and develop recommendations to inform ongoing roll-out of the initiative.

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

Have you any questions to ask before we start?

1. How familiar are you with PIR? What, if any, role have you had in developing, supporting or implementing the programme?

2. What is your understanding of the key aims and objectives of PIR? How do you think the PIR model or approach compares with other programmes or initiatives targeting people with multiple and complex mental health and related needs?

3. What are the key strengths of the model in your view? Any limitations or drawbacks?

4. Is there any overlap or duplication with other initiatives, to your knowledge?

5. What do you think will be critical to the success of PIR over the next three years?

6. What do you think will be the key challenges that PIR may face? How do you think these will be best addressed?

7. What sort of evidence would you be looking for to assess the effectiveness of PIR after three years?

8. PIR is still in the early days of implementation. What if any feedback have you received about this establishment phase? What is going well? What is going less well? (Prompt: Consortia arrangements, governance, staffing, service models, service system engagement)

9. Is this across the board or does it vary a lot across the PIRs? Why is that do you think?

10. Which PIRs seem to be making most progress? What are the key success factors there?

11. Which PIRs seem to be making slower progress? What are the challenges and difficulties they are facing? How do you think they can be best supported to overcome these?

12. How critical or effective have the capacity building (Flinders University), tools and resources (Siggins Miller) initiatives and Departmental programme management been in this PIR planning and implementation phase?

13. Have you any ideas as to how PIR or its implementation could be strengthened at this stage?

14. Have you any other comments to make that are relevant to the evaluation?

THANKYOU FOR YOUR PARTICIPATION
Appendix C National Partnership Survey Instrument
Evaluation of Partners in Recovery (PIR)  
National Online Survey of PIR Organisations

**PURPOSE**

Urbis is conducting the Evaluation of Partners in Recovery (PIR). A component of the evaluation involves a longitudinal survey of PIR Organisations (including consortium members) to assess implementation progress, key barriers and enablers, key achievements and changes in partnership functionality and effectiveness over the next two years or so. The survey will be repeated in 2016.

The survey is an important element of the evaluation as it will, amongst other things, help assess various aspects of system reform as demonstrated through the operation of the PIR partnership.

**WHO SHOULD COMPLETE THIS SURVEY?**

We are seeking one response from each member of the PIR Organisation, including each consortium member and the Lead Agency. We are not seeking responses from the broader PIR Network, i.e. contracted agencies not in a PIR Organisation.

*Only one person from each consortium member agency should complete the questionnaire.* However, that person may find it useful to consult with others in their agency before completing the questionnaire to reflect an organisational view. If you are a consortium member in your own right (e.g. as a consumer or carer representative), just complete the questionnaire from your own viewpoint.

The questionnaire should take 10-12 minutes to complete.

**CONFIDENTIALITY**

In reporting, your responses will not be identifiable in any way, nor will your PIR Organisation. We ask you to name your agency because we want to ensure we receive only one response from each consortium member within your PIR Organisation.

**CONTACT**

If you have any questions about this questionnaire or the Evaluation please contact Ben Harris-Roxas at Urbis on (02) 8233 9993 or email bharrisroxas@urbis.com.au
SECTION A: YOUR PIR PARTNERSHIP

We’re firstly going to ask you some background information on your PIR Organisation.

A1: As a member of a PIR Organisation, do you represent

Please tick one box

☐ 1  An agency/service/department
☐ 2  Consumers (in your own capacity)
☐ 3  Carers (in your own capacity)
☐ 4  Other

If 2 or 3 above go to A3

A2: Which agency do you represent within your PIR Organisation? (We need to know this to ensure only one response is received from each agency)

____________________________________________

A3: Which PIR Organisation are you a member of?

____________________________________________

A4: What is the Lead Agency within your PIR Organisation?

Please tick one box

☐ 1  A Medicare Local
☐ 2  A mental health services provider (eg Schizophrenia Fellowship, Richmond PPA)
☐ 3  Other NGO (eg Centacare, Red Cross)
☐ 4  Joint Lead (please SPECIFY the Lead Agency__________________________)
☐ 5  Other (please SPECIFY__________________________________________)

A5: Is your agency the Lead Agency?

Please tick one box

☐ 1  Yes
☐ 2  No
A6: How many consortium members are there in your PIR Organisation?

☐ 1 RECORD NUMBER _________
☐ 2 Not sure

A7: In which State or Territory does your PIR Organisation mainly operate?

Please tick one box

☐ 1 Australian Capital Territory (ACT)
☐ 2 New South Wales
☐ 3 Northern Territory
☐ 4 Queensland
☐ 5 South Australia
☐ 6 Tasmania
☐ 7 Victoria
☐ 8 Western Australia

A8: How are Support Facilitators employed within your PIR Organisation?

Please tick one box

☐ 1 Employed by the PIR Organisation Lead Agency only
☐ 2 Employed by PIR Organisation consortium members other than the Lead Agency only
☐ 3 Employed by a mixture of PIR Organisation consortium members and the Lead Agency
☐ 4 Other (please SPECIFY__________________________________________)
☐ 5 Not sure

A9: Which of the following best describes the region your PIR Organisation covers?

Please tick all that apply

☐ 1 Urban/Metropolitan
☐ 2 Regional
☐ 3 Rural/Remote

A10: When did your PIR Organisation first start accepting referrals?

Please tick one box

☐ 1 MMYY
☐ 2 Not accepting referrals yet
☐ 3 Not sure
## SECTION B: PARTNERSHIP

We’re now going to ask you a series of questions asking you to rate various aspects of your partnership (consortium) arrangements and functionality. When we use the word ‘partner’, we are referring to consortium members.

How much do you agree or disagree with each of the following statements?

### B1: Within your PIR Organisation

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Not sure</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) There is a shared understanding about the purpose of PIR</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>b) There is a shared understanding of the Recovery Model</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>c) There is a clear approach to system reform activities</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>d) Consumer representatives play a key role in decision-making</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>e) Carer representatives play a key role in decision-making</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
</tbody>
</table>

### B2: Determining the need for the partnership

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Not sure</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) There is a perceived need for the partnership in terms of areas of common interest and complementary capacity</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>b) There is a clear goal for the partnership</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>c) There is a shared understanding of, and commitment to, this goal among all potential partners</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>d) The partners are willing to share some of their ideas, resources, influence and power to fulfil the goal</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>e) The perceived benefits of the partnership outweigh the perceived costs</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
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</table>
### B3: Choosing partners

<table>
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<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Not sure</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) The partners share common ideologies, interests and approaches</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>b) The partners see their core business as partially interdependent</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>c) There is a history of good relations between the partners</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>d) The coalition brings added prestige to the partners individually as well as collectively</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>e) There is enough variety among members to have a comprehensive understanding of the issues being addressed</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
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</tbody>
</table>

### B4: Making sure partnerships work

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Not sure</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) The managers in each agency support the partnership</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>b) Partners have the necessary skills for collaborative action</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>c) There are strategies to enhance the skills of the partnership through activities to support the membership or workforce development</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>d) The roles, responsibilities and expectations of partners are clearly defined and understood by all other partners</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>e) The administrative, communication and decision-making structure of the partnership is as simple as possible</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
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<td>□ 5</td>
</tr>
</tbody>
</table>
### B5: Planning collaborative action

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Not sure</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>All partners are involved in planning and setting priorities for collaborative action</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>b)</td>
<td>Partners have the task of communicating and promoting the coalition in their own agencies</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>c)</td>
<td>Some staff have roles that cross the traditional boundaries that exist between agencies in the partnership</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>d)</td>
<td>The lines of communication, roles and expectations of partners are clear</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>e)</td>
<td>There is a participatory decision-making system that is accountable, responsive and inclusive</td>
<td>□ 1</td>
<td>□ 2</td>
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<td>□ 4</td>
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</table>

### B6: Implementing collaborative action

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Not sure</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Processes that are common across agencies such as referral protocols, service standards, data collection and reporting mechanisms have been standardised</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>b)</td>
<td>There is an investment in the partnership of time, personnel, materials or facilities</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>c)</td>
<td>Collaborative action by staff and reciprocity between agencies is rewarded by management</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>d)</td>
<td>The action is adding value (rather than duplicating services) for the community, clients or the agencies involved in the partnership</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td>e)</td>
<td>There are regular opportunities for informal and voluntary contact between staff from the different agencies and other members of the partnership</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
</tbody>
</table>
B7: Minimising the barriers to partnerships

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Not sure</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a)</strong> Differences in organisational priorities, goals and tasks have been addressed</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td><strong>b)</strong> There is a core group of skilled and committed (in terms of the partnership) staff that has continued over the life of the partnership</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td><strong>c)</strong> There are formal structures for sharing information and resolving demarcation disputes</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td><strong>d)</strong> There are informal ways of sharing information and resolving demarcation disputes</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td><strong>e)</strong> There are strategies to ensure alternative views are expressed within the partnership</td>
<td>□ 1</td>
<td>□ 2</td>
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<td>□ 4</td>
</tr>
</tbody>
</table>

B8: Reflecting on and continuing the partnership

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Not sure</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a)</strong> There are processes for recognising and celebrating collective achievements and/or individual contributions</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td><strong>b)</strong> The partnership can demonstrate or document the outcomes of its collective work</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td><strong>c)</strong> There is a clear need and commitment to continuing the collaboration in the medium term</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td><strong>d)</strong> There are resources available from either internal or external sources to continue the partnership</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
<tr>
<td><strong>e)</strong> There is a way of reviewing the range of partners and bringing in new members or removing some</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
</tr>
</tbody>
</table>

B9: Reflecting on strengths and challenges

**a)** What do you think have been the key strengths of your partnership/consortium, to date?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
b) What, if any, challenges or risks do you see the partnership/consortium facing in the next 12 months or so?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Thank you

Thank you for participating in this survey. If you have any questions about this survey or the Evaluation please contact Ben Harris-Roxas at Urbis on (02) 8233 9993 or email bharrisroxas@urbis.com.au

Appendix D  National Partnership Survey Results
FIGURE 27 – ELEMENTS OF PIR EMBEDDED IN THE PARTNERSHIP

1% 23% 27% 37% 12%
Carer representatives play a key role in decision-making

1% 21% 23% 39% 16%
Consumer representatives play a key role in decision-making

10% 32% 50% 8%
There is a clear approach to system reform activities

7% 67% 23%
There is a shared understanding of the Recovery Model

1% 57% 34%
There is a shared understanding about the purpose of PIR

Source: 2014 Survey data; N=155. Single response question. Responses have been grouped to facilitate reporting.

FIGURE 28 – DETERMINING THE NEED FOR THE PARTNERSHIP

1% 17% 55% 24%
The perceived benefits of the partnership outweigh the perceived costs

1% 78% 65% 24%
The partners are willing to share some of their ideas, resources, influence and power to fulfil the goal

1% 7% 14% 63% 16%
There is a shared understanding of, and commitment to, this goal among all potential partners

6% 8% 60% 27%
There is a clear goal for the partnership

46% 65% 27%
There is a perceived need for the partnership in terms of areas of common interest and complementary capacity

Source: 2014 Survey data; N=155. Single response question. Responses have been grouped to facilitate reporting.
FIGURE 29 – CHOOSING PARTNERS

There is enough variety among members to have a comprehensive understanding of the issues being addressed

- Strongly disagree: 4%
- Disagree: 11%
- Not sure: 65%
- Agree: 21%
- Strongly agree: 0%

The coalition brings added prestige to the partners individually as well as collectively

- Strongly disagree: 1%
- Disagree: 23%
- Not sure: 59%
- Agree: 14%
- Strongly agree: 0%

There is a history of good relations between the partners

- Strongly disagree: 7%
- Disagree: 24%
- Not sure: 54%
- Agree: 15%
- Strongly agree: 0%

The partners see their core business as partially interdependent

- Strongly disagree: 5%
- Disagree: 22%
- Not sure: 65%
- Agree: 8%
- Strongly agree: 0%

The partners share common ideologies, interests and approaches

- Strongly disagree: 8%
- Disagree: 19%
- Not sure: 61%
- Agree: 10%
- Strongly agree: 0%

Source: 2014 Survey data; N=155. Single response question. Responses have been grouped to facilitate reporting.

FIGURE 30 – PLANNING COLLABORATIVE ACTION

There is a participatory decision-making system that is accountable, responsive and inclusive

- Strongly disagree: 16%
- Disagree: 17%
- Not sure: 57%
- Agree: 16%
- Strongly agree: 0%

The lines of communication, roles and expectations of partners are clear

- Strongly disagree: 10%
- Disagree: 26%
- Not sure: 56%
- Agree: 7%
- Strongly agree: 0%

Some staff have roles that cross the traditional boundaries that exist between agencies in the partnership

- Strongly disagree: 16%
- Disagree: 33%
- Not sure: 47%
- Agree: 14%
- Strongly agree: 0%

Partners have the task of communicating and promoting the coalition in their own agencies

- Strongly disagree: 22%
- Disagree: 72%
- Not sure: 0%
- Agree: 20%
- Strongly agree: 0%

All partners are involved in planning and setting priorities for collaborative action

- Strongly disagree: 18%
- Disagree: 14%
- Not sure: 63%
- Agree: 18%
- Strongly agree: 0%

Source: 2014 Survey data; N=155. Single response question. Responses have been grouped to facilitate reporting.
FIGURE 31 – IMPLEMENTING COLLABORATIVE ACTION

There are regular opportunities for informal and voluntary contact between staff from the different agencies and other members of the... [Graph with data]

The action is adding value (rather than duplicating services) for the community, clients or the agencies involved in the partnership... [Graph with data]

Collaborative action by staff and reciprocity between agencies is rewarded by management... [Graph with data]

There is an investment in the partnership of time, personnel, materials or facilities... [Graph with data]

Processes that are common across agencies such as referral protocols, service standards, data collection and reporting mechanisms... [Graph with data]

Source: 2014 Survey data; N=155. Single response question. Responses have been grouped to facilitate reporting.

FIGURE 32 – MAKING SURE PARTNERSHIPS WORK

The administrative, communication and decision-making structure of the partnership is as simple as possible... [Graph with data]

The roles, responsibilities and expectations of partners are clearly defined and understood by all other partners... [Graph with data]

There are strategies to enhance the skills of the partnership through activities to support the membership or workforce development... [Graph with data]

Partners have the necessary skills for collaborative action... [Graph with data]

The managers in each agency support the partnership... [Graph with data]

Source: 2014 Survey data; N=155. Single response question. Responses have been grouped to facilitate reporting.
FIGURE 33 – MINIMISING THE BARRIERS TO PARTNERSHIPS

- There are strategies to ensure alternative views are expressed within the partnership
  - Strongly disagree: 6%
  - Disagree: 17%
  - Not sure: 60%
  - Agree: 16%

- There are informal ways of sharing information and resolving demarcation disputes
  - Strongly disagree: 6%
  - Disagree: 19%
  - Not sure: 63%
  - Agree: 12%

- There are formal structures for sharing information and resolving demarcation disputes
  - Strongly disagree: 8%
  - Disagree: 23%
  - Not sure: 54%
  - Agree: 14%

- There is a core group of skilled and committed (in terms of the partnership) staff that has continued over the life of the partnership
  - Strongly disagree: 8%
  - Disagree: 68%
  - Not sure: 20%

- Differences in organisational priorities, goals and tasks have been addressed
  - Strongly disagree: 16%
  - Disagree: 37%
  - Not sure: 41%
  - Agree: 3%

Source: 2014 Survey data; N=155. Single response question. Responses have been grouped to facilitate reporting.

FIGURE 34 – REFLECTING ON AND CONTINUING THE PARTNERSHIP

- There is a way of reviewing the range of partners and bringing in new members or removing some
  - Strongly disagree: 3%
  - Disagree: 37%
  - Not sure: 46%
  - Agree: 10%

- There are resources available from either internal or external sources to continue the partnership
  - Strongly disagree: 5%
  - Disagree: 18%
  - Not sure: 61%
  - Agree: 18%

- There is a clear need and commitment to continuing the collaboration in the medium term
  - Strongly disagree: 8%
  - Disagree: 59%
  - Not sure: 32%

- The partnership can demonstrate or document the outcomes of its collective work
  - Strongly disagree: 8%
  - Disagree: 19%
  - Not sure: 65%
  - Agree: 12%

- There are processes for recognising and celebrating collective achievements and/or individual contributions
  - Strongly disagree: 0%
  - Disagree: 39%
  - Not sure: 47%
  - Agree: 7%

Source: 2014 Survey data; N=155. Single response question. Responses have been grouped to facilitate reporting.
Appendix E  Membership of the PIR Expert Reference Group
<table>
<thead>
<tr>
<th>PREFIX</th>
<th>FIRST NAME</th>
<th>LAST NAME</th>
<th>POSITION</th>
<th>ORGANISATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms</td>
<td>Judy</td>
<td>Bentley</td>
<td></td>
<td>Carer representative</td>
</tr>
<tr>
<td>Ms</td>
<td>Karen</td>
<td>Pickering</td>
<td>Branch Manager, Community Wellbeing and Mental Health Branch</td>
<td>DSS</td>
</tr>
<tr>
<td>Dr</td>
<td>Julian</td>
<td>Freidin</td>
<td></td>
<td>St Kilda Road Clinic</td>
</tr>
<tr>
<td>Ms</td>
<td>Janet</td>
<td>Meagher AM</td>
<td></td>
<td>Consumer representative</td>
</tr>
<tr>
<td>Mr</td>
<td>David</td>
<td>Meldrum</td>
<td>Executive Director</td>
<td>Mental Illness Fellowship of Australia</td>
</tr>
<tr>
<td>Ms</td>
<td>Fiona</td>
<td>Nicholls</td>
<td>Assistant Secretary, Mental Health Services Branch</td>
<td>Dept. of Health and Ageing</td>
</tr>
<tr>
<td>Mr</td>
<td>Frank</td>
<td>Quinlan</td>
<td>Chief Executive Officer</td>
<td>Mental Health Council of Australia</td>
</tr>
<tr>
<td>Assoc. Prof.</td>
<td>Morton</td>
<td>Rawlin</td>
<td>Vice President and Chair</td>
<td>Royal Australian College of General Practitioners</td>
</tr>
<tr>
<td>Prof.</td>
<td>Alison</td>
<td>Ritter</td>
<td>Director, Drug Policy Modelling Program, National Drug and Alcohol Research Centre</td>
<td>University of New South Wales</td>
</tr>
<tr>
<td>Ms</td>
<td>Sally</td>
<td>Sinclair</td>
<td>Chief Executive Officer</td>
<td>National Employment Services Association</td>
</tr>
</tbody>
</table>
SYDNEY
LEVEL 23, DARLING PARK TOWER 2
201 SUSSEX STREET
SYDNEY, NSW 2000
T 02 8233 9900
F 02 8233 9966

MELBOURNE
LEVEL 12, 120 COLLINS STREET
MELBOURNE, VIC 3000
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F 03 8663 4999

BRISBANE
LEVEL 7, 123 ALBERT STREET
BRISBANE, QLD 4000
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F 07 3007 3811

PERTH
LEVEL 1, 55 ST GEORGES TERRACE
PERTH, WA 6000
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