Evaluation of Crisis Respite Services:

Evaluation Plan

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CARS	Consumer Activity Report System
CBIS	Community Based Information System
CRS	Crisis Respite Services

1 Introduction

SA Health has commissioned a research team from the Social Policy Research Centre (SPRC) at UNSW Australia, in partnership with Époque Consulting, to undertake an evaluation of Crisis Respite Services in South Australia (SA). The overall aim of this research is to build a strong evidence base for the provision of best practice and improved policy in the delivery of recovery-oriented sub-acute crisis respite services in South Australia.

This Evaluation Plan presents the detailed methodology the research team will use to answer the evaluation questions:

- Section 1 provides the background to the Crisis Respite Services program
- Section 2 provides an overview of the evaluation scope and focus
- Section 3 describes the research methodology that will be used
- Section 4 outlines the stakeholder engagement strategy.

1.1 Background

South Australia's mental health system is undergoing significant reform in relation to structure, services and approaches (SA Health, 2012). A key aspect of the South Australian mental health reform is a move to a recovery-oriented approach and the development of more rehabilitation services to support individuals' unique and personal journeys to social inclusion and wellness (SA Health, 2008, 2010, 2012). Recovery and rehabilitation do not entail a cure for an individual's mental illness, but rather helping individuals to achieve an improved level of wellbeing and a renewed sense of identity, purpose and meaning in life in the presence or absence of symptoms of illness (SA Health, 2010, 2012). There is no time frame set for an individual's recovery, as everyone's recovery journey is unique (SA Health, 2010, 2012).

Overall, psychosocial rehabilitation entails a shift from an illness model towards a social functioning model that aims to improve individuals' competencies and to introduce environmental changes to improve the quality of life of individuals with mental illness. The delivery of psychosocial rehabilitation requires a partnership approach across government and non-government sectors, including specialist providers, Government providers, non-government organisations, consumer run providers, brokerage agencies, and General Practice.

Research evidence supports the use of psychosocial rehabilitation and shows positive consumer outcomes that potentially reduce health system service use, including through reduced and avoided hospital admissions and lengths of stay. (Barbato, 2006; Barton, 1999; Crosse, 2003).

1.1.1. Policy background

The reform of mental health services in South Australia has been guided by a number of national and state directives.

At a national level, key policy documents include **the National Action Plan on Mental Health 2006–2011** (which emphasises coordination and collaboration between government, private and nongovernment providers), **the COAG National Mental Health Policy 2008** (which provides a strategic vision for a mental health system that enables recovery, prevents and detects mental illness early, and ensures that all Australians with a mental illness can access effective and appropriate treatment and can participate fully in society); the **Fourth National Mental Health Plan 2009–2014** (which offers a framework to develop systems of care that are able to intervene early and provide integrated services across health and social domains); the **National Standards for Mental Health Services 2010** (which incorporate a recovery standard and cover bed-based and community mental health services, those in the clinical and non-government sectors, the private sector, and primary care and general practice).

At the South Australia level, five key policy documents are the Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007–2012, the Psychosocial rehabilitation support services standards (SA Health, 2008), the South Australia's Mental Health and Wellbeing Policy 2010–2015 (SA Health, 2010), the Mental Health Act 2009, and Statewide Aboriginal Mental Health Consultation: Summary Report.

Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007– 2012 set the vision for mental health services in South Australia to provide a service that is people-centred and recovery-oriented. It recommended the implementation of a stepped system of care, which entails that the mental health service system is arranged as a tiered care system consisting of support across the community, supported accommodation, community rehabilitation, intermediate care, acute care and secure care (SA Health, 2012). The **Psychosocial Rehabilitation Support Service Standards** (SA Health, 2008) offered a framework for the provision of quality services under a recovery model within the South Australian context. **The South Australia's Mental Health and Wellbeing Policy 2010–2015** (SA Health, 2010) built on the Stepping Up reform and set key goals in relation to the well-being, service provision and social inclusion of individuals with mental illness. The **Mental Health Act 2009** provided a legislative framework that explicitly articulated the rights of people with mental illness and facilitated their recovery and participation in community life (SA Health, 2012). Finally, the **Statewide Aboriginal Mental Health Consultation: Summary Report** July 2010 proposed thirteen recommendations aimed to improve mental health and wellbeing for Aboriginal South Australians and seven core elements relevant to all services.

1.1.2. The Mental Health Subacute Crisis Respite – Residential and Home Based Services

As part of the National Partnership Agreement, Mental Health Subacute Crisis Respite – Residential and Home Based Services, in South Australia there will be a total of 24 residential based subacute crisis respite beds and 10 home based bed equivalent places within metropolitan Adelaide (SA Health, 2014c). Sub-acute Crisis Respite Services complement the stepped model of care (see Section 1.2.1) and provide an additional service delivery option for people with mental illness (SA Health, 2014b). The Sub-acute Crisis Respite Services are informed by a recovery based philosophy and aim to provide a period of respite care for consumers experiencing deterioration in their mental health. Consumers will receive clinical and psychosocial support to assist in addressing the issues leading to the presentation in crisis and in restoring usual or improved functioning and living skills that support them to reside in the community (SA Health, 2014a, 2014b).

Overall, Crisis Respite Services are expected to reduce the number of emergency department presentations and or hospital admissions and reduce the burden of care experienced by carers. Their objectives are (SA Health, 2014a, p. 4):

- To provide home or bed-based respite for individuals presenting in crisis with issues largely social in nature, and requiring predominantly social and psychological interventions.
- To provide appropriate and timely out of hospital care for people experiencing a mental health crisis.
- To improve mental health outcomes, stop deterioration in mental health, and/or restore the individual to usual or improved functioning.
- To provide an alternative to hospitalisation or emergency department presentation in a more appropriate environment.
- To provide a therapeutic environment.
- To provide interventions up to 7 days (extension can be negotiated on the basis of acceptable rationale).
- To minimise mental health hospital admissions resulting from crisis.
- To decrease wait and stay times in emergency departments.
- To provide a timely response to referrals from mental health triage, emergency departments, community mental health services taking into account consumer, carer and mental health system context.
- To provide an alternative to hospitalisation or emergency department presentation in a more appropriate environment.
- To improve mental health outcomes.
- To stop deterioration in mental health.

Crisis Respite Services is a partnership program between Mental Health Services and the non-government sector (SA Health, 2014b). It will be operated 24 hours/7 days per week by offering both bed based crisis respite and home based crisis respite for up to 7 days (SA Health, 2014b). Each of the three metropolitan Local

Health Network (LHN) – i.e. Southern Adelaide LHN, Central Adelaide LHN and Northern Adelaide LHN – will have a Crisis Respite Service, which will consist of 8 residential beds and a home based (outreach) service with about 3.33 home based bed equivalent places per metropolitan LHN (SA Health, 2014b).

Target groups

Crisis Respite Services use the following criteria to identify people who are eligible for the programme:
- Individuals aged between 18–65. People who are younger or older are accepted if developmentally appropriate and suitable for the environment and service.
- Individuals who are experiencing disruption to usual mental health and require a short term crisis respite response which may be due to one or a combination of the following or other reasons:
    - Existence of a high prevalence disorder where acute admission is not indicated, and assessed level of risk can be managed in the environment.
    - Carer whose stress levels have precipitated mental health issues.
    - Family and/or relationship issues (usual supports under stress).
    - Accommodation stress.
    - Substance misuse which is impacting on mental health and ability to function but where clinical response is not required.
    - Financial issues which impact on usual living situation (e.g. unpaid electricity bill, rent money etc.).
    - Loss and grief issues.
    - Physical health issues which impact on usual mental health and/or have prompted a crisis presentation and which can be managed within the crisis respite environment.
- Referrals must have an element of hospital avoidance, i.e. an emergency department presentation or an acute admission.
- Engagement in the Crisis Respite Service is voluntary.
- Catchment for each crisis respite facility will be based on source of referral as well as residence. The three facilities will work closely together to offer a place if the service is deemed appropriate. Equal consideration will be given to individuals from country locations, particularly those who have presented to a metro emergency department, or where a respite stay is the most appropriate and least restrictive option for care.
- Homelessness is not an exclusion for this service.
- Scheduled or planned respite is not in scope for this service.

Programme and clinical governance

Programme governance. The Crisis Respite Services programme governance is managed by a Crisis Respite Project Control Group, which is convened by the

Mental Health and Substance Abuse Division (the Program Management Unit responsible for the establishment and oversight of Crisis Respite Services) (SA Health, 2014b). The Crisis Respite Project Control group will be convened by the Executive Lead of the Mental Health and Substance Abuse Division and will have representation from senior staff within the Local Health Networks, Country Health SA Local Health Networks, any Non-Government Organisation contracted to provide the service and a consumer and carer representative (SA Health, 2014b).

The Mental Health and Substance Abuse Division, which convenes the Control Group, is an administrative division of the Department for Health and Ageing with responsibility for the implementation of the Crisis Respite Services "which involves the provision of funding to the Local Health Networks (for the clinical component) and to the non-government sector (for the residential management and non-clinical component)" (SA Health, 2014b, p. 6).

Clinical governance. Each of the three metropolitan Local Health Networks (LHN) has clinical governance for a Crisis Respite Service. The Clinical Director, within each LHN, has overall clinical responsibility for the treatment and care provided to consumers of Crisis Respite Services. Each LHN establishes a Crisis Respite Services Partnership Committee, which meet on a regular and agreed basis. The Partnership Committee includes representation from the LHN and from the Non-Government Organisation(s) contracted by the Department for Health and Ageing to provide Crisis Respite Services within the LHN (SA Health, 2014b). The representatives, from each of the LHN's, will report to the Project Control Group (SA Health, 2014b).

2 Evaluation scope and focus

The evaluation has been commissioned by SA Health Department, Mental Health and Substance Abuse Branch. The evaluation period is from March 2015 to November 2015. The evaluation involves a process and outcomes evaluation, including a cost-effectiveness analysis.

The **process evaluation** will determine the effectiveness of the Crisis Respite Services, including governance structure, stakeholder relationships, collaboration, inter-agency service delivery approach, and consumer/ carer experiences of receiving services and support in their home/ facility.

The **outcomes evaluation** will determine the impact of Crisis Respite Services on participants in the areas of quality of life, health and mental health, and community participation; and will determine if Crisis Respite Services are assisting in reducing presentations at Emergency Departments and other acute care settings.

The **cost-effectiveness analysis** will compare Crisis Respite Services daily program cost per 'bed day equivalent' to cost of EDs and hospital bed day costs.

SPRC has an inclusive approach to evaluation research; researchers will consult and involve a number of key stakeholders in the development, design and data collection phases of this evaluation research. The communication and stakeholder engagement strategy is outlined in Section 4.

The evaluation will consist of the following components:

- Review of program documentation including program policy documents.
- Ethics application for qualitative and quantitative components through SA Health and the service provider.
- Quantitative evaluation using de-identified program and administrative data, including analysing the cost-effectiveness of the program.
- Qualitative research including interviews with consumers, carers, staff (department staff, service providers, the Crisis Respite Services evaluation subcommittee, the Crisis Respite Project Control Group and others identified), and other stakeholders.
- Analysis through the triangulation of findings.

Each component of the evaluation is described in detail in Section 3. Appendix A summarises how the components of the evaluation fulfil the research objectives and research questions.

3 Evaluation methodology

The evaluation will adopt a participatory research approach, which relies on a close working relationship with SA Health, the Manager of the Strategy and Planning, Mental Health Strategy, Policy and Legislation, and the Manager Mental Health Information Management and Performance, so as to maximise utility in the project.

The evaluation will be informed by a review of program documentation and data from a variety of sources. The evaluation will analyse existing data generated by the program or other administrative data sources (including information available through CARS and CBIS) and identify outcomes for the program overall as well as for specific target groups, e.g. Indigenous people, young people, other demographic groups, people with different diagnoses, or circumstances.

Qualitative data (e.g. interviews and group discussions) will be conducted with consumers, their informal carers, service providers and managers from the government and NGO services and department staff, and other key stakeholders to be identified in collaboration with the Crisis Respite Services evaluation subcommittee, the Manager of the Strategy and Planning, Mental Health Strategy, Policy and Legislation, and during the qualitative data collection.

An overview of data sources and number of participants/records that will inform the evaluation is presented in Table 1 below.

Table 1 Summary of data sources

	Per location	Total (n)
Program data (CBIS and CARS)[a]		
Consumers – profile, outputs and outcomes	all	~200
Financial and administrative data	all	~200
Interviews (face-to-face)		
Consumers (past program participants)	4	12
Family and carers	2	6
Focus groups/ interviews		
Service providers (gov and NGOs)	3	~9
Phone interviews (Department staff/ program Directors, other)	-	~8

[a] Consumers in and exited Crisis Respite Services.

3.1 Review of program documentation

To better understand the program its objectives, partnership arrangements and governance structure the research team will review a small number of key program policy documents, specifications and related documents that will inform the research design and approach. We will also review existing literature.

3.2 Ethics process

Human research activities are governed by the principles outlined in the National Statement on Ethical Conduct in Research Involving Humans (National Health and Medical Research Council, 2007). The Research Code of Conduct sets out the obligations on all UNSW researchers, staff and students to be aware of the ethical framework governing research at the University and to comply with institutional and regulatory requirements.

All research will be conducted under ethics approval. UNSW Human Research Ethics Committee (HREC) recognises SA Health HREC, therefore applications have been made to SA Health.

The following ethics processes have been submitted:

- Application made to SA Health Human Research Ethics Committee for the use of de-identified administration and program data for the evaluation (ref HREC-15-SAH-11).
- Application made to SA Health Human Research Ethics Committee for the overall conduct of the evaluation in accordance with this Evaluation Plan (ref HREC-15-SAH-28) – including all fieldwork on the condition that specific site assessment assessments are conducted with each Local Health Network.
- Application made to four Local Health Networks.
- Application made to NEAMI, the Crisis Respite Service provider to seek approval to interview staff and consumers.

All fieldwork will be conducted in accordance with best ethical practice in human research. Participants will be recruited through people known to them (the service provider in the case of consumers), will be provided with information about the research, will be asked if they would like to participate, will be asked to give consent to participate, and will be given every opportunity to withdraw consent should they change their mind. Researchers are experienced in conducting fieldwork with vulnerable people and will be able to recognise any signs of distress should they arise, and also be able to guide a person to the relevant supports and follow up. Research participants will be able to select where, when and how they would prefer to be interviewed.

3.3 Quantitative data analysis

The quantitative analysis will rely on de-identified program and administrative data relating to costs, service use, consumer outcomes, and other relevant program data. The program costs will include funding of the Local Health Networks for the clinical support component, as well as separately for NGO services provided for residential management. The service usage and consumer outcome data will include pre and post program support as the basis of the before and after time series framework.

In addition to the core before and after analysis, data sources were initially considered for the possibility of undertaking propensity score matching as the basis for a non-consumer comparison group. Following initial discussion with the Crisis Respite Services (CRS) project team it was established that a study control group could be identified in country regions where the CRS program is not yet available. This approach for the evaluation comparison group is expected to provide a more suitably matched basis for those in comparable crisis situations as presented in the following sections.

The quantitative outcomes analysis will also be integrated with program financial and cost data aligned with service delivery to assess the cost effectiveness of the program.

3.3.1 Before/after design

The CRS program is a short term 7-day intervention typically without further scheduled follow up with consumers once they have left the program, although it is understood that in exceptional circumstances consumers may receive slightly extended support or a longer stay.

In this short timeframe context, the preliminary phase of the quantitative analysis will develop a time series framework as the basis of comparative analysis of consumer outcomes before and after support from the CRS program. This will include service delivery timing combined with consumer growth during the establishment and program development period, as well as identification of program capacity trends.

Program outcomes will include changes in inpatient admissions and lengths of stay, ED presentations, as well as hospital services avoided as a result of responsive program intervention. Similarly, before and after comparisons will be undertaken for community mental health services, and where sufficient before and after data are available, for mental health outcomes based on HoNOS, K10 or LSP measures.

CRS data sources

During their engagement with CRS, providers collect a range of data on service delivery and consumer outcomes. The program also has access to acute inpatient and mental health data from hospitals and possibly some other providers. The

longitudinal analysis will therefore focus, for example, on frequency and intensity of use of EDs, hospital bed use, other mental health specialist support – prior, during and post CRS intervention – to measure change over time for consumers and possible effectiveness of the program. The analysis will focus on identifying, where there is sufficient data, for which groups of program participants, for example by age, gender, other demographics, cultural backgrounds or mental health diagnosis, the program is more effective than for other groups.

The longitudinal outcome analysis will be linked to CRS service delivery for clinical and/or residential support, as recorded in the CBIS and CARS datasets. As all CRS program operation is currently in metropolitan Adelaide areas, the outcome data is understood to be available through the CBIS system. This linked analysis will examine if particular support models are more effective than others, or particular groups of consumers experience different outcomes if they receive residential or home based respite services. The research team is experienced in evaluation of similar programs (e.g. IHBSS and HASI) and will use their existing knowledge to analyse the program costs and outcomes through the administrative data and, where feasible linkage between available departmental and service provider datasets.

Time series framework

In line with the CRS program intervention short duration, the evaluation of outcomes will necessarily focus on a corresponding post program timeframe, perhaps of one to six months. Where sufficient data are available, the framework will develop prior quarters of consumers' service use and outcomes to establish a pre-program baseline, for comparison with the immediate crisis period before entering, and then the corresponding immediate periods following support.

The before and after comparative figures will be assessed in perspective of client throughput and program capacity, as a rolling 3 or 6 month average outcome base case for the available evaluation and post program period. This will also potentially provide a basis for developing modelled projections of outcomes beyond the evaluation timeframe.

The data will be collated into groups of post program duration clusters, where sufficient consumer sample sizes are available, ideally for the first quarter (3 months), and additionally for a further second quarter (6 months) post program. This will potentially provide sufficient sample sizes for paired statistical analysis on the same individual consumers before and after. The paired 'balanced' before and after clusters control for client covariance in baseline characteristics as they focus on timeframes directly before and after CRS support and the only explicit change is participation in the program.

Consumer duration analysis

In line with the short CRS program intervention, the post program period will be assessed to determine the duration of any service use or other client outcomes. Where feasible to substantiate, the longest post program duration will be utilized, to capture as much comparative timeframe as possible. It should be noted in this context, that the analysis may be limited to some extent, firstly by the numbers passing through the program (which could limit the degree to which sub-group analysis can be undertaken) and also as a result of 'right censoring' – e.g. the fact that some consumers may have left the program only recently (or might still be in the program) and therefore insufficient time will have passed to fully assess the impact of the program on hospital admission patterns. In order to account for these factors we will use duration analytic techniques if possible to ascertain the effect of the program on hospital admission and other service use.

The duration analysis will include the number of months that consumers continued post program without recording a 'relapse', defined for example as the point at which a consumer either returned to hospital, or presented to an ED. This definition is particularly conservative given that consumers may have a baseline average number of admitted days over pre-program quarters, in which case relapse is reasonably the point that a consumer exceeds this longer term average service usage. Where sufficient data are available, the analysis will examine potential measures of relapse, to evaluate post CRS outcomes in terms of total relapse free periods.

3.3.2 Propensity score matching

Propensity score matching (PSM) is an approach that may be used in observational studies, to estimate the treatment effect of an intervention when potential program participants have not been randomly allocated to treatment and non-treatment groups. The approach aims to control for variation in consumer baseline characteristics, to conditionally predict where individuals outside of the program may have been accepted for support services, and compare outcomes on this basis.

However, it is well recognised that mental health episodes are complex and specific to a wide range of individual factors and diagnoses, including potentially important non observable characteristics.

The evaluation team initially considered sampling non-CRS consumers to assess whether a comparative cohort could be identified of sufficient quality to adequately estimate propensity scores as the basis for control group matching. Under this approach consumers are potentially matched on a number of pre-program variables, in particular:

- Age, gender, Aboriginal status
- Primary and where feasible secondary diagnoses
- History of mental health use, particularly hospital admission

The target country region CRS non-consumer control group provides a more suitable matching basis for comparison and will replace the PSM component.

The matching timeframe for non-CRS consumers is understood to be available for up to two years prior to crisis assessment, in line with the program study group.

3.3.3 CRS non-consumer control group

As the CRS evaluation is based in metropolitan Adelaide areas where the initial pilot sites have been established, it was not initially considered that country regions were accessible for comparative investigation. The related reason a metropolitan Adelaide control group was not feasible was due to sufficient initial capacity at the pilot sites so that effectively all clients presenting for crisis respite support services are able to access the program. This initial available capacity is considered a temporary situation during the program development phase which prevents the identification of control cases in metropolitan areas as there are very few crisis situation presenting for referral that do not proceed to the program.

In this context, following discussion with Transfer of Care Co-ordinators and clinicians in the Emergency Triage and Liaison Service (ETLS), crisis cases presenting within the Rural & Remote Mental Health Service, commenced being confidentially identified for the control group in May 2015 and will continue until the end of the study period in October 2015. Identification details are recorded internally by SA Health and will be used for verification of the country patient data system (CCCME) ID code. At this point all identifying details will be removed and the health service data will be extracted for inpatient admissions and potentially emergency department presentations, in line with the equivalent content that will be collated for CRS program consumers.

The de-identified non-consumer control group will then be developed into the equivalent time series framework as program participants to compare service usage before and after the time of crisis assessment.

3.3.4 Cost effectiveness

The program economic component will build on the quantitative analysis by incorporating and aligning cost data for both bed based and home based sub-acute services to estimate the cost effectiveness of providing CRS and whether this is a viable service delivery model for the SA Department of Health.

The program service delivery cost basis will be derived from consumer support hours, combined with funding and cost data to the level of detail available. The resulting average cost estimates will be aligned with program utilisation patterns, in context of the timing of cost offsets including reduced hospital lengths of stay and reduced ED presentations post program. The cost offsets will also include avoided health service usage, both inpatient and ED, resulting from the responsive provision

of crisis respite support when entering the program. The CRS daily costs will also be compared where available with program cost per 'bed day equivalent' figures.

The overarching perspective is the characteristic short CRS timeframe, generally of one week, which may limit the sensitivity of service usage changes over subsequent months or quarters. The countering aspect will be to identify where possible the crisis circumstances that may have resulted in deteriorating mental health outcomes and the implications for the consumer if CRS support had not been available.

Program costs and outcomes

The initial phase will review and collate data from the CBIS and CARS systems and verify potential data linkage between these and other datasets where possible. This will establish CRS client profiles across funding, service delivery, geographic and demographic dimensions. The preliminary data will then provide the basis for average benchmark costs in context of service support hours per month as recorded in CARS to establish the cumulative program cost trajectory. The service delivery costs will then be aligned with consumer outcomes and health system service usage from CBIS in terms of the developed times series framework.

Given that clients remain in the program a relatively short period, it is not expected that the data will be able to be grouped by clusters of program support duration, although in the case that a sub group of clients do received extended support, this will be investigated. This would help identify the usage profile of program participants, and where feasible, the intensity of support, to better distinguish outcomes in comparison with 'tailored' service levels, or if relevant the composition of bed based and sub-acute services.

Cost effectiveness and model scenarios

As part of the cost effectiveness analysis, a number of scenarios will be developed to investigate potential costs and outcomes across a potentially extended timeframe, perhaps over 2 to 3 quarters post program. As the evaluation timeframe extends to the current period, developed model scenarios will help reflect possible ongoing program benefits such as reduced health service usage and relapse, as compared to any significant up front early intervention cost of the CRS intervention.

This approach will support the development of a core cost effectiveness base case, established from the before and after evaluation dataset. In this context, the cost effectiveness approach will maintain the focus on relatively short term outcomes, supported by the developed time series framework, and combine the established base case with identified program demand to develop a projected rolling program estimate based on consumer utilisation.

From the established base case, the cost effectiveness approach will also support scenarios of potential longer term benefits, say beyond 6 months to 9 months. In the

case that post program consumer outcomes are identified over longer timeframes, this will potentially contribute significantly to the profile of ongoing health service cost offsets and correspondingly to the program cost effectiveness.

3.4 Qualitative research

The qualitative research consists of individual interviews and group discussions with key stakeholders and mangers (during Phase 1, either face-to-face or over the phone) and with clients and carers in the three LHNs (face-to-face).

The range of qualitative data collected will assist in answering the evaluation questions for the different stakeholder groups and inform the different components of the evaluation (outcome, process, and cost-effectiveness).

Table 2 below shows different stakeholder groups and suggested number of interviews by location/ group.

Table 2 Qualitative sample by method and location

Stakeholder group	Consumer interviews	Carer interviews	Stakeholder focus groups and phone interviews [a]	Total
Southern Adelaide LHN	4	2	3	
Central Adelaide LHN	4	2	3	
Northern Adelaide LHN	4	2	3	
Non-geographically based (e.g. Department staff/ program Directors, other)			8	
Total	**12**	**6**	**17**	**35**

[a] CRS managers and service providers (NGO, SA mental health service); department staff and program directors.

Fieldwork will be carried out in the three LHNs locations where Crisis Respite Services are delivered.

In accordance with ethical requirements:

- Participants will be recruited at arm's length through a trusted person, for example a member of the Crisis Respite Service staff. The details will be negotiated in Stage 1.
- If initial consent is provided to the trusted person, their contact details will be passed to the researchers to arrange fieldwork and full consent.
- The rights and dignity of research participants will be respected.
- Participants will be provided with clear information about the research and will be provided with continuous opportunities to withdraw from the research.
- Participants will be reimbursed for their time should they participate.
- Interviews will be offered individually, in groups, with or without trusted support persons/ service provider staff as needed and at a location

comfortable to the participant and taking into account the safety of the researcher.
- • Researchers will follow the advice of staff to ensure no harm to research participants.

Confidentiality will be maintained and any data reported will be de-identified.

3.4.1 Consumer interviews

We propose to collect a small number of interview data from consumers who have recently left the program (if and where this is possible). In total 18 people across the three LHNs.

The interviews will focus on consumers' previous and current state of wellbeing and personal circumstances, the types of support and services they receive currently and in the past, and outcomes they may have experienced as a result of being involved with CRS.

3.4.2 Carer interviews

Carers will also be interviewed to better understand the experience of receiving Crisis Respite Services and whether families feel more supported and better connected to their local communities (in total 6 family members across the three LHNs). Family members/carers can also provide insights into outcomes consumers may have experienced as a result of receiving Crisis Respite Services.

3.4.3 Stakeholder focus groups and phone interviews

The research team, with the evaluation sub-committee and other key stakeholders, will identify Crisis Respite Service providers and departmental staff, for example, program directors, policy makers, to be consulted for this evaluation. The research team will conduct a workshop with staff to identify processes and governance arrangements that impact on the effectiveness of the initiative (its strengths and weaknesses), and how issues can be addressed for the future service improvement. For example:

- • Implementing the Crisis Respite Services initiative including the specific challenges of implementing the program, training, workforce, etc.

- • Targeting – including geographic location, client groups targeted, engagement and retention of potential clients

- • Delivering – bed based crisis respite and home based crisis respite, including inter disciplinary roles and responsibilities, coordination of work, information sharing.

- Delivering – both inter-agency and inter-sectoral services, with a particular focus on differences across pathways into (e.g. admissions) and out of (e.g. exit/transfer processes) Crises Respite Services.

- Addressing issues around reporting, governance, and resourcing.

Stakeholders will be able to participate in the evaluation through either a focus group or telephone interviews.

3.5 Analysis and triangulation of findings

The analysis will involve triangulation of data including program policy and documentation, quantitative program and administration data, and qualitative data collected. The final report will draw together the preliminary findings of the quantitative and qualitative components of the research, and any feedback received from the Crisis Respite Services Evaluation sub-committee.

The final report will be produced, along with a brief summary of findings that is written in a language suitable for wider distribution to stakeholders, such as participating consumers and providers.

4 Stakeholder engagement strategy

The successful undertaking of any evaluation depends on effective engagement and communication with relevant key stakeholders. The key stakeholders and stakeholder groups are:

- Department of Health, Mental Health Unit
- Crisis Respite Services subcommittee
- Crisis Respite Services Project Control Group
- Crisis Respite Services Partnership Committee
- Manager, Strategy and Planning of the Mental Health Strategy, Policy and Legislation branch
- Manager, Mental Health Information Management and Performance
- Staff and mangers of Crisis Respite service providers
- Mental health service providers involved with the CRS program
- People receiving support under the Crisis Respite Services
- Family and informal supporters (carers) of Crisis Respite consumers
- Other community support services (e.g. Department of Housing, employment, education providers, etc.)

The communication strategy is summarised in Table 3 below. The SPRC project manager and SA Health Crisis Respite Services Evaluation project manager will have regular meetings throughout the duration of the evaluation to ensure the evaluation is progressing in accordance with this framework and that deliverables are being met (both by SA Health in terms of the provision of data, and by SPRC in terms of feedback and reports). The project managers will identify any risks to the evaluation and escalate as necessary to the Crisis Respite Services evaluation subcommittee.

The Chief Investigator and key evaluation staff will attend up to three meetings with the Crisis Respite Services evaluation subcommittee to discuss the framework, present interim and final reports. The project team will also be available for teleconferences throughout the duration of the evaluation as necessary.

All reports will be written in clear English and provided in draft form for comment. With permission of SA Health, the evaluation plan and reports will be published on the SPRC website and elsewhere as agreed with the department. This ensures that findings are shared with stakeholders. A short summary of the research findings may be published separately and distributed to the participants of the evaluation.

Table 3 Communication strategy

Communication to	Form	Frequency
SPRC Project manager, Chief Investigator, Crisis Respite evaluation subcommittee, service providers	Regular meetings (weekly or as necessary), phone, email, presentations, written reports, and attendance of program management meetings	Start and finish of each evaluation Phase and as required
Consumers and family carers	With permission of the SA Health written summaries of evaluation findings distributed through service provider	End of evaluation, after approval
Other interested persons or organisations	With permission of SA Health, written evaluation plan and reports published on SPRC website and elsewhere as agreed with Department	After each evaluation Phase after approval

The evaluation will be conducted between March 2015 and early 2016, with reporting back to ethics and the community in March 2016 (after acceptance of the final report). The timeline for the evaluation is presented in Table 4 below. This allows maximum program data to be gathered during 2015 for analysis.

Table 4 Timeline for the evaluation

Key step (key deliverables in bold)	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec/ Jan	Feb	Mar
Ethics applications												
Evaluation plan	19/3							Rev				
Analysis of program/ administration data												
Draft findings of quantitative analysis												
Fieldwork (interviews with consumers and carers, workshops & interviews with staff)												
Draft findings of fieldwork												
Cost effectiveness analysis												
Final draft report												
Incorporate comments from governance												
Final report												
Feedback to community and ethics												

A risk and issues log is maintained over the duration of the evaluation. Appendix B outlines some of the challenges that could arise over the course of the Crisis Respite Services Evaluation, their potential consequences, likelihood, impact and mitigation strategies. These risks will be monitored and addressed during the evaluation and any new risks identified will be added to this table and managed accordingly.

5 References

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Appendix A   Evaluation framework data sources

Evaluation objectives	Evaluation questions	Data source					
		Program policy and documents	Gov data (e.g. CBIS)	Non-gov data (e.g. CARS)	Consumer interviews	Carer interviews	Stakeholder focus groups & interviews
Outcomes	**To determine the extent and impact of the Crisis Respite Services initiative/services on consumers and their informal carers, and the wider service system.**						
For consumers	Improved mental health		✓		✓	✓	✓
	Enhanced capacity to live independently		✓	✓	✓	✓	✓
	Participate in community life			✓	✓		✓
	Enhanced quality of life		✓	✓	✓		✓
	Achieved or maintained housing stability			✓	✓	✓	✓
	Reduced frequency and severity of crisis (recovery oriented – avert crisis, prevent relapse		✓	✓	✓		✓
	Increased self-efficacy to manage mental illness (e.g. use of flexible supports)		✓	✓	✓	✓	✓
For carers	Carers and informal supporters of consumers feel better supported and informed to care for their family/friend					✓	✓
For service system/ community/ consumers	Reduced reliance on acute sector and community MH specialists (e.g. number of admissions and days in hospital)		✓			✓	✓
	Reduced need for emergency services (e.g. presentations at EDs)		✓			✓	✓
For service providers	Feel supported and well equipped to meet the needs of people with severe mental-ill health	✓					✓
Process	**To determine the effectiveness of the Crisis Respite Services initiative overall: governance arrangements, service model and implementation, inter-agency partnerships, integrated care and case management, consumer journey from engagement to exit, and aspects of the service that can be improved.**						

Evaluation objectives	Evaluation questions	Program policy and documents	Gov data (e.g. CBIS)	Non-gov data (e.g. CARS)	Consumer interviews	Carer interviews	Stakeholder focus groups & interviews
	Services are tailored at a level of intensity and duration appropriate to the consumer's needs	✓		✓	✓	✓	✓
	recovery oriented services and support meeting the needs of the target group (people with serious mental illness, complex needs), in particular Indigenous and young people	✓		✓	✓	✓	✓
	Implementation is consistent (integrated care / consumer journey from engagement to exit)	✓					✓
	effective inter-agency partnership approach (gov & non-gov; local and regional etc.)	✓				✓	✓
	Program is reaching its target groups (in particular Indigenous and young people)		✓	✓	✓	✓	✓
	Program governance structures are effective	✓		✓			✓
	The program is enhancing partnerships with the community to build capacity (social recreational services, education and training, CALD and Indigenous services etc.)	✓					✓
	The program is enhancing partnerships between government and non-government community mental health services, consumers and carers				✓	✓	✓
Cost-effectiveness	**This will involve an analysis of outcome measures, activities and where data is available financial comparisons of bed equivalent costs with hospital bed days and emergency department presentations.**						
	compare Crisis Respite Services daily program cost per 'bed day equivalent' to cost of Emergency Department and hospital bed day costs		✓	✓			✓

Appendix B   Risk log

Risk #	Description of risk	Impact on project/ consequences	Likelihood	Impact	Mitigation strategies (these are employed in all projects to minimise risk)	Responsibility
1	Short timeframe for project	This cohort has serious mental illness or at risk. It is possible that insufficient CRS clients will be able to participate in interviews within the timeframe of the evaluation.	M	H	Set up the evaluation so that other evaluation activities can replace interviews with clients, eg written narrative case studies collected by workers. Manage expectations about what the project can deliver within a short timeframe. Discuss benefits and possibility of extending timeframe.	SPRC Project manager/CI
2	Managing expectations of stakeholders and Evaluation Sub-committee regarding agreed scope of the project	If this is not managed well, the project could experience scope creep and stakeholders could be unhappy with the outcomes of the evaluation	L	H	Contract needs to include detailed work plan and research scope Detailed evaluation plan to be developed in consultation with stakeholders Formal signoff of plan is needed Any changes to the scope or schedule requires a change in contract Communication plan will be developed to ensure clear communication occurs	CI/ Project manager
3	Turnover of research team	It is possible that staff could leave the organisation while the evaluation is ongoing	M	H	Good PM processes are needed to ensure that all evaluation decisions are clearly documented As part of a large research institution, we have the ability to hire experienced researchers as needed.	Project manager
4	Difficulties gaining access to administrative data	Will reduce the rigour of the evaluation and the extent to which the evaluation can answer key questions	H	M	Research team will begin communicating early with key stakeholders in order to identify how to access administrative data. Progress of the data collection will be clearly communicated to stakeholders throughout the	CI/ SA Health

Risk #	Description of risk	Impact on project/ consequences	Likelihood	Impact	Mitigation strategies (these are employed in all projects to minimise risk)	Responsibility
					project	
5	Recruitment of residents as research participants	Difficulty recruiting would threaten the quality of the research outputs	M	L	Ensure that stakeholders are aware of their responsibility to assist with recruitment Build trust and rapport with stakeholders and service providers Thoroughly inform staff on the ground about the importance of all residents to participate in interviews	Project manager/ stakeholders
6	Poor quality qualitative data	Jeopardise the qualitative findings and the extent to which they add value to the evaluation	L	M	Close supervision of research staff. CI to review the quality of the interviews and oversee the analysis process. Data collection and analysis to be standardised across the team: NVivo will be used to code transcripts, which are also double coded in the beginning of the project to ensure consistency of analysis. Internal document management systems are used to provide version control and consistency of document storage.	CI
7	Limited access to data held by other programs	Will limit the extent to which, as desired, the evaluation can compare outcomes	M	M	Negotiation on access to data held by other programs needs to be facilitated from early in the project	Stakeholders and CI
8	Research does not adhere to budget	Will put pressure on overall evaluation	L	H	Careful planning. The budget represents excellent value for money as the researchers are experts in the area and have prior knowledge of the datasets which will ensure efficiency in many project tasks. The budget is based on previous experience of similar projects, all of which have reported on time and within budget. The risk is borne by SPRC.	