



Evaluation of Outcomes for People Nominated to the Integrated Services Program (ISP)

Never Stand Still

Art & Social Sciences

Social Policy Research Centre



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SPRC
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All names of ISP clients have been changed to ensure anonymity.

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Abbreviations

ABS	Australian Bureau of Statistics
ADHC	Ageing, Disability and Home Care
AVO	Apprehended Violence Order
CJP	Community Justice Program
CLA	Community Living Award
DSW	Disability support workers
FACS	Family and Community Services
GP	general practitioner
HASI	Housing and Accommodation Support Initiative
HREC	UNSW Human Research Ethics Committee
IRG	Interagency Reference Group
ISP	Integrated Services Program (the Program)
MACNI	Multiple and Complex Needs Initiative
MHDAO	Mental Health and Drug and Alcohol Office
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
NSW	New South Wales
PWI	Personal Wellbeing Index
SPRC	Social Policy Research Centre
TAFE	Technical and Further Education institution

Executive summary

The Integrated Services Program (ISP) coordinates cross-agency support for adults who have multiple and complex support needs, often as a result of mental illness, intellectual disability or drug and alcohol use. Funded by the NSW Government, the ISP has operated in the Sydney metropolitan area since 2005. This report presents the findings of an evaluation of the ISP commissioned by the Program's lead agency, NSW Ageing, Disability and Home Care (ADHC).

The evaluation aimed to examine the longer term client outcomes achieved by the ISP and to inform policy makers about cost and operationally effective models of service provision for people with complex needs.

This evaluation showed that over time the ISP client cohort has developed to include clients with more complex needs who require longer stays, and that when they are ready to transition, adequate support is difficult to find.

The limitations of the evaluation findings are the small sample sizes and lack of systemic data available to indicate whether outcomes are sustained. A further piece of work with the Ministry of Health is underway to obtain and analyse systemic data about health service use, outcome and cost data for 101 current, former and non-ISP clients.

The evaluation found that:

- the ISP fills a gap in the NSW service system: client outcome data indicates that clients' quality of life has improved in the ISP, compared to support they received previously
- cost data gives some indication of savings to the service system achieved through ISP support
- case studies provide examples of positive client trajectories, compared with people with similarly complex needs who were not accepted into the ISP and continue to be inadequately supported
- staff and stakeholders emphasise the importance of maintaining clinical governance, staff capacity and interagency partnerships, and of building service capacity as part of the integrated model; these elements create transition pathways.

This report is structured around the ISP's logic model (Appendix A). It examines client characteristics and analyses the outcomes experienced by clients. It also discusses the processes of supporting clients, ISP governance and the Program's impact on the service system, and it analyses Program cost. Comparisons with the previous evaluation are made where possible. The final section presents conclusions and implications for the future of programs for people with complex needs.

Key findings

1. The findings establish longer term trends observed in the previous ISP evaluation (McDermott et al., 2010). Data shows that the ISP achieves a range of positive outcomes for many clients while they are in the Program.
2. The findings presented in this evaluation consistently indicate that the ISP fills a gap in the NSW service system: client outcome data shows that clients' quality of life has improved in the ISP compared to their previous support options.
3. Program costs are about \$274,000 per client per year. This covers housing, intensive accommodation support, clinical and other support as needed, and case management. Cost effectiveness could not be fully determined, as comparable costs for non-clients or former clients were not available. The previous evaluation estimated that support packages for clients post ISP were about one-third lower than during the ISP. This evaluation showed a 76 per cent reduction in costs for days spent in custody after clients entered the ISP and a further reduction after clients left the Program.
4. Case studies about former clients and non-clients indicate that clients who exit the ISP can live in the community with adequate support and considerably lower cost to the service system compared to before they entered the ISP, and compared to non-clients, who continue to cycle through hospitals, jails and community services that cannot address their complex needs.
5. Staff and stakeholders are clearly committed to the ISP. They consider the Program effective in meeting clients' complex needs, and they credit the ISP approach involving holistic, individualised, coordinated and expert support with achieving positive outcomes for many clients.
6. The main challenges for the ISP have not changed since the previous evaluation. The majority of clients need longer than the intended 18 months to be ready to leave the Program; and once clients are ready to leave, adequate support outside the ISP is difficult to find.
7. Between 2013 and 2014, delays in exiting clients have reduced the Program's capacity to accept new clients. At the time of data collection, referring agencies had become somewhat less involved in the ISP.
8. The lack of available options for transition may indicate that the service sector outside the ISP has, on the whole, insufficient experience, expertise and integration to support many people with multiple and complex needs adequately.

Implications

1. Longitudinal follow-up of clients after exiting the ISP seems essential to determine whether the Program is effective in improving clients' lives in the long term. Comparable data could be collected about non-clients (those who are referred to the Program but not accepted) to confirm which outcomes can be attributed to the ISP.
2. In the future the ISP, or any similar program, needs to monitor its governance arrangements regularly, to ensure sustained input and commitment by all agencies

involved. This includes, for ISP, revisiting the roles and activities of the interagency reference group.

3. Within the Program, staff expertise and flexibility of support need to be continually assessed, and training and support arrangements revised if necessary.
4. Regarding client outcomes, relatively small proportions of ISP clients became involved in work, education or training while in the Program. In the future, a stronger focus on supporting economic participation of clients might contribute to improved outcomes in this area.

ISP update October 2016

During the evaluation period 2011 to early 2014, the ISP was supporting several clients who required a long stay as well as people for whom services were not available in the community. New intake rounds were suspended from mid-2013 until 2015 while the ISP re-configured its support and accommodation models to achieve a more sustainable flow-through of clients.

The Family and Community Services (FACS) implementation of the *Ready Together* funding growth created new resources and system capacity for ISP clients to move on from the program to permanent support options. From 2013 to 2016, 10 clients were transitioned from the ISP, and eight new clients were accepted through a new intake round.

The ISP is also participating in the *NSW NDIS Operational Plan for the Transition to Full Implementation of the NDIS*, working with and preparing the ISP residents for a safe transition to the National Disability Insurance Scheme (NDIS).

1 Background

The Integrated Services Program (ISP) is a NSW Government initiative that coordinates cross-agency support in the Sydney metropolitan area for adults who have multiple and complex support needs, often as a result of mental illness, intellectual disability or drug and alcohol use. The ISP commenced in 2005 as a demonstration project and became a recurrently funded program in 2010 following an independent evaluation conducted by the Social Policy Research Centre (SPRC), UNSW Australia (McDermott et al., 2010). A further descriptive study was conducted in 2011, which produced a profile of people nominated to the ISP.

From September 2013 to December 2014 the SPRC conducted a follow-up evaluation commissioned by NSW Ageing, Disability and Home Care (ADHC). The evaluation plan was published in 2014 (Fisher et al., 2014). This is the final evaluation report. It provides:

- information about the Program
- a profile of current and former clients served by the ISP from September 2005
- client outcomes
- analysis of service provision and governance processes
- analysis of Program costs and outcome
- recommendations for the ISP within the changing policy context and introduction of the National Disability Insurance Scheme (NDIS).

1.1 Disability policy and service delivery context

The ISP was established for people with complex needs. The term complex needs was coined by Rankin and Regan (2004) to describe people experiencing a range of interrelated support needs that are not simple to meet. People with complex needs may have one or multiple disabilities, significant medical conditions, alcohol and/or drug issues, behaviours causing harm to themselves or others, issues relating to past trauma or neglect, insufficient family support and/or involvement in the criminal justice system. Complex needs are characterised by a compounding effect (Baldry and Dowse, 2013), where an increase in one area or need is likely to increase the influence of another area or need. This dynamic further heightens people's vulnerability. Evidence shows that people with complex needs often have unstable accommodation and a considerably higher use of health and justice services than the population average (Bruce et al., 2012; Flatau et al., 2008).

When the ISP was established in early 2005, there was increasing recognition in NSW that people with complex needs were not well supported in the existing service system, often due to insufficient service integration, resourcing or communication barriers. New service

models were developed to address complex needs directly and to build capacity within the service system. For example, the Housing and Accommodation Support Initiative (HASI) was established in 2003 to provide stable housing and accommodation support services to people with severe mental illness and insecure tenancy (NSW Department of Health, 2006).

The Community Justice Program (CJP) also supports people with complex needs, specifically people with intellectual disability, who have been in contact with the criminal justice system. Established in 2006, the CJP provides accommodation options, accommodation support and clinical services targeted to individual need (ADHC, 2010a).

In this context, the ISP was established for people who, due to the complexity of their diagnoses and behaviours, required even higher levels of expert support (McVilly, 2004, Victorian Department of Human Services, 2003).

Currently the ISP is working in an environment where Australian disability services are undergoing major change. Funding and provision of services are moving from a block-funded model to individual funding, and from service-based to person-centred planning. The Australian Government is committed to rolling out the National Disability Insurance Scheme (NDIS) by 2018 (<http://www.disabilitycareaustralia.gov.au/>). The aim of the NDIS is to give people with disability greater control over their life and the support they receive.

NSW has been among the states to spearhead the transformation of disability policy. Under the Government's *Stronger Together* strategy, significant changes and investments were made to disability services. The second phase of *Stronger Together*, now known as *Ready Together*, runs from 2011 until 2016 and focuses on service expansion and sector reforms (ADHC, 2010b).

In July 2013, NSW commenced a trial of the NDIS in the Hunter area. Outside of the trial site, ADHC is preparing the service system for the NDIS through a gradual rollout of individual funding packages and a change of service delivery models to person-centred planning. In November 2013 the NSW Government announced the transfer of all state-funded and state-provided disability services to the non-government organisation (NGO) sector as part of the rollout of the NDIS. Sector development work for people with complex support needs includes the introduction of a University Chair in Intellectual Disability and Mental Health, hosted by UNSW Australia.

1.2 Program overview

The ISP is a specialist service that coordinates a cross-agency response to adults who have been identified by NSW Government human service agencies as having complex support needs. The ISP is a time-limited service and is based in the Sydney metropolitan area.

The ISP is administered by ADHC and is integrated into ADHC's organisation regarding governance, monitoring, policy and procedures. The Mental Health and Drug and Alcohol Office (MHDAO) in the NSW Ministry of Health partners with Family and Community Services (FACS) to oversee the ISP directions, liaise regarding complex client matters and maintain an integrated approach to service delivery. FACS is the lead agency providing services.

People in the ISP are 18 years or above and have been identified as having multiple and complex interrelated needs that place them and/or others at high risk of harm. They have

had significant barriers accessing coordinated cross-agency responses, and their local support options are in most cases exhausted. Most people in the ISP have one or more overlapping support needs, including intellectual and other disabilities, brain injury, mental health and substance use issues, or personality disorder. Many people have experienced insecure housing or had contact with the justice system (as victims and/or offenders) prior to entry into the Program.

Since the start of the ISP in 2005, 177 people have been referred to the Program, 71 have been accepted, and nearly one-half of these have exited the Program. The current annual operating budget of the ISP is \$11.3 million.

Program aims

The aim of the ISP is to apply a systematic, holistic and person-centred approach to meet the person's needs using a coordinated interagency response. The overarching objective is to support people with multiple and complex support needs, improve their life outcomes, and reduce the cost of this group to the service system and the wider community.

The specific aims of the Program are to:

- develop person-centred interventions (clinical and non-clinical) and support plans that reflect the person's individual needs
- decrease the adverse impact of behaviours that put the person and other people at risk
- improve housing, health, social connections and safety for people in the Program
- improve service access, coordination and durability of engagement with services
- improve coordination and capacity of local supports (where possible)
- develop a sustainable model with the person so that they can, as much as possible, regain independence and transition to receive support in the mainstream service system.

The ISP program logic is illustrated in Appendix A.

Governance

Like other programs in NSW, such as HASI and CJP, the ISP has adopted a partnership approach to service provision. The Program is led by ADHC and situated within the Department, and it is managed in conjunction with NSW Health and Housing NSW. These three agencies are represented on the ISP's Program Management Committee.

In addition, the Departments of Corrective Services, Juvenile Justice, and Community Services; the Office of the Public Guardian in the NSW Department of Justice (OPG); NSW Police; and the Council for Intellectual Disability are represented on the Interagency Reference Group, which provides a consultative body that informs ISP activities.

ADHC, as the service provider, has the core responsibility for governance – both clinical and administrative. ISP staff includes senior clinical consultants, case managers, system support and accommodation support staff. The ISP also has on staff a consultant psychiatrist and clinical psychologist. The detailed governance structure of the ISP is illustrated in Appendix B.

Nomination process

Nominations to the ISP are invited when the Program has capacity to accept new clients. Nominations are accepted from the seven NSW Government human service agencies mentioned above. The nomination process includes a review of comprehensive information about the person's diagnoses, service history and therapy outcomes. A set of prioritisation factors are applied to the eligible nominees to support the acceptance of up to eight new clients into the Program.

To be eligible, a person must:

- be 18 years or older
- reside in the Sydney metropolitan area, and have been residing in the area for at least 12 months prior to their nomination
- show behaviour that places themselves and/or others at risk of harm as guided by the Overt Behaviour Scale
- have one or more disabilities or diagnoses
- require a high level of coordinated, multi-agency response
- live in insecure accommodation
- have significant difficulties accessing essential services (e.g. due to their behaviour)
- not present an unreasonably high risk to the safety of staff, other people or the community in the types of services provided by the ISP
- have exhausted all other options for support.

Nominations are accepted by the Program Management Committee. The ISP aims to keep nominating agencies involved while the person is in the ISP, in order to build the capacity of services to better support people with complex, interrelated support needs.

Service delivery features

The ISP is designed to provide holistic, integrated, cross-agency services to approximately 30 people with multiple and complex support needs that have not been met within the existing service system. The key service features of the ISP include:

- a holistic view of the person and their support needs
- a multidisciplinary, comprehensive assessment
- person-centred case management, planning and coordination
- assistance and access to intensive clinical and non-clinical support (including disability support and therapeutic rehabilitation)
- provision of safe and supported accommodation for people in the Program, such as 24-hour supported group homes, self-contained units with staff on site, or other community housing with drop-in support
- assistance in building the person's local support networks
- identification of sustainable, long-term service options, and systematic withdrawal and handover of support to relevant agencies.

When a person enters the ISP, the multidisciplinary support team conducts an assessment. Case plans and lifestyle plans are developed in conjunction with the person, nominating agency staff, clinical staff, the person's case manager, accommodation managers and, where appropriate, relatives and guardians. The plans identify the person's goals and what is important to them in achieving these goals. This approach aims to keep the person engaged and proactively working towards achieving goals so that they can successfully exit the Program into a longer term, community-based support model.

After the initial comprehensive assessment, the clinical staff, in consultation with the accommodation staff, develops comprehensive support plans, which are implemented by residential and clinical staff and revised as the person's needs change. A model of ISP accommodation and support services is in Appendix C.

From 2011 to 2013 ADHC led reforms to the ISP's supported accommodation stream. These reforms included the new Work Health Safety legislation, Community Living Award for Disability Support Workers, a competency accreditation scheme for disability support workers involving compulsory education and developmental planning, and the Quality Improvement Framework. As part of these reforms, new positions were added to the accommodation networks, such as coordinators and managers of accommodation, system support analysts and practice improvement coordinators.

The ISP also added positions and a governance system specific to the integrated nature of the Program. The positions included the case management roles, consultant psychiatrist and psychologist and identified therapeutic consultants for clients, in addition to the established senior clinical consultants for behaviour support. Senior managers with a clinical role and skills were also incorporated to the structure from 2011. These roles are not found within broader ADHC.

These structural changes to the clinical team increased its focus on developing models of support for clients with specific diagnoses including borderline personality disorder and acquired brain injury. ISP has also seen the introduction of an adapted systemic dialectical behavioural therapy program in partnership with the CJP, and it has implemented a capacity-building program for service providers who required assistance with an individual in the Illawarra/Shoalhaven districts. The Program currently services up to 32 clients in supported accommodation settings and provides capacity-building support for clinical and case management services for an additional eight clients.

The ISP aims to develop sustainable, long-term models of support for clients and to identify appropriate agencies to implement them. Where possible, this is with the nominating agency, but this option is not always available, particularly when no established service provider was previously involved, the nominating agency is not appropriate to provide ongoing support (e.g. a criminal justice agency), or if a client is outside the geographical boundary of the original service provider.

Originally the ISP was designed to provide time-limited, intensive support for up to 18 months. However, people referred to the ISP remain in the Program for as long as they need to. In some cases they cannot leave the Program because of guardianship orders (McDermott et al., 2010), shortage of accommodation placements or because a suitable model for them has not yet been found.

2 Methodology

This evaluation provides an extension of the previous evaluation of the ISP (McDermott et al., 2010), which assessed initial outcomes of the ISP and found generally positive results. The current evaluation aimed to examine longer term client outcomes achieved by the ISP and to compare these outcomes to people with complex needs who were eligible for the ISP but did not enter the Program. Ethics approval for the evaluation was granted by the UNSW Human Research Ethics Committee. More detail about the methodology can be found in Fisher et al. (2014).

2.1 Evaluation aim and approach

This evaluation aimed to assess:

- the outcomes of ISP for three groups of clients:
 - current clients (people using ISP services during the evaluation)
 - former clients (people who used ISP services in the past)
 - non-clients (people referred to the ISP who were not accepted into the Program)
- the effectiveness of processes for supporting clients
- the efficacy of ISP governance arrangements in steering the Program and informing system change
- ISP costs compared to avoided costs to the service system if ISP did not exist.

The purpose was to examine the longer term client outcomes achieved by the ISP and to inform policy makers about cost and operationally effective models of service provision for people with complex needs.

The evaluation used a mixed-methods approach involving the collection and analysis of both quantitative and qualitative data, specifically:

- demographic and program data
- incident reports
- financial data about service provision
- secondary data (administrative data from external agencies)
- case studies of ISP clients and non-clients
- interviews with clients about their personal wellbeing outcomes
- focus groups and interviews with ISP staff and other stakeholders.

The focus groups and interviews with ISP staff and other stakeholders were conducted

by the SPRC. All other data was collected by ISP and other agency staff, using templates developed by the SPRC. Data templates and questions for interviews and focus groups are in Appendix D. Data templates for current and former clients were the same as in the 2010 evaluation, thus providing some comparative and follow-up data. The types of data and their use in the evaluation are described below.

2.2 Sample and data sources

The study sample included all current and former ISP clients (29 in each group, a total of 58 at 31 March 2014) and a similar number of non-ISP clients (43) (Table 2.1). The non-clients were people nominated to the ISP but not accepted into the Program (they might have different characteristics to the ISP client group not recorded in the dataset that might relate to why they were not accepted). These sample sizes were sufficient for outcome analysis and comparison between groups.

Table 2.1 is a summary of data sources by client group. It excludes the focus groups and interviews with ISP staff and other stakeholders, as these were not client-specific. All data sources listed in the table were available for the current clients and all except the interviews, for the former clients. For the non-clients, the evaluation had only demographic data and case studies.

Table 2.1 Evaluation data sources for current clients, former clients and non-clients

Data sources	Current clients (n=29)	Former clients (n=29)	Non-clients (n=43)
Demographic data	✓ ¹	✓	✓
Program data	✓	✓	
Incident reports	✓	✓	
Financial data	✓	✓	
Secondary data	✓	✓	
Case studies	✓	✓	✓
Client interviews	✓		

Notes: ¹ ✓ indicates that the data source was available for the client group
 Total former client records=40. Eight were excluded: 2 died before entering ISP; 2 did not enter the program; 4 clients had insufficient data. Data collation for 3 clients was not attempted due to time constraints in ISP.
 Data was collected through reviewing case notes, monthly reports, professional reports, incidents and behaviour plans. Data was not complete.

2.3 Types of data

Demographic data included client age, gender and cultural background. This was used for establishing a demographic profile of the three client groups and for comparing their characteristics.

Program data consisted of:

- client mental health and disability diagnoses on entering the ISP

- duration in the Program
- use of health and criminal justice services
- independent living skills, social connections and economic participation
- self-reported personal wellbeing and health
- a case summary for current clients (progress, setbacks, goals achieved in 2013).

This data enabled further comparison between current and former clients regarding their diagnoses and their duration in the ISP, and it provided quantitative and qualitative information about client outcomes while in the Program. The data collection template is in Appendix D.

Service use and outcome data for current clients covers the evaluation period January to September 2013. For former clients, data was collated from case files for the time while clients were in the ISP. Much of this case file data was not available electronically, so to make collation manageable for ISP staff, data was collated for selected time periods. This decision followed an assessment of former client records by ISP staff, which determined that clients generally followed a relatively stable pattern of service use and outcomes from quarter to quarter (80 per cent of clients reviewed, or 20 out of 25). Therefore, the approach was to collate quarterly blocks (three months) of program data as follows:

- the first three months from admission into the ISP
- three months annually from the entry anniversary
- the last three months before leaving the ISP.

As former client program data was collated in quarterly blocks per year, they were separately reviewed as a longitudinal sample. This data was not a formal time series, as the number of clients in the ISP decreases for longer timeframes, and correspondingly the sample size reduces with the higher number of quarters. For this reason the figures are not statistically significant, but they are reported as indications of client trajectories and outcomes.

Unlike in the previous evaluation, data about post-ISP accommodation of former clients was not available due to different service agreements with the accommodation providers and different client consent processes.

Incident reports recorded risky or damaging events that the current and former clients were involved in during their time in the ISP. The incident reports included date, incident type and severity of incident according to a four-point scale used by ISP staff. Incidents ranged from those with a minor impact (e.g. harassment, unauthorised absence or minor physical damage), to those with a serious impact (e.g. significant injury, serious assault or uncontrolled fire).

Number and severity of incidents were used as outcome measures in the evaluation.

Financial data consisted of Program cost data in client level blocks, typically average cost per client in each location. The cost of days in custody were calculated from the days in custody figures for before, during and post program. The average cost in custody per

day was used from the Productivity Commission Report on Government Services¹. All cost figures are presented in 2013–14 Australian dollars, indexed for prior year source figures. Health cost data is defined to be consistent with CheReL² specifications.

Secondary data was administrative data from external agencies about current and former ISP clients. The main source of secondary data for this evaluation was Corrective Services NSW, which provided ADHC with the number of days in custody for both current and former ISP clients for 12 months prior to entering the ISP and while in the Program. For former clients, days in custody were also provided for 12 months post ISP.

The custody days prior and post ISP were an annual total for each client. The custody days during the ISP were provided as a total for each client. Since clients were in the Program for various durations, the total number was annualised to enable comparison between clients.

Days in custody was used as an outcome measure for current and former clients while in the ISP. This was the only quantitative measure of outcomes post ISP available for this evaluation.

Case studies of ISP clients was the main qualitative data source for the evaluation. ISP staff collected 13 case studies: four each about current clients and those ready for transition, and five about former clients (Table 2.2). The Office of the Public Guardian collected four case studies about people who were referred to the ISP by the OPG but not accepted into the Program, and one case study about a former ISP client.

Table 2.2 Number of case studies per client group

Client group	Case studies (n)
Current clients	4
Current clients ready for transition	4
Former clients	6
Non-clients	4
Total	18

The case studies are narratives that describe the person's family background, any diagnoses, and their service use, experiences and support they received in key life areas, such as health and housing, before and after referral to the ISP. For both the clients who were accepted into the Program and those who were not, the case studies describe how the person's experiences and outcomes changed over time. The case studies about non-clients include suggestions from ISP staff about how the Program would have addressed the clients' needs.

The case studies were selected by ISP staff to illustrate significant change over time in client experience, and to include diversity in demographics, reasons for referral and support used. They are not a representative sample. The case studies are in Appendix E.

The **client interviews** focused on subjective personal wellbeing outcomes. The program

1 www.pc.gov.au/___data/assets/pdf_file/0015/132324/rogs-2014-volume-c-8.pdf: Table 8A.7.

2 Centre for Health Record Linkage

data template included the quantitative Personal Wellbeing Index (PWI) (Cummins, 2005), a widely-used, validated survey instrument that was also applied in the previous ISP evaluation. Client participation was voluntary, and of the 29 current clients in the evaluation, eight chose to complete the PWI.

As this sample was too small for meaningful statistical analysis, or to draw conclusions about the larger group of current clients, ISP staff devised a qualitative client questionnaire covering the PWI life outcome areas in a conversational style (Appendix D). Staff presented this questionnaire to the clients, and if a client consented to take part, they completed it in the way they preferred. Often this was as part of a longer conversation with the staff member, sometimes by themselves. This method of data collection proved successful, presumably because it built on a trusted relationship between staff member and client, and because clients appeared to prefer talking about their experiences rather than ticking numbered scales. The questionnaire was completed by 21 current clients (including seven of the eight clients who completed the survey).

Focus groups and interviews with ISP staff and other stakeholders covered the participants' views about ISP governance arrangements, operation and management of the support provided to clients, client outcomes and the future of the ISP (Appendix D). In total, 22 staff members and stakeholders participated. Recruitment was through invitation from ISP management.

The SPRC conducted two focus groups: one with 11 ISP staff who covered different roles in the Program including Practice Support Coordinator, Case Manager and Group Home Leader; the other with five participants from the ISP Interagency Reference Group. To obtain further stakeholder input into the evaluation, four telephone interviews were conducted: one with two ADHC ISP managers and three with individual Interagency Reference Group members who were unable to attend the focus group.

2.4 Limitations

Outcome data for the three groups of clients was limited. As detailed in the evaluation plan (Fisher et al., 2014), the research intended to use a range of secondary data from external agencies about current, former and non-clients. The aim was to assess and compare longer term outcomes of the three groups in various life areas, including health, housing, service use, living independently, and social and community participation.

Within the timeframe of this evaluation, ADHC could not obtain comprehensive secondary outcome data. At the time of writing this report, ADHC was progressing an application to NSW Health for health service use, outcome and cost data for current, former and non-ISP clients. For the ISP clients, this would include data prior to entering the Program, during Program participation, and post Program for former clients. The SPRC assisted with developing data specifications. When this data is available, it can be used to track longer term health outcomes for the three client groups, including hospital, emergency department and mental health service use, and the costs of these services.

For this evaluation, the only outcome data available for non-clients were four case studies. Similarly, outcome data for former clients after exiting the ISP was sparse, comprising the number of days in custody for 12 months post ISP and six case studies. The case studies

were used to illustrate client profile, outcomes, and process and service system issues, but quantitative outcome comparison between the three groups was limited.

Qualitative data directly from clients was limited to interviews with current clients about their wellbeing, and some client testimonials that were included in the case studies. This qualitative data was collected by ISP staff rather than external researchers due to evaluation budget constraints, and because staff could build on trusted relationships with their clients.

2.5 Report structure

This report is structured around the ISP's logic model (Appendix A). It examines client characteristics and analyses the outcomes experienced by clients. It also discusses the processes of supporting clients, ISP governance and the Program's impact on the service system, and it analyses Program cost. Comparisons with the 2010 evaluation are made where possible. The final section presents conclusions and implications for the future of programs for people with complex needs.

3 Client profile

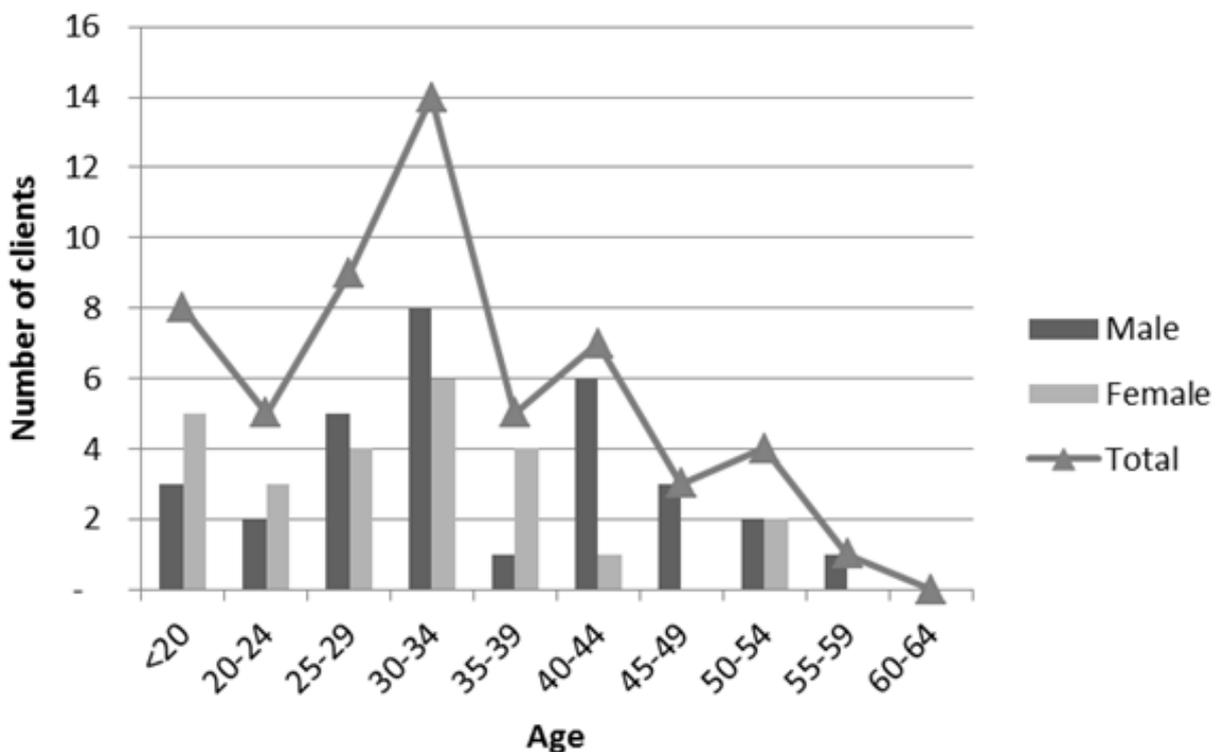
Profile data included demographics, health characteristics on entry to the ISP, and length of time clients were in the Program.

3.1 Demographic profile

Among the 58 ISP clients in the evaluation (29 current, 29 former clients), demographic details were available for 56 clients. Men were slightly over-represented (31 men – 55 per cent; 25 women – 45 per cent; Figure 3.1). These proportions were the same as in the previous evaluation. Among the former ISP clients there were more women than men (15 compared to 12, or 56 per cent), indicating that women were more likely to exit the Program than men.

The youngest client in the ISP was aged 19 years, the oldest was 63. The average age of clients overall was 35 years. This ISP orientation towards younger people may help to change lifetime pathways. Men were on average slightly older than women, at 37 versus 31 years (Figure 3.1). The largest group of clients was 30–34 years old.

Figure 3.1 Age distribution of ISP clients by gender



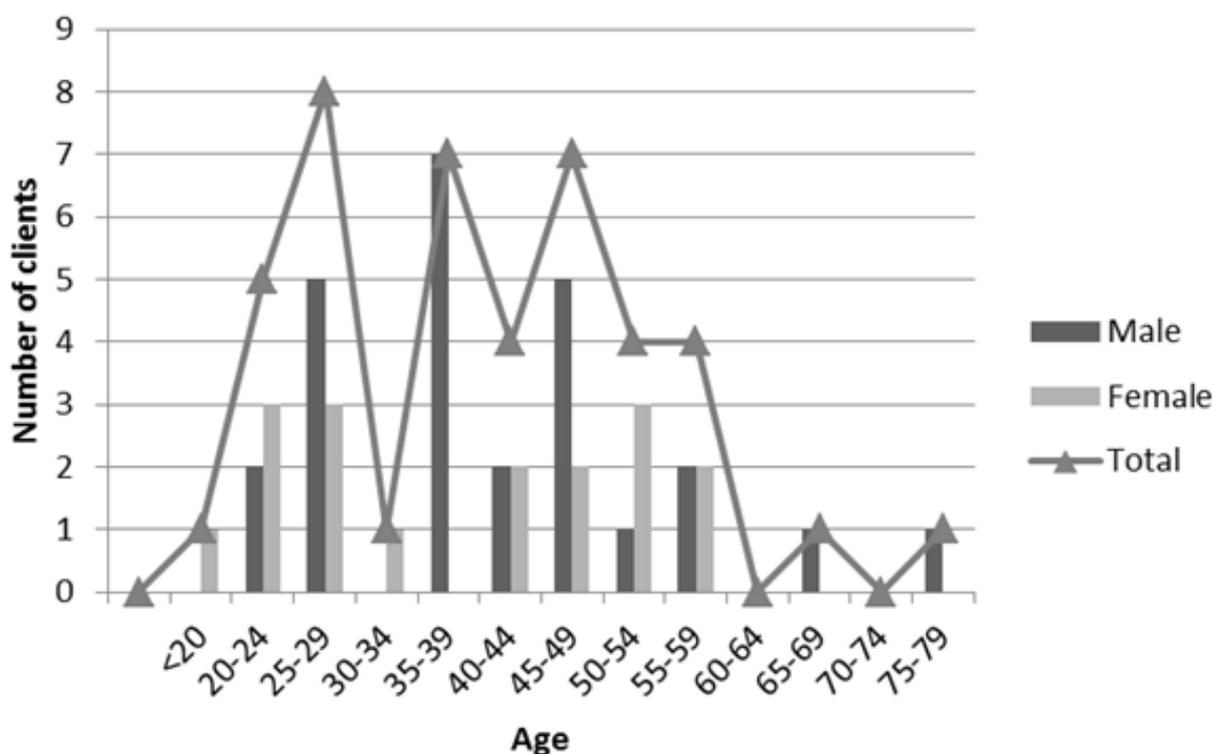
Source: ISP client program data (n=56, missing=2)

Notes: Includes current and former ISP clients. Client age is presented as age on entry to the Program. One client identified as female, age not available.

Similar to the 2010 evaluation, a large majority of clients were single and had never been married (45 clients or 82 per cent, compared to 95 per cent in 2010). A further eight clients (15 per cent) were separated or divorced, and two clients (4 per cent) were married or in a de facto relationship.

The sample of non-ISP clients included a slightly larger proportion of men than the ISP clients, 62 per cent (n=26), and 38 per cent women (n=16, Figure 3.2). The age distribution was older than the ISP clients.

Figure 3.2 Age distribution of non-ISP clients by gender



Source: ISP nomination data (n=43)

As Table 3.1 shows, Indigenous people comprised 9 per cent of clients and 12 per cent of non-clients, while 33 and 16 per cent respectively were from a culturally and linguistically diverse background. Compared with the NSW population, Indigenous Australians were over-represented among both ISP clients and non-clients (ABS, 2013b), and people from a culturally and linguistically diverse background were over-represented among ISP clients and under-represented among non-clients (<http://www.mhcs.health.nsw.gov.au/services/cald-community>).

Table 3.1 Cultural background of ISP clients and comparative populations

Cultural background	ISP clients		Non-ISP clients		NSW population	Australians with a mental health condition ¹
	N	%	N	%	%	%
Indigenous	5	9	5	12	2.9	-
Culturally and linguistically diverse	19	33	7	16	27.5*	9.8*
Other	33	58	31	72	-	-
Total	57	100	43	100	-	-

Source: ISP client program data (n=57; missing=1); ISP nomination data

Notes: ¹ ABS 2012

* Language other than English

The sample sizes are insufficient to make statistically significant comparisons, but the figures show that ISP clients are culturally diverse. The case studies (Appendix E) illustrate how ISP considers clients' diverse cultural backgrounds and supports them, for example:

Lilly (45) is a refugee who did not speak English initially. ISP provided support by workers who spoke her native language.

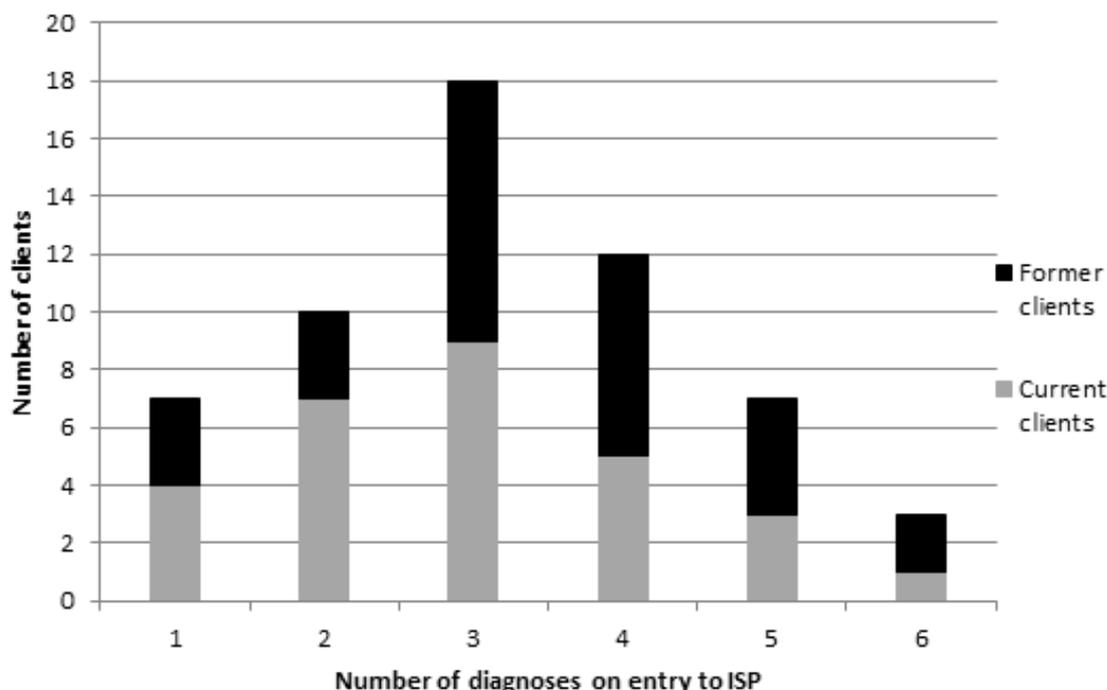
Petra (40) is Aboriginal. ISP supported her to establish contact with her culture through vocational experience at a local radio station.

3.2 Complex needs

ISP is a program for people with complex needs, who may have multiple diagnoses including mental illness, physical or intellectual disability, alcohol and drug issues or acquired brain injury. This section reports on the clients' diagnoses and core-activity restrictions when entering the ISP.

A large majority of clients (88 per cent) had multiple diagnoses, ranging from two to six with a median of three (Figure 3.3). The similar proportions across former and current clients indicate that the mix and number of diagnoses were a consistent, ongoing characteristic of ISP clients.

Figure 3.3 Number of diagnoses on entry to the ISP



Source: ISP client program data (n=58)

The case studies (Appendix E) illustrate the type of complex needs that people experience. Most clients live with several simultaneous serious diagnoses, and therefore they need the coordinated support and the highly experienced specialists that the ISP provides. For example:

Claire has mild intellectual disability, severe borderline and anti-social personality disorder, experiences psychotic hallucinations, and she has a history of poly-substance abuse including alcohol, cannabis and amphetamines.

John has mild intellectual disability, psychosis, borderline personality disorder with dependent personality traits, schizophrenia and complex post-traumatic stress syndrome. He uses drugs including methamphetamine, LSD and marijuana.

Julia has a brain lesion, schizoaffective disorder and a personality disorder, and she uses various drugs (amphetamines, cocaine, marijuana, heroin, methadone and benzodiazepines).

Consistent with the 2010 ISP evaluation, the most common diagnosis was mental illness: 90 per cent of current (n=26) and 89 per cent of former clients (n=25) had at least one mental illness as a primary or secondary diagnosis (Table 3.2). Primary diagnosis refers to the condition which causes most distress and difficulty for the person. Approximately one-half of clients had an intellectual disability and/or alcohol and drug disorder. Acquired brain injury and physical disabilities were identified for one-quarter to one-third of clients.

Table 3.2 Diagnoses of ISP clients

Diagnoses	Current clients		Former clients		Total clients	
	(n=29)	% ^b	(n=28)	% ^b	(n=57)	% ^b
Mental illness ^a	26	90	25	89	51	89
- Primary diagnosis	25	86	24	86	49	86
- Secondary diagnosis	12	41	15	54	27	47
Intellectual disability	14	48	17	61	31	54
Alcohol and drug disorder	15	52	15	54	30	53
Physical disability	8	28	10	36	18	32
Acquired brain injury	7	24	7	25	14	25
Other ^c	5	17	8	29	13	23

Source: ISP client program data (n=58)

Notes: a) Total clients diagnosed with a primary or secondary mental health diagnosis

b) Total percentages greater than 100 due to clients presenting with multiple diagnoses

c) 'Other' diagnoses include: attention deficit and hyperactivity disorder, post-traumatic stress disorder (PTSD), obsessive compulsive disorder, thought disorder, attachment disorder, reactive attachment disorder, factitious disorder, persecutory delusional disorder

Most ISP clients had at least one mental illness and/or alcohol and drug disorder, and ISP client assessments often link these diagnoses back to childhood abuse and trauma. Exploring clients' family histories and possible trauma is an important element in the ISP approach, as it allows support to be tailored to individual client need. Examples are described in the case studies (Appendix E):

Rick was neglected and abandoned and made a ward of the state at 13 weeks. At 14 months old Rick was adopted. As a child, he showed behaviours that put himself and others at risk, including uncontrollable outbursts of anger. His adoptive family asked Rick to leave when he was 13 years old. For the next two years Rick attended a special boarding school, from where he was expelled at the end of Year 8 due to his behaviour. From that time Rick received little support from services and had unstable accommodation.

Petra lived in numerous foster homes from age two and experienced physical and sexual abuse.

Gina's father verbally and physically abused her mother. Gina experienced domestic violence in her own relationship.

Among the primary mental illness diagnoses, schizophrenia and personality disorders were predominant, with 36 and 19 per cent of all clients respectively (Table 3.3). This was similar to the 2010 ISP evaluation. Current ISP clients had a particularly high proportion of schizophrenia diagnoses (45 per cent), possibly reflecting the barriers to exiting the Program for clients with schizophrenia. The other primary diagnoses were recorded for relatively small proportions of the clients (7 per cent or lower).

Table 3.3 Mental illness primary diagnoses of ISP clients

Primary diagnosis	Current clients		Former clients		Total clients	
	N	%	N	%	N	%
Schizophrenia	13	45	8	28	21	36
Personality disorder	4	14	7	24	11	19
Psychotic disorder	2	7	2	7	4	7
Schizo affective disorder	2	7	2	7	4	7
Other	0	0	4	14	4	7
Asperger's syndrome	2	7	0	0	2	3
Anxiety	1	3	1	3	2	3
Mood disorder	1	3	0	0	1	2
<i>No primary mental health diagnosis</i>	4	14	5	17	9	16
Total clients	29	100	29	100	58	100

Source: ISP client program data (n=58)

In addition to primary mental illness diagnoses, almost one-half of all clients (47 per cent, Table 3.4 below) had a secondary mental illness diagnosis. Among the secondary diagnoses, personality disorder was significant, with 31 per cent of current, 10 per cent of former and 21 per cent of all clients. Each other secondary diagnosis was at or below five per cent. This mirrored the 2010 evaluation data.

Table 3.4 Mental illness secondary diagnoses of ISP clients

Secondary diagnosis	Current clients		Former clients		Total clients	
	N	%	N	%	N	%
Personality disorder	9	31	3	10	12	21
Anxiety	2	7	1	3	3	5
Bipolar disorder			2	7	2	3
Other	1 ^a	3	9 ^b	31	10	17
<i>No secondary mental health diagnosis</i>	17	59	14	48	31	53
Total clients^c	29	100	29	100	58	100

Source: ISP client program data (n=58)

Notes: a) Post-traumatic brain damage

b) One client each with: schizophrenia, schizo-affective disorder, depression, psychotic disorder, thought disorder, attachment disorder, reactive attachment disorder, factitious disorder, persecutory delusional disorder

c) Percentages may not add up to 100 due to rounding errors

On entry to the Program, ISP staff also recorded the level of core-activity restriction resulting from the clients' diagnoses. In line with the 2010 evaluation, this was done using the ABS categories identifying four levels of core-activity restriction based on the extent to which someone needs help, has difficulty undertaking, or uses aids or equipment to perform core activities including communication, mobility and self-care tasks (ABS, 2003). The four levels

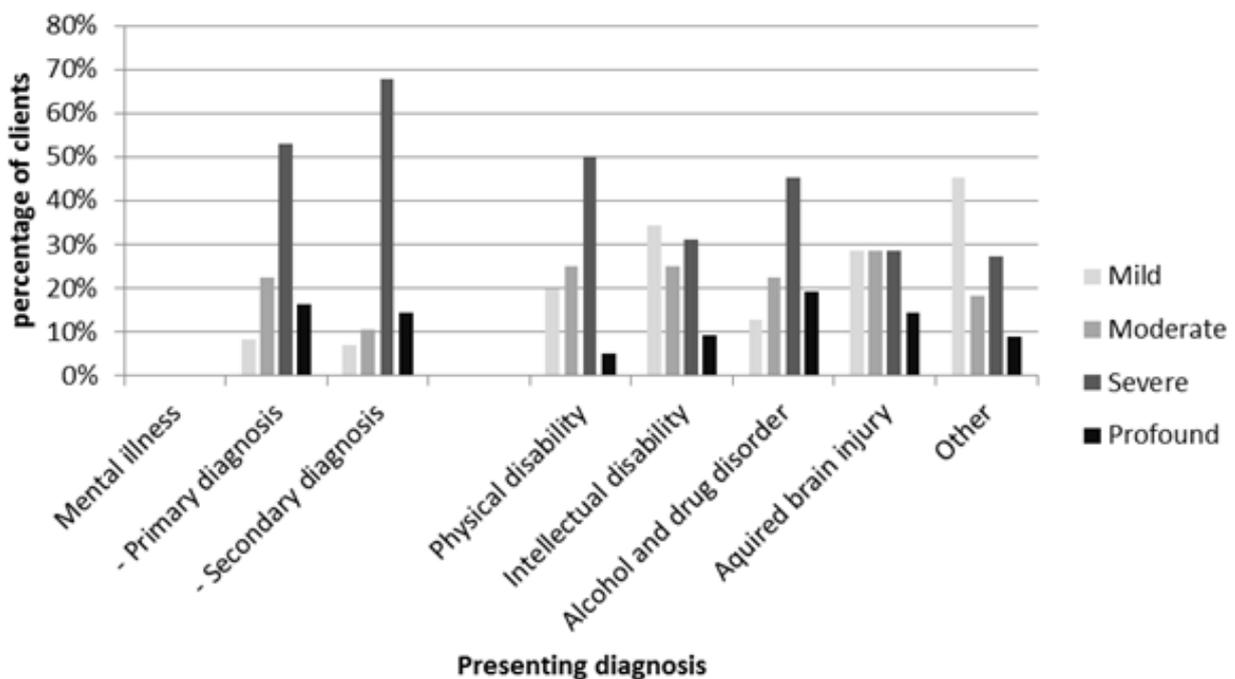
are defined as:

- Profound: where the person is unable to do, or always needs help with, a core-activity task
- Severe: where the person sometimes needs help with a core-activity task and has difficulty understanding or being understood by family or friends
- Moderate: where the person needs no help but has difficulty with a core-activity task
- Mild: where the person needs no help and has no difficulty with any of the core-activity tasks, but has minimal restriction(s) and may use aids and equipment or require other support.

Figure 3.4 and Table 3.5 show that a high proportion of clients experienced severe or profound levels of restriction on entry to the ISP. The greatest core-activity restrictions were experienced by clients who had mental illness, physical disability and alcohol and drug disorders, while a majority of clients with intellectual disability, acquired brain injury and other diagnoses had mild or moderate levels of restriction. This is reflected in the weighted averages, which are similar to the figures in the 2010 evaluation.

Since most people had multiple diagnoses on entering the ISP, the combined restrictions that clients experienced in daily life were more extensive than the figures suggest.

Figure 3.4 Core-activity restrictions by diagnosis for ISP clients, per cent



Source: ISP client program data (n=58)

Note: Bars denote per cent of clients per diagnosis

Table 3.5 Core-activity restrictions by diagnosis for ISP clients, n=58

Diagnosis	Total clients (n=58)	Mild	Moderate	Severe	Profound	Weighted average ^b	Weighted average ^b 2010 evaluation
Mental illness ^a	51						2.8
- Primary diagnosis	49	4	11	26	8	2.8	
- Secondary diagnosis	27	2	3	19	4	2.9	
Physical disability	18	4	5	10	1	2.4	2.1
Intellectual disability	31	11	8	10	3	2.2	2.2
Alcohol and drug disorder	30	4	7	14	6	2.7	2.7
Acquired brain injury	14	4	4	4	2	2.3	2.7
Other ^c	13	5	2	3	1	2.0	2.4

Source: ISP client program data (n=58); McDermott et al., 2010

Notes: a) Total clients diagnosed with a primary or secondary mental illness

b) Weighted average is the average degree of restriction, with the following weighting applied: Mild=1, Moderate=2, Severe=3, Profound=4.

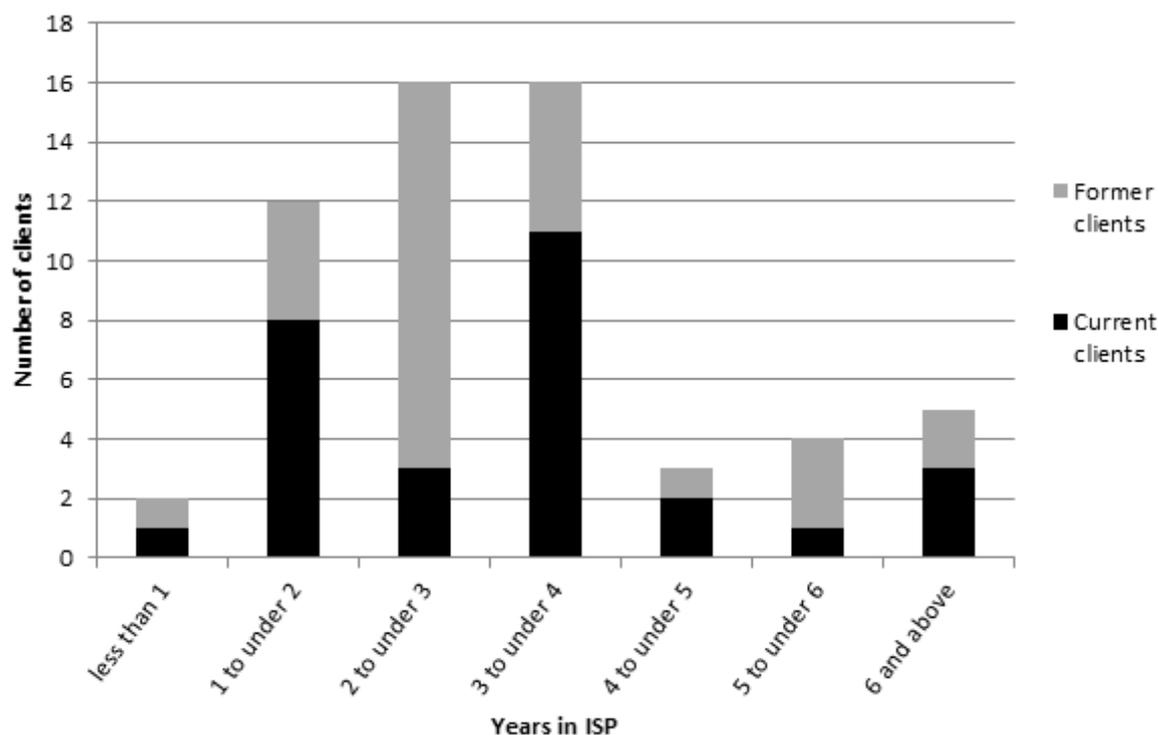
c) 'Other' diagnoses include: attention deficit and hyperactivity disorder, post-traumatic stress disorder (PTSD), obsessive compulsive disorder, thought disorder, attachment disorder, reactive attachment disorder, factitious disorder, persecutory delusional disorder

3.3 Length of time in the ISP

As described in the introduction, the ISP was established in 2005 as a time-limited program intended to support clients for up to 18 months. In practice, many clients remained in the Program for longer periods. At the time of the 2010 evaluation, current clients had been in the ISP for an average of 21 months and former clients, for 25 months.

At the current evaluation point at 31 March 2014, both current and former clients had been in the ISP for a similar average length of time of just over three years: current clients 37.7 months, former clients 36.1 months. As Figure 3.5 shows, a large majority of clients had been in the Program for between one and four years. There were 12 longer term clients (20 per cent), who had been in the ISP for more than four years, and five of those had remained for six years or more. This reflects the longer time required to address some clients' multiple and complex needs, and limited options for client transition to alternative support, even when their support needs have become stable.

Figure 3.5 Client length of time in the ISP



Source: ISP client program data (n=58)

The case studies illustrate why some clients remain in the ISP well beyond the intended program timeframe. For example:

Julia (31) has been in the ISP since 2007. By 2014, ISP has not been able to identify appropriate support outside the Program. Julia is not eligible for direct services provided by ADHC, and Community Mental Health have deemed that mental health services may not be appropriate because her challenges primarily result from brain injury and personality disorder.

Claire (45) has been in the ISP since 2006. Her conditions have improved through long-term, intensive support, and she is now ready to leave. The ISP has identified a service provider and is negotiating appropriate services for Claire.

Scott (35) entered the ISP in 2006, where he was supported successfully to manage his high-risk behaviours. He moved through three accommodation settings while in ISP, preparing him for transition back into the community. As no suitable places outside the ISP were found in the region, Scott exceeded the planned period in the ISP by four years. He exited the ISP in 2012.

At 31 March 2014, 12 of the current clients (41 per cent) were considered ready for transition.

3.4 Summary of client profile

- Among the 29 current clients and 29 former clients in the evaluation, men were slightly over-represented (55 per cent of all clients).
- The average age of clients was 35 years, and 82 per cent were single.
- Compared with the NSW population, Indigenous Australians and people from a culturally and linguistically diverse background were over-represented among ISP clients.
- On entering the ISP, 88 per cent of clients had multiple diagnoses. Clients had up to six diagnoses, with an overall median of three, indicating the complexity of support needs.
- About 90 per cent of ISP clients had at least one mental illness, and about 50 per cent had an intellectual disability and/or alcohol and drug disorder. Acquired brain injury and physical disabilities were identified for one-quarter to one-third of clients. Clients had mild to profound core-activity restrictions corresponding to their diagnoses.
- Diagnoses often stemmed from childhood abuse and trauma. Exploring clients' family histories is part of the ISP assessment process so that support can be better tailored to individual client need.
- Although the ISP was established as a time-limited program intended to support clients for up to 18 months, clients stayed in the ISP for about three years on average. This reflects the longer time required to address some clients' multiple and complex needs, and limited options for client transition to alternative support, even when their support needs have become stable.
- The ISP client profile was largely consistent with the previous evaluation.

4 Client outcomes

This section reports on outcomes experienced by ISP clients. Quantitative client outcome data available for this evaluation was: incident reports, client use of health and criminal justice services, and information about community living and participation, personal wellbeing and self-assessed health. This data was available for current and former clients while in the Program, giving an indication of change in client experiences during the time they participated in the ISP.

The only quantitative outcome data available for former clients after their exit from the ISP were days in custody. No quantitative outcome data was available for non-clients.

The case studies provided qualitative outcome data about current, former and non-clients. In addition, qualitative client interviews about personal wellbeing were available for the majority of current clients. The qualitative data is illustrative rather than representative and is included throughout this section to show how the ISP effected change and what this change meant for clients.

Comparison with client outcome data in the 2010 evaluation is made where comparable data was available.

4.1 Incident reports

Due to their complex needs, ISP clients may act in a way that can cause risk or harm to themselves or others. The support provided in the Program aims to reduce such events. To determine the impact of ISP support on client behaviours and harmful events, the evaluation analysed incident report data. This data source replaced the analysis of so-called 'challenging behaviours' in the 2010 evaluation. At the time of the previous evaluation, ISP used the term 'challenging behaviour' to refer to a range of behaviours that placed the person and/or others at significant risk of harm and precluded the person from accessing the service system (Martin and Associates P/L, 2001). The term is no longer used within ISP service provision because it ignores the social and environmental factors that may contribute to the behaviour, such as mental illness, childhood trauma, and social, criminal, and substance-abuse problems (Mansell, 2007).

The previous evaluation used the Overt Behaviour Scale (Kelly et al., 2006) to measure changes in clients' 'challenging behaviours' over time. The evaluation had behaviour data available for most clients at three points – Program entry, 2008 and 2009. Findings were mixed: the levels and severity of challenging behaviours decreased between Program entry and 2008 but increased again between 2008 and 2009. However, the frequency and impact of some behaviours decreased significantly over the course of the evaluation.

For the current evaluation, incident report data was assessed to determine the frequency, severity and trend of reported client incidents. The data was primarily available through

ADHC's Client Information System (CIS) and was supplemented from case files where necessary. In total, there were 4,380 records covering 58 current and former clients for the duration of their time in the Program.

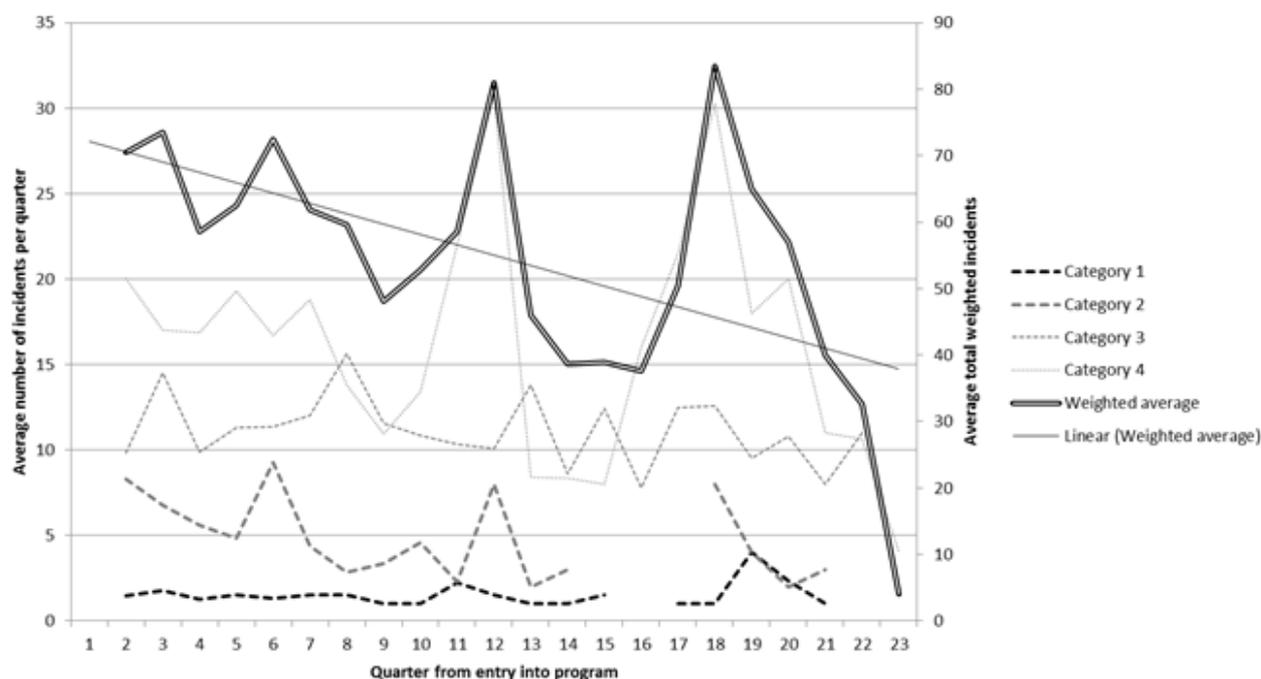
ADHC assigned each individual incident to a scale of severity, ranging from:

- Category 1: Incidents with a serious impact (e.g. sexual assault, child abuse, property destruction)
- Category 2: Incidents with a less serious impact (e.g. sexual harassment, major property damage)
- Category 3: Incidents with a moderate impact (e.g. verbal abuse, minor injury, risk of fire)
- Category 4: Incidents with a minor impact (e.g. intimidation, unauthorised absence).

To observe incident trends over time, the records were grouped by quarter for each person, starting from Program entry. Figure 4.1 shows the average quarterly number of incidents per client in each category by clients' length of time in the ISP – in other words, the average number of incidents for all clients in their first, second, third, fourth (and so on) quarter since entering the ISP. Average numbers of incidents are shown on the left-hand vertical axis. Since client numbers declined significantly after more than four years, or 16 quarters, in the Program (Figure 3.5 above), the data for quarters 17 and above was based on a relatively small sample and should be viewed with caution.

Figure 4.1 indicates significant variation in incident numbers across time, reflecting the complex needs of clients and the often changing nature of mental illness. Overall, higher-impact incidents were less frequent than those with a moderate or minor impact. There was a slight decline in the overall number of incidents over time. The two prominent spikes in the incident scores resulted from a small number of clients experiencing a relatively high number of minor impact (Category 4) events. The more severe categories 1, 2 and 3 were either relatively stable or declined with increasing time clients spent in the Program.

Figure 4.1 Incident reports over time



Source: Client Information System (CIS) (n=58)

Notes: Incident report figures include all records grouped by quarter of each client's time in the ISP.

The data for former clients is based on collation of one quarter per year.

Incidents are assigned categories that decrease in severity from 1 to 4.

Gaps in category 3 and 4 incidents indicate no incidents reported in a particular quarter.

Weighting: most serious impact category 1 multiplied by 4, less serious category 2 multiplied by 3, moderate category 3 multiplied by 2, and minor category 1 incidents remain unweighted. Large spikes occurred when a few clients experienced a high number of minor-severity incidents.

To examine the trend of incident severity, incidents were weighted to reflect increasing severity across categories. For the weighted analysis, most serious impact Category 1 incidents were multiplied by 4, less serious Category 2 multiplied by 3, moderate Category 3 multiplied by 2, and minor Category 1 incidents remained unweighted. Weighted incident averages (right-hand vertical axis) show a decline over time. This trend would be more obvious if the two spikes, which were generated by a few clients experiencing a high number of minor-severity incidents, were excluded. Given the complex needs of ISP clients, it may be unrealistic to expect a continuous reduction of incident frequency and severity across clients. Therefore, an overall downward trend can be seen as a positive outcome.

The findings mirror the 2010 evaluation, which observed that the frequency and impact of some behaviours decreased significantly over time. The current findings also establish a longer term trend of decreased incident numbers and severity while clients were in the ISP. Data was not available to examine whether this trend continued after clients left the ISP.

The case studies (Appendix E) illustrate how ISP support led to fewer incidents over time for many clients, while other clients' needs remained highly complex or fluctuated. For example:

Graham's aggression and leaving the accommodation reduced significantly over time. He has transitioned into accommodation with fewer restrictions.

Philip has ceased all substance abuse since joining the ISP, is maintaining his own Department of Housing accommodation and has not been charged for any offence

since entering the ISP.

Julia's progress in ISP has recently deteriorated due to suspected organic reasons. ISP is working with NSW Health to identify the cause of deterioration and appropriate treatment or response. Meanwhile Julia is receiving a higher level of support.

4.2 Use of health services

Given the multiple diagnoses of ISP clients, coupled with other support needs, clients were typically frequent users of hospitals, emergency services and psychiatric units before entering the ISP, as detailed in the previous evaluation. Using NSW Health data, the 2010 evaluation showed that use of these health services, and therefore costs to the system, declined significantly while clients were in the ISP.

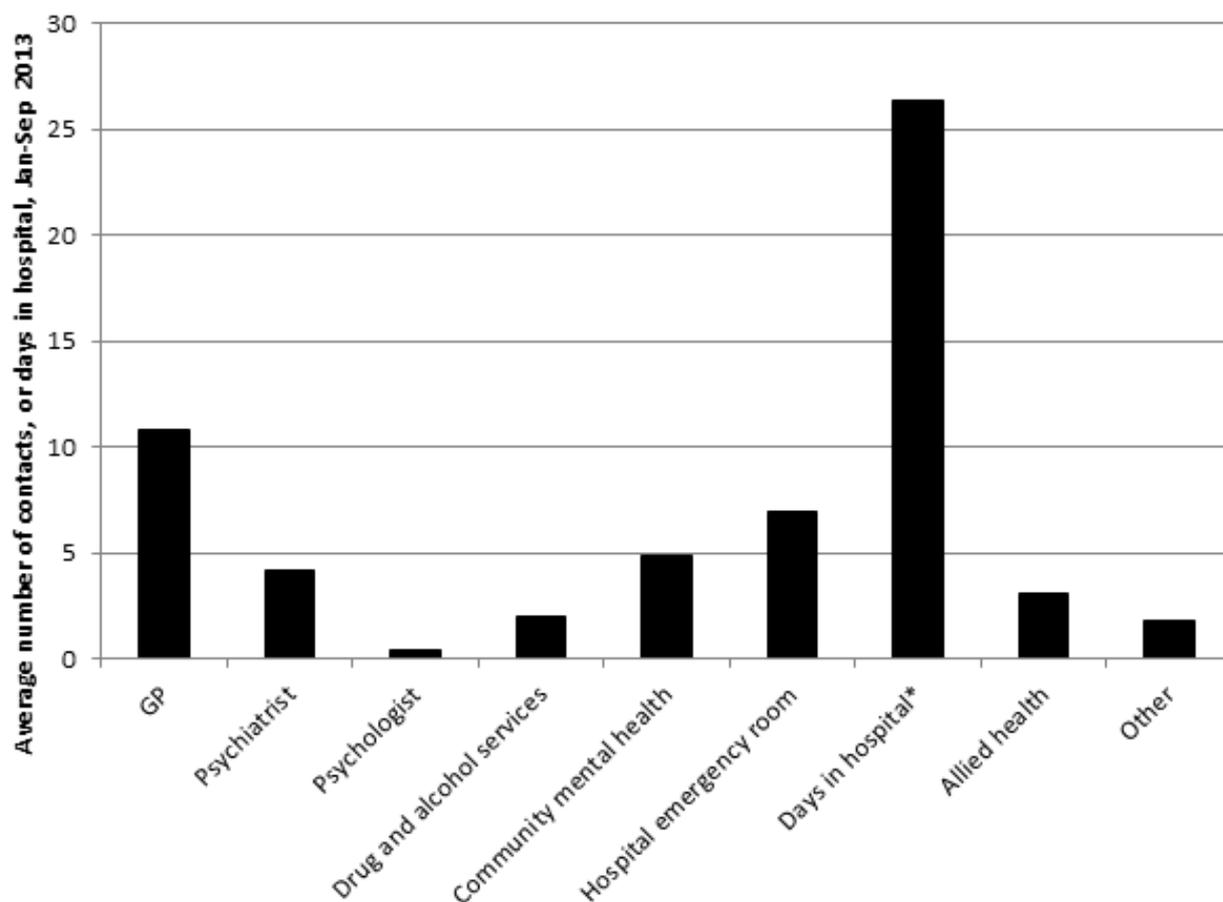
Comparative NSW Health data was not available for this evaluation. As mentioned above, at the time of this report ADHC was in the process of applying to NSW Health for data release.

The health service usage data available for this evaluation was collated by ISP staff for current and former clients, using the data templates in Appendix D. For current clients, service usage was recorded as a total for the evaluation period January to September 2013. For former clients, data was collated for one quarter per year per client, which provided consecutive once-yearly data samples for each client for the period they were in the ISP. These figures were annualised based on the duration each client had been in the Program.

Figure 4.2 shows that, on average, current clients visited a GP approximately 11 times during the nine-month evaluation period, attended a hospital emergency department seven times and accessed other health services five times or less. The average number of days spent in hospital was relatively high at 26.

There was large variation among clients. For example, the hospital figure includes one client who spent the entire evaluation period in a psychiatric hospital and another who was in a psychiatric hospital for half of the period. If these two clients were excluded, average hospital use would drop to 12 days. Regarding other higher use services, the number of GP visits varied between zero and 55 among clients, and visits to a hospital emergency room, between zero and 48. Most clients used multiple types of health services. The data illustrates that ISP facilitates client access to health services, with variations likely due to individual client need.

Figure 4.2 Health service usage by current ISP clients



Source: Current client program data (n=29)

Notes: *includes general and psychiatric hospitals, includes 1 client who was in a psychiatric hospital for the entire evaluation period and 1, for four and a half months. If these 2 clients were excluded, the average was 12 days in hospital.

NSW Health reported in April 2014 that 25 of the 29 current ISP clients received mental health support either through NSW Mental Health or through private consultation from a physician or psychiatrist. Some clients accessed more than one type of support:

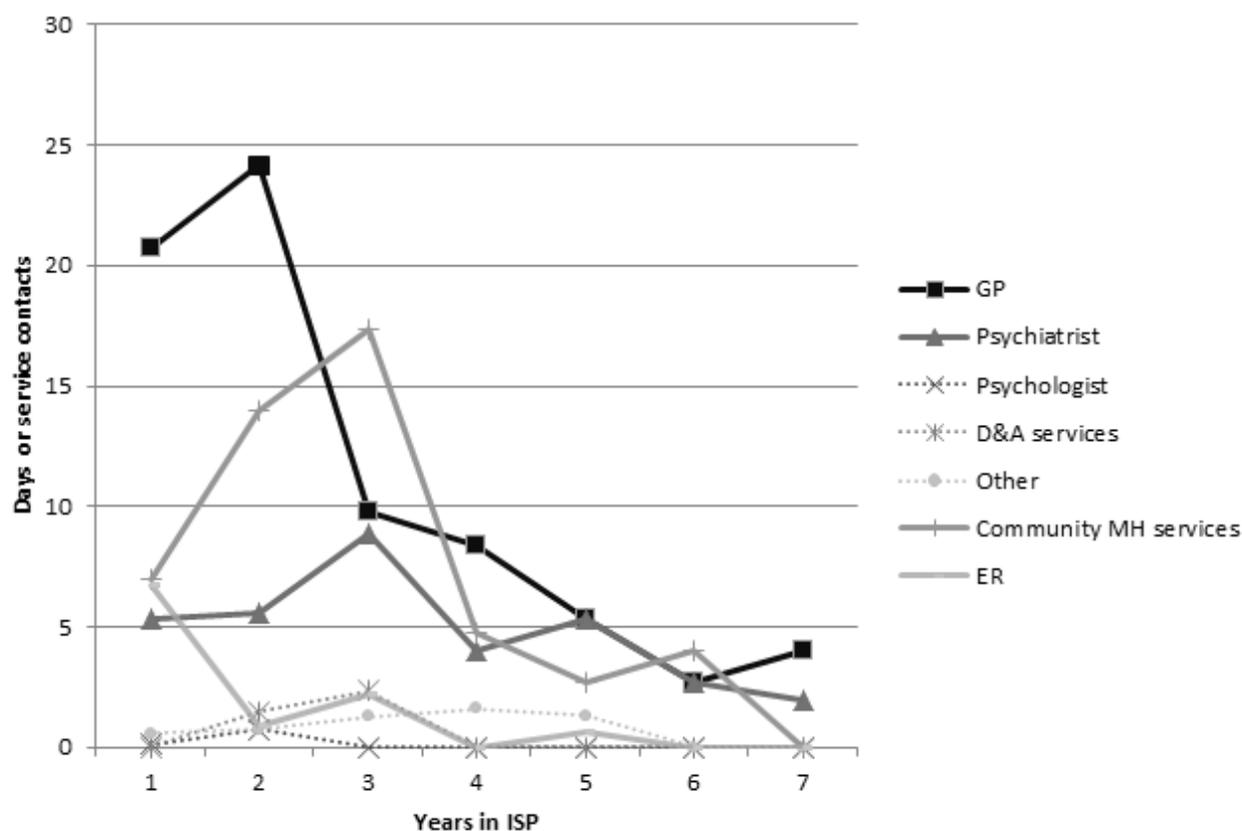
- 18 clients accessed their local community mental health teams
- 5 were supported by a community treatment order
- 4 visited a clozapine clinic
- 1 received support through the Disability Assessment Schedule.

The time series data for former clients is presented in Figure 4.3. The variation in numbers of clients using each service and high-use figures for a small number of clients contribute to volatility. Additionally, the number of clients in the Program declines with increasing number of years, and although the average is based on the number remaining, the sample sizes become smaller and are not sufficient to produce statistically significant comparative figures. The figures are indicative and subject to verification when NSW Health data is available.

With these caveats in mind, Figure 4.3 suggests that the overall number of health service contacts declined during the clients' time in the Program, particularly the number of general

practitioner, community mental health service and psychiatrist visits. These significant reductions occurred in the service categories with the highest annual usage. The other services remained relatively stable at low levels, representing expected ongoing service use.

Figure 4.3 Average health service usage per former client by years in ISP



Source: Former client program data (n=29)

Notes: GP = General Practitioner, ER = Hospital Emergency Room, MH = Mental Health, D&A = Drug and Alcohol

4.3 Use of criminal justice services

In addition to their high use of hospital services, many ISP clients were in contact with criminal justice services prior to entering the Program, in particular spending time in custody. Analysing data from NSW Corrective Services, the previous evaluation found that ISP support resulted in a dramatic reduction of clients' time spent in custody, along with a corresponding reduction in costs to the criminal justice system.

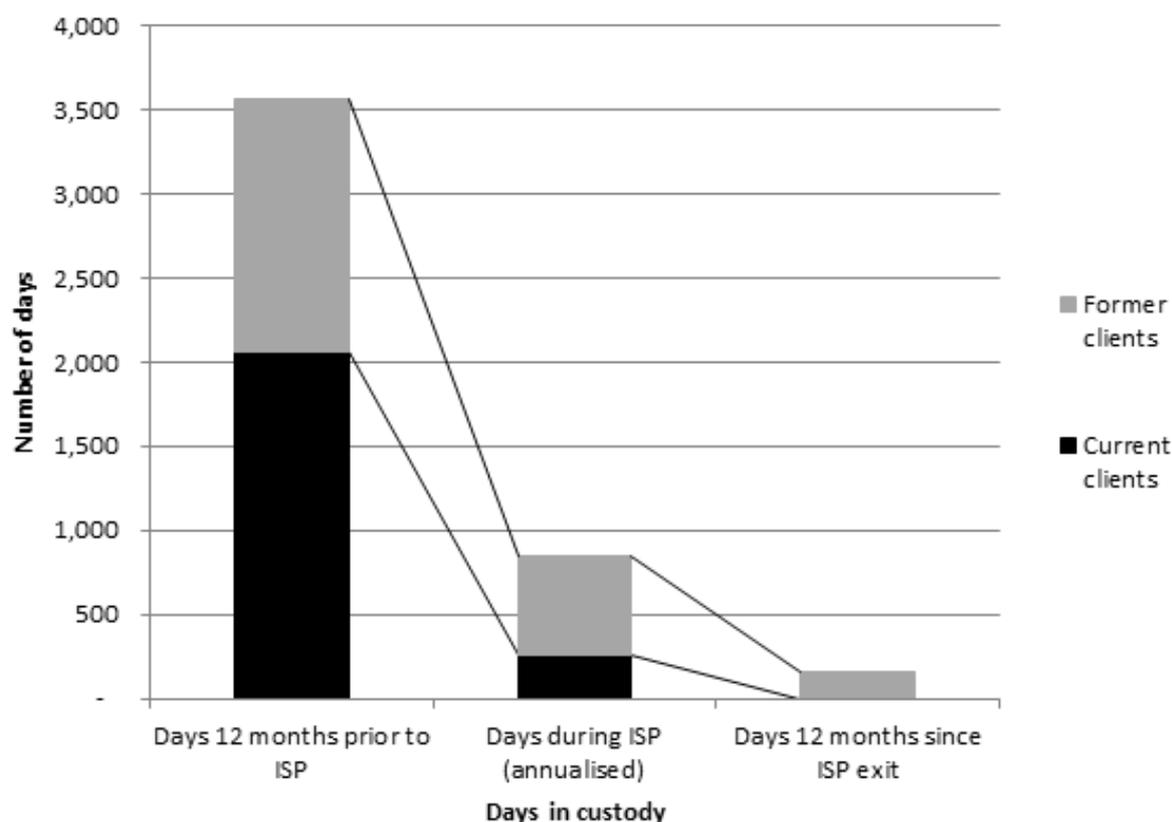
The current evaluation had custody data from NSW Corrective Services for current and former ISP clients, for their time before entering the ISP, during the Program and, for former clients, after exiting. In addition, ISP provided program data about the use of various criminal justice services for current and former clients. Details of the data collection methodology and analysis are in section 2.3.

The NSW Corrective Services data shows that days in custody decreased markedly after clients entered the ISP (Figure 4.4). In the 12 months prior to ISP, nine current clients (31 per cent) had spent a total of 2,057 days in custody. On entering the ISP the annualised number of days decreased substantially for eight of these clients, including three clients who did not spend any time in custody during the Program. Overall there was an 88 per cent decrease in

the total number of days in custody per year, from 2,057 prior to 256 during the Program.

Additionally, 10 former clients had spent 1,506 days in custody during the 12 months prior to the ISP, which decreased to an annualised 590 days during the Program, and further to 155 days in the 12 months following exit from the Program (Figure 4.4). This represents a total drop of 90 per cent.

Figure 4.4 Total days in custody per year prior, during and post ISP



Source: NSW Department of Corrective Services (n=58)

This data indicates that the ISP is highly effective in reducing clients' time in jail while in the Program. This positive outcome appears to continue and be further enhanced after clients exit. The cost of these reduced days in custody is analysed in Section •.

In addition to the Corrective Services figures, ISP program data included details on current and former clients' use of various criminal justice services while in the Program. The data relate to: number of days in jail, on probation, in court, in community service and in other diversional programs, and number of police contacts and appointments in compulsory drug and alcohol programs.

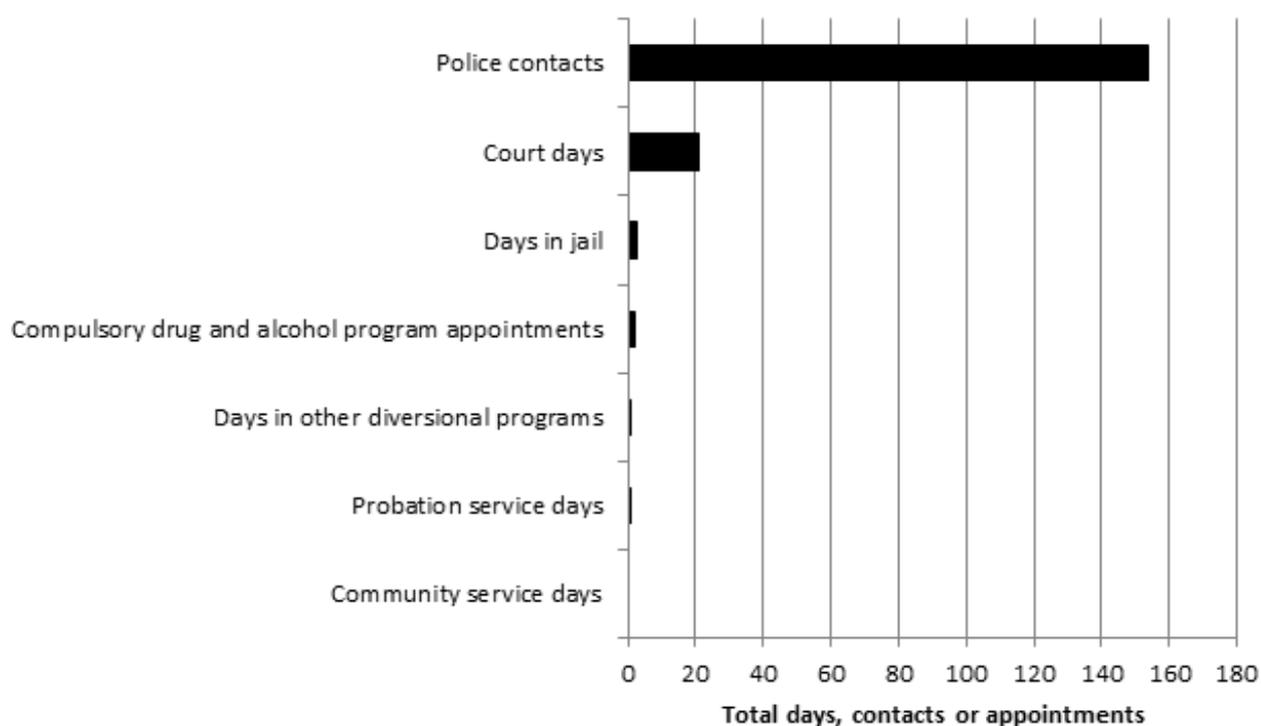
As for the health service figures above, the criminal justice data for current clients consisted of a total for each client's contact with these services during the evaluation period January to September 2013. Figure 4.5 shows that the only item of significant frequency was contact with police. Across the 29 current clients, 154 police contacts occurred during the nine-month evaluation period, or a little more than five contacts per client. The 29 clients had 21 court days between them, and three or fewer contacts with any of the other justice services.

Use of criminal justice services, where they did occur, varied among clients. Police contacts ranged from zero to 48, and court days, from zero to five. Only seven clients had any court days recorded, and just below one-half of current clients (14) had any contact with the police.

One client had 273 appointments with compulsory drug and alcohol programs, or one appointment per day. This was not included in Figure 4.5 as it would have skewed the findings excessively.

Overall the program data indicates that current ISP clients had relatively infrequent contact with the criminal justice system, considering their multiple and complex needs and their life histories. The only significant item was police contacts, and these were concentrated among a small number of clients: five clients had more than 10 contacts with the police during the evaluation period, and all other clients had fewer or none.

Figure 4.5 Use of justice services, current clients



Source: Current client program data (n=29)

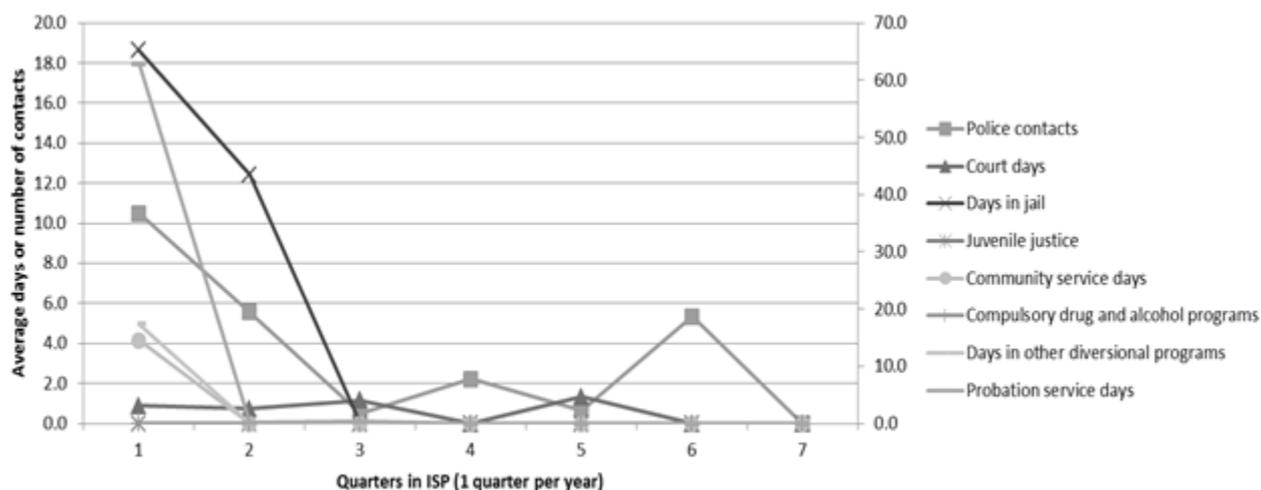
Notes: n=28 for compulsory drug and alcohol program appointments. One client was excluded from the presented data because they were a single, extreme outlier: they had 273 appointments, or one a day, during the evaluation period.

The former client data was collated for one quarter per year for each client, as explained in section 2.3. This time series data is presented in Figure 4.6. As with the health service usage data above, the number of clients in the Program declines with increasing number of years and therefore, particularly for longer periods in the Program, reduction of criminal justice services is not statistically significant. Comparable data was not available from the 2010 evaluation.

Figure 4.6 shows that the first four years in the Program, while client numbers were still relatively high, saw large decreases in the number of probation service days (from 62 to 0), number of police contacts (from 10 to 2), days in other diversional programs (from 5 to 0),

and community service days (from 4 to 0). The steep decline in days in jail was consistent with the Corrective Services data reported above, and the other types of contact with the criminal justice system remained at low levels or zero throughout former client involvement with the ISP.

Figure 4.6 Average criminal justice services usage per former client by years in ISP



Source: ISP former client program data (n=29)

Note: Juvenile Justice is zero throughout. Although ISP is for adult clients, it is included because one client entered the ISP aged 17. That client had no involvement with Juvenile Justice.

Together, the Corrective Services and ISP program data indicates that the ISP is highly effective in reducing client contact with the criminal justice system. This is true while clients are in the program and, regarding days in custody, for one year post ISP. Longer term follow-up of former clients would establish whether this success is sustained and whether it extends to all criminal justice services.

4.4 Ability to live safely in the community

The ISP aims to support clients to live safely in the community. As in the earlier evaluation, this was measured as the level of clients' independence in carrying out activities of daily living. These activities include self-care tasks, such as dressing and taking medication, and household activities like cooking and shopping.

In both evaluations, independence levels were measured on a scale of 1 to 4, as follows:

- 1 – Independent
- 2 – Supported less than half the time
- 3 – Supported more than half the time
- 4 – Fully dependent.

Independence was defined as responses 1 or 2, that is the client carried out a particular activity independently or was supported less than half the time.

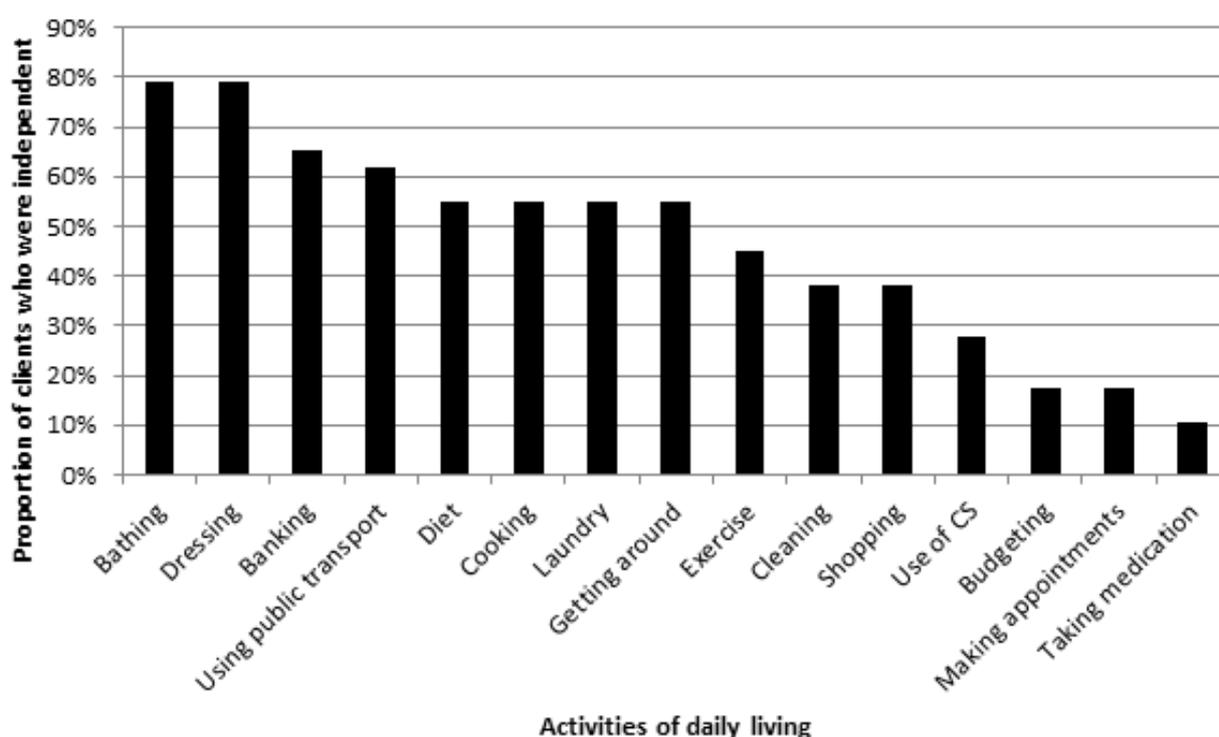
Over the one-year timespan of the previous evaluation, clients' independence levels remained roughly the same, with small increases in some of the activities, particularly

budgeting, bathing, dressing and cleaning. At the time, these findings suggested that living skills may need longer timeframes to improve.

The data collected for the current evaluation provided opportunity to examine current clients' independence levels and to assess whether former clients' living skills improved during the time they were in the Program. For the current clients, independence levels were assessed at the time program data was collected, in 2013. For the former clients, independence levels over time were recorded as one measure per year per activity.

Figure 4.7 shows that a majority of current clients were independent in many activities, namely bathing, dressing, banking, using public transport, eating meals, cooking, doing their laundry and getting around. Overall, independence levels were slightly higher than in the previous evaluation. Reasons may include different client profiles, or longer time spent in the Program compared to clients in the previous evaluation.

Figure 4.7 Independence in activities of daily living, current clients



Source: ISP program data (n=29)

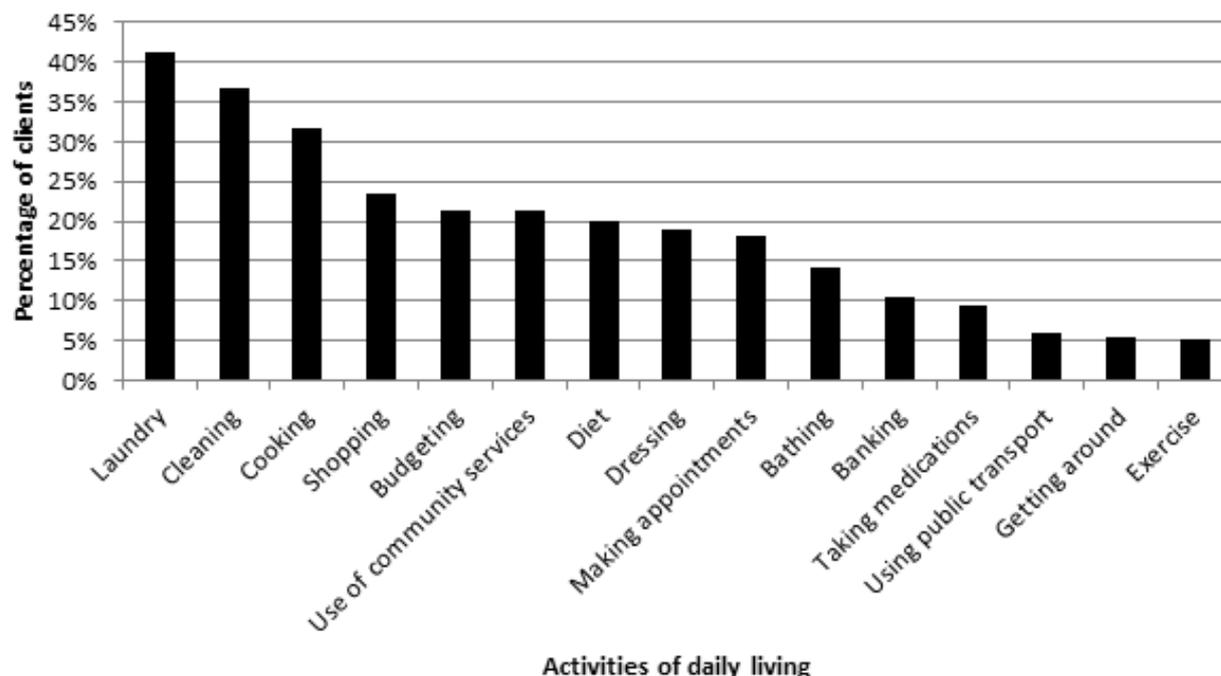
Notes: Independence is defined as: client carried out a particular activity independently or was supported less than half the time
CS = community services

As described in section 2.3, the former client program data was collated in quarterly blocks per year, giving a longitudinal view of client development over the course of their participation in the ISP. Records were incomplete, as independence scores were not available from the case files for all clients for all activities and years they were in the Program. For the assessment below, the former clients' first and last scores were compared. Availability of scores varied across activities; they were available for between 17 and 21 of the total 29 former clients.

Figure 4.8 shows improvement in each of the assessed activities. Between 5 and 41 per cent

of former clients enhanced their independence while in the ISP. The largest proportions of clients became more independent in doing their laundry, house cleaning and cooking (41 per cent, 37 and 32 respectively). The smallest proportions had increases in independently using public transport, getting around and exercising.

Figure 4.8 Improvements in independence during ISP, former clients



Source: ISP program data (n=29)

Note: Percentages are those who improved among clients with first and last scores recorded, per activity (n varies between 17 and 21, depending on activity).

In the program data collection forms, ISP staff described how client independence had improved for people while they were in the Program. For example:

2009 – Robert is an inpatient in a psychiatric hospital awaiting transition to an ISP accommodation placement. He has all meals delivered to him daily and has his prescribed medications administered by nursing staff daily.

2010 – Robert's self-care skills have improved, but he needs prompting to plan and complete activities of daily living. He is familiar with all cooking utensils in the kitchen. He usually cooks a piece of meat and almost always declines staff assistance. Staff administer his medications and support him to attend appointments and access the community.

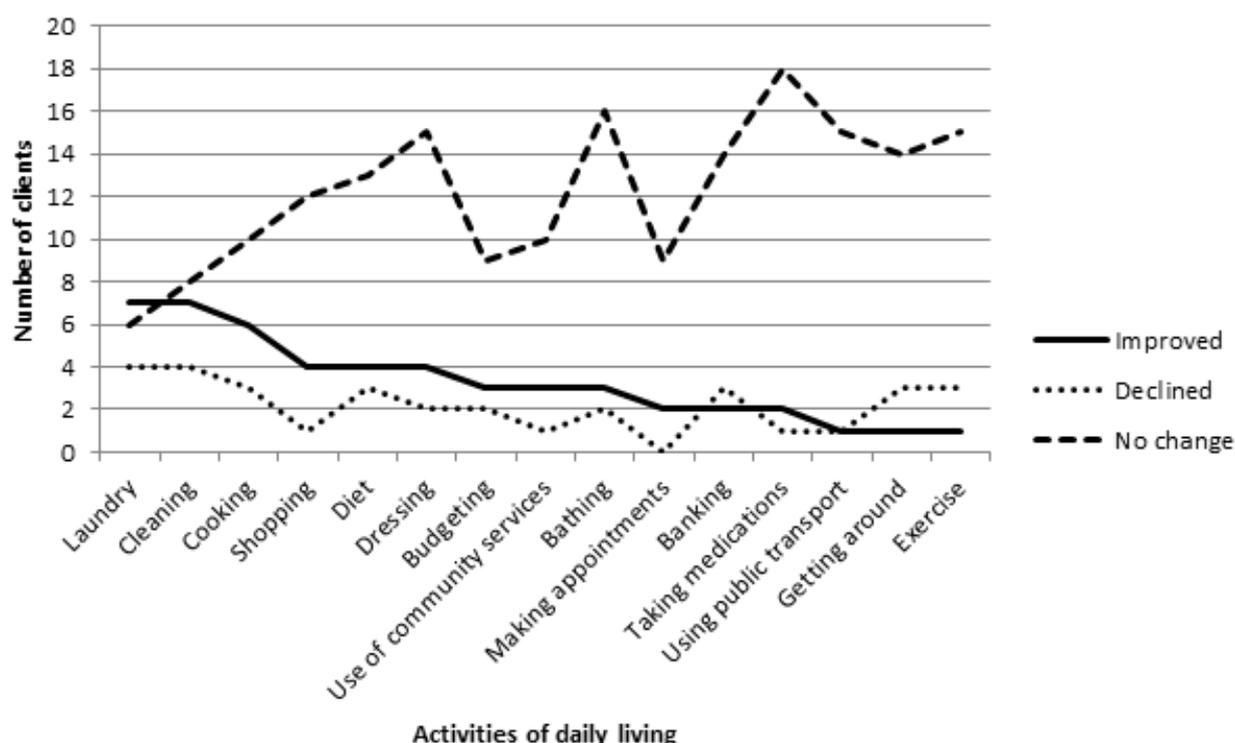
2012 – Robert has recently completed training to administer his medications independently. He is now responsible to purchase grocery cards and complete grocery shopping weekly. He is mostly independent in completing activities of daily living, however he may need prompting to initiate these activities.

Other statements in the program data illustrate that many behaviours may be long established, but that ISP staff observe and encourage even small changes in clients' daily living activities. For example:

Samuel now initiates showering and changing his clothes himself. He will only do this approximately once a week to every 10 days, however, this is a significant improvement.

These examples, together with the case studies in Appendix E, show that some clients substantially improved their capacity to live safely and independently with support from the ISP. Overall, the available data indicates that the vast majority of former clients for whom first and last scores were available maintained or improved the independence levels that they had on entering the ISP (Figure 4.9). Decreases in independence were observed for relatively small numbers of clients in almost all activities, demonstrating the high complexity of client needs and the difficulty of changing well-established behaviours.

Figure 4.9 Change in independence scores during ISP, former clients



Source: ISP program data (n=29)

In summary, the available data shows that ISP can support clients' ability to live safely in the community, by maintaining or increasing their level of independence. A majority of current ISP clients were independent in a majority of daily living activities, and the data about former clients shows preservation of independence levels for most clients, increases for some, and decline in independence for a few clients. The case notes and case study examples show that even small increases in independence levels can lead to substantial improvements in people's lives and prepare them for independent living in the community.

4.5 Social connections and economic participation

The ISP encourages clients to develop positive social connections and economic participation, so they can live as independently and safely as possible once they leave ISP. In the current and previous evaluations, client outcomes were measured as frequency

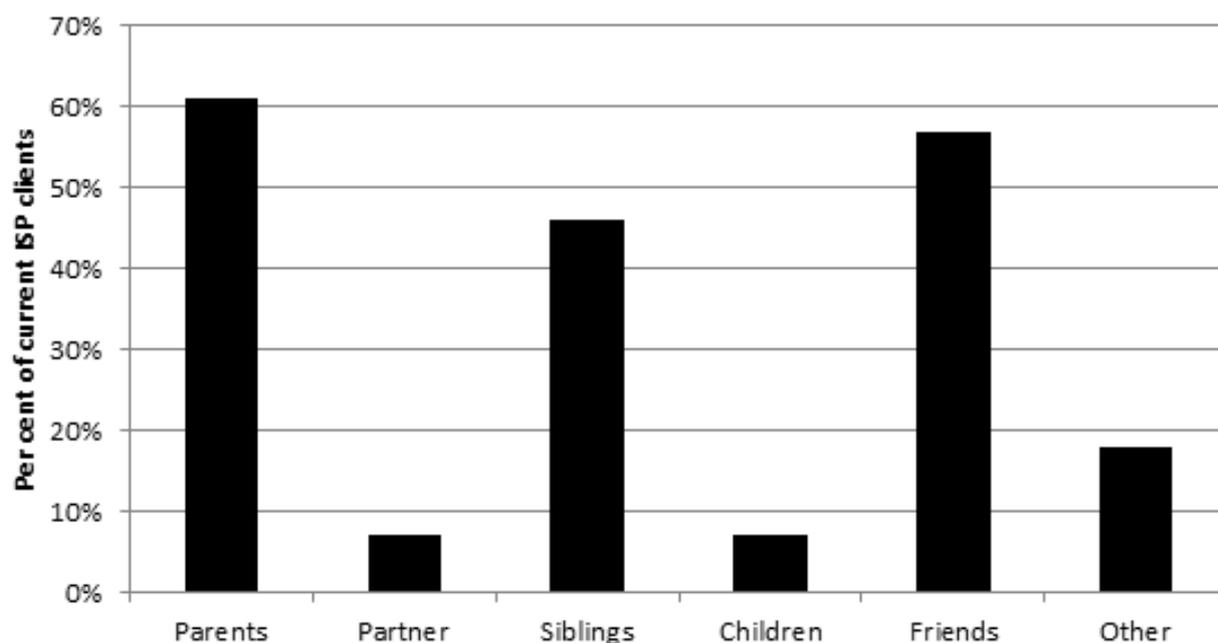
of social contact with various people, including family and friends, and involvement in community activities, employment and education.

The 2010 evaluation found that most clients increased their social contacts and economic participation after entering the ISP. In particular, 81 per cent started social and community activities, and 31 per cent became involved in education. Staff also reported that relationships with friends and family had improved for most clients since entering the ISP.

Data collected for the current evaluation provided comparison with the previous findings and possible indication of whether clients' social connections and economic participation had improved over time. For the current clients, data was recorded in 2013. For the former clients, social connections and economic participation were recorded as one measure per year per item while they were in the ISP.

Figure 4.10 shows that more than one-half of current ISP clients had regular contact (at least once a month) with their parents and friends, and almost one-half had regular contact with siblings. The proportions of clients who were in touch with partners or children were low, partly because, as mentioned above, 82 per cent of current clients were single and had never been married. Two current clients were reported to have an intimate relationship.

Figure 4.10 Social contact of current ISP clients



Source: ISP program data (n=29)

Note: Per cent of current ISP clients with regular social contact, i.e. at least once a month.

During the nine-month study period in 2013, 12 current clients, or 41 per cent of all current clients, had made new friends or renewed relationships with families and friends; and 18 clients (62 per cent) had become involved in new social or community activities. This was consistent with the 2010 evaluation and shows that ISP support is effective in improving clients' social connections.

Social contact data about former clients was collected as one measure per year while they were in the ISP, potentially showing changes over longer time periods. Data was incomplete,

with first and last scores available for between zero and 12 former clients (10 for contact with parents, 12 with siblings, seven with friends, zero with partner, three with children and one with other contacts). Reasons for limited data availability included that clients had social contacts during independent outings into the community, and that they chose not to share information about their social contacts with ISP staff.

The limited available data is presented in Table 4.1. It shows that more than one-half of clients for whom data was available improved their relationship with their parents and one-third, with their siblings. One client enhanced relationships with friends while in the ISP. For several clients, social connections remained unchanged, and for a few they deteriorated. One reason for deterioration was complex family relationships, including violence.

Table 4.1 Changes in social contact during ISP, former clients

	Parents	Siblings	Children	Friends	Other
Improvement	6	4	0	1	0
Decline	1	2	2	1	0
No change	3	6	1	5	1
Total clients with available data	10	12	3	7	1

Source: ISP program data (n=29)

Note: There was no available data for change in contact with partner.

Staff described in the data collection template how clients' social connections improved over time while in the ISP. For example:

2007 – Vicki does not have any known social contact and no family members living in Australia. She speaks little English.

2008 – Vicki has access to 24/7 staff at [accommodation], and she visits the office at least twice a day for medication and other matters. She participates in social groups and gatherings run by the [accommodation] multiple times per week. She is polite and quiet and appears to be socially appropriate in her interactions with neighbours.

2009 – Vicki continues to access staff at least twice a day, and she receives regular drop-in support by carers from another organisation who can speak her language. She becomes increasingly sociable as her confidence in her English-speaking skills develops. She continues to participate in social events organised by the [accommodation], engages well with others and has made friends with several people in the community.

2010 – Vicki lives in the community and receives drop-in support for a few hours per week. She is polite and is believed to have made friends in the local community.

Other clients re-established contact with family while in the ISP. For example:

2006 – Prior to living in the ISP Assessment Unit, Albert lived with his family, but the placement broke down. Albert entered ISP as part of his bail condition. His relationship with his family appears to be slowly improving, given they have recently re-established regular phone contacts.

2007 – Albert has been proactive in maintaining his family contacts. He nearly always initiates contact and organises visits to his parents, brothers, cousins and extended family at least weekly. He also went to the hospital to visit his sick father.

2008 – Albert has re-established close relationships with his family. He regularly phones and meets his immediate and extended family members. He visits his parents on the weekends and attends prayer sessions with family members every Thursday. He seems to enjoy his family's company.

Examples from the case studies (Appendix E) illustrate how ISP arranges flexible service provision to support and enhance clients' existing relationships:

Sara left ISP group homes several times to stay with her partner. The ISP developed a service agreement with the couple and provided drop-in support to their home. Sara's activities of daily living and engagement with community increased significantly. She also takes her medications and as a result has not relapsed since her discharge from hospital.

Louise was ready to leave the ISP and wanted to return to her region of origin, where her family lived. The ISP overcame administrative barriers to secure funding for Louise and is now working with its partners in the region to identify a service model that can support Louise adequately.

Largely, ISP appears effective in maintaining or improving clients' social connections. Qualitative and quantitative data shows that social connections rarely decline while in the ISP, and if so, this is due to external factors. The examples indicate that the flexibility of ISP and its holistic approach are important elements in fostering clients' social connections.

ISP staff recorded economic participation of current clients in 2013, and of former clients when there were changes. Table 4.2 presents the numbers and percentages of current clients who were engaged in work, education or training in 2013, and of former clients who were engaged at any point during their time in the ISP. All economic participation commenced after clients had joined the ISP.

Table 4.2 Economic participation of ISP clients

Primary diagnosis	Current ISP clients (n=29)		Former ISP clients (n=29)	
	N	%	N	%
Engaged in paid work	3	10	8	28
Doing volunteer work	0	0	2	7
Enrolled in education or training	7	24	5	17

Source: ISP client program data (n=58)

All current clients who were in education or training were enrolled at TAFE. One of the current clients who was in paid employment had increased his work days from one to three during 2013, and he had joined the social club and developed further friendships at work. According to staff, the workplace provided a safe place for him to manage his gambling addiction and anxiety.

Staff recorded that many current clients were not interested or not able to engage in work or training at present, sometimes due to their mental illness or advanced age. Some were in a planning process with their case manager to find suitable work or education opportunities.

Records about former clients show that four clients developed stable or ongoing employment during their time in the ISP. Others' involvement in paid work varied because they started a job but it did not continue long-term. Reasons included clients' mental health issues, such as anxiety.

Overall, relatively low proportions of ISP clients became involved in work, education or training while in the Program. This indicates that economic participation outcomes were difficult to achieve for this client group, due at least in part to the complexity and interconnectedness of their needs, which may constrain regular engagement at work; and due to the general challenge of finding and maintaining employment for people with mental illness. In the future, a stronger Program focus on economic participation might contribute to improved outcomes in this area.

4.6 Health and wellbeing

ISP aims to improve clients' health and wellbeing. Whether these outcomes were achieved for current clients was assessed through a measure of self-reported personal wellbeing and health, at the evaluation data collection point in 2013. There was no comparable data for former clients, but comparative survey data about personal wellbeing and self-assessed health was available from the 2010 evaluation. This data is presented alongside the 2014 findings below.

Of the 29 current ISP clients, eight (28 per cent) completed the survey questions about their health and personal wellbeing (Appendix D), and 21 (72 per cent) took part in the conversational, qualitative interviews about personal wellbeing (Appendix D). These 21 included seven of the eight clients who completed the survey.

Eight current ISP clients answered questions about their health. Table 4.3 compares their answers with the 2010, phase 2 evaluation findings. The 2014 answers were distributed across the categories of very good, good and fair, with a larger proportion than in 2010 in the lower 'fair' category. The 2014 sample was too small to draw conclusions about the wider client group.

Table 4.3 Self-assessed health

In general, how would you rate your health?	2010 evaluation (n=24)		2014 evaluation current clients (n=8)	
	%	N	%	N
Excellent	29	0	0	0
Very good		2	25	
Good	46	3	37.5	
Fair	25	3	37.5	
Poor		0	0	
Total	100	8	100	

Sources: McDermott et al., 2010; ISP client program data
2010 evaluation data combined answers for excellent/very good and fair/poor.

Clients were also asked how they rated their health compared to one year ago. Of the eight clients who answered the question, seven felt that their health had improved or remained the same. This was similar to the 2010 evaluation, but again the sample was too small to draw wider conclusions.

The Personal Wellbeing Index (PWI), an internationally validated instrument, was used to measure subjective wellbeing in relation to a client's life as a whole and seven life domains (Cummins, 2005) (Table 4.4). The 2010 evaluation found that clients' personal wellbeing improved in all domains while in the ISP, thus moving clients closer to the Australian norm and in some domains, above it. In contrast, the small group of clients who completed the survey in the current evaluation rated their personal wellbeing well below the Australian norm in all domains, although this sample was too small to generalise.

Table 4.4 Personal Wellbeing Index (PWI) scores, ISP clients and Australian population

Thinking about your own life and personal circumstances, how happy are you with your:	ISP clients 2010 evaluation (n=26)		ISP clients 2014 evaluation (n=8)	Australian population
	2008	2009	2013	2012
Life as a whole	55.2	70.8	60.0	77.8
Standard of living	56.8	83.6	58.9	78.9
Health	59.2	71.2	55.0	74.0
Achievements in life	58.0	73.6	44.5	73.8
Personal relationships	54.7	64.4	44.2	78.8
Safety	66.6	77.2	48.5	80.9
Feeling part of the community	60.0	74.0	35.7	72.4
Future security	57.9	74.4	42.0	70.8

Sources: Mc Dermott et al., 2010; ISP client program data; Cummins et al., 2012
Method for calculation of scores: Survey participants are asked to rate their satisfaction with each PWI domain on a scale of 0–10. Each score is an average of the answers of survey participants, converted to a 0–100 point range.

Seven of these eight current clients also took part in the conversational interviews about

personal wellbeing (Appendix D). Their answers explain why they were not happy about some aspects of their lives and their health:

I don't want to live here. I want to go home and live with my mother as I need to help her. Mum is sick and [my sister] does not help her.

I don't feel healthy because I can't do what I used to and I am shaky and my ears hurt.

I would like to meet a nice person who will respect me and never cause arguments.

However, these clients also talked about parts of their lives that they enjoyed:

I enjoy the speedway very much. [The people there] are all my friends.

I feel at home.

The staff are very supportive.

I enjoy coffee and cakes at the local cafés and talking to people I know.

Unlike the PWI, the 21 client interviews reflected an overall positive picture of personal wellbeing. In each topic area, a majority stated they were, at least in part, satisfied with their situation and development (Table 4.5). Since almost three-quarters of current clients took part, these interviews give some indication of the wellbeing of the current client group as a whole.

Table 4.5 Positive answers to conversational personal wellbeing questions, number of current clients

Topic	Question	Yes
Satisfaction with life as a whole	Are there any good things happening for you in your life at the moment?	15
Standard of living	Are you happy with where you live?	14
Health satisfaction	Do you feel healthy?	15
Goals/ achievements	Are you making progress in achieving your goals?	11
Relationships	Are you happy in at least some of your relationships with: staff, co-residents, family, friends, significant others?	20
Community	Do you feel you are part of your community?	12
View of the future	Are you hopeful about your future?	13

Source: Qualitative interviews about current clients' personal wellbeing, n=21

According to the clients' qualitative answers, important factors that made them feel good about their lives were: eating a healthy diet, losing weight, receiving support from staff, living in comfortable and safe ISP accommodation, and getting out into the community. A few examples:

People talk to me in the community and know my name.

I could not ask to have better staff, they are very caring.

Having my own room and a bed and shower.

Eating the right food, losing weight.

I have a good routine, staff are friendly, I have a good time.

The qualitative answers also illustrate how ISP clients, like any other person, reflect on and distinguish between various aspects in their lives. For example, when asked about their satisfaction with relationships, one client responded:

Yes: trying to repair relationships with staff – going well. No: male staff rostered on, unable to tell them why I don't want male staff, so struggle through it. No house mates at present. Family good. Friends not so good, trying to find friends who don't use drugs. No partner at present, would like to find a partner.

Clients were clear and concrete about their plans for the future. Many aspired to live in the community, for example:

[I want to] live independently, have my girlfriend visit my place, finish the cooking course, continue with the gym, have my friends visit my house.

I want to live in [a suburb name], I don't want any carers, I will take my medications at the time, and I will keep in contact with [a person's name].

I want to live outside of ISP with staff support and I need them to support me. I have spoken to people about getting a part-time job.

The clients also mentioned barriers to achieving their goals and to being happy with their life circumstances. These barriers included their mental illness, drug use, inability to access the community or leave ISP, and conflicts with co-residents.

On the whole, the clients appeared to engage well in the interviews, and they seemed open, considered and insightful in their answers. This indicates that ISP staff had gained the clients' trust, and that clients had a high level of awareness about their problems and had developed goals and strategies to deal with them – a likely outcome of effective ISP support.

4.7 Summary of client outcomes

Overall program outcomes for current and former clients while in the ISP were:

- On average, the frequency and severity of incidents where clients acted in a way that could cause risk or harm to themselves or others declined as clients spent more time in the Program.
- Average health service usage decreased as clients spent longer in the ISP, particularly in the service categories with the highest annual usage: visits to GPs, community mental health services and psychiatrists.
- The ISP appears highly effective in reducing average number of client contacts with the criminal justice system, in particular days in custody and number of contacts with police while clients are in the program. Average days in custody for one year post ISP also reduced (the number of contacts with police after ISP is unknown).
- The findings about reduction in incidents and use of health and criminal justice services established that the trends observed in the earlier ISP evaluation continued long-term while people remained in the Program. Follow-up of former clients would establish whether this success is sustained after leaving the Program.

- Clients who needed support with activities of daily living often achieved increases in independence while they were in the ISP, particularly in domestic tasks such as doing the laundry, house cleaning and cooking. This often took considerable time, but clients' capacity to live safely in the community improved somewhat overall.
- Personal relationships and community connections improved for many clients while in the ISP. Successes were often a result of the ISP's flexible and holistic approach.
- Economic participation outcomes, such as work, education or training, were difficult to achieve, due at least in part to the complexity and interconnectedness of client needs, which may constrain regular economic engagement; and due to the general challenge of finding and maintaining employment for people with mental illness.
- Client perceptions about their health and personal wellbeing were mixed, reflecting their complex lives that included problems with mental illness and drugs. They said that contributors to their wellbeing were satisfaction with support from ISP staff, living in safe housing and getting out into the community.
- Social, economic, health and wellbeing outcomes appeared more positive in the previous evaluation than the current one. One possible explanation may be different client profiles, for example more clients in the current evaluation who had highly complex needs so they had remained in the ISP for a longer time.

5 Processes for supporting clients

ISP nomination and service delivery processes were described in section 1.2. This section analyses ISP staff and stakeholder perceptions of these processes, as well as developments since the 2010 evaluation. Findings are based mainly on the focus groups and interviews with ISP staff and stakeholders, described in section 2.3. Case study data is used to illustrate findings.

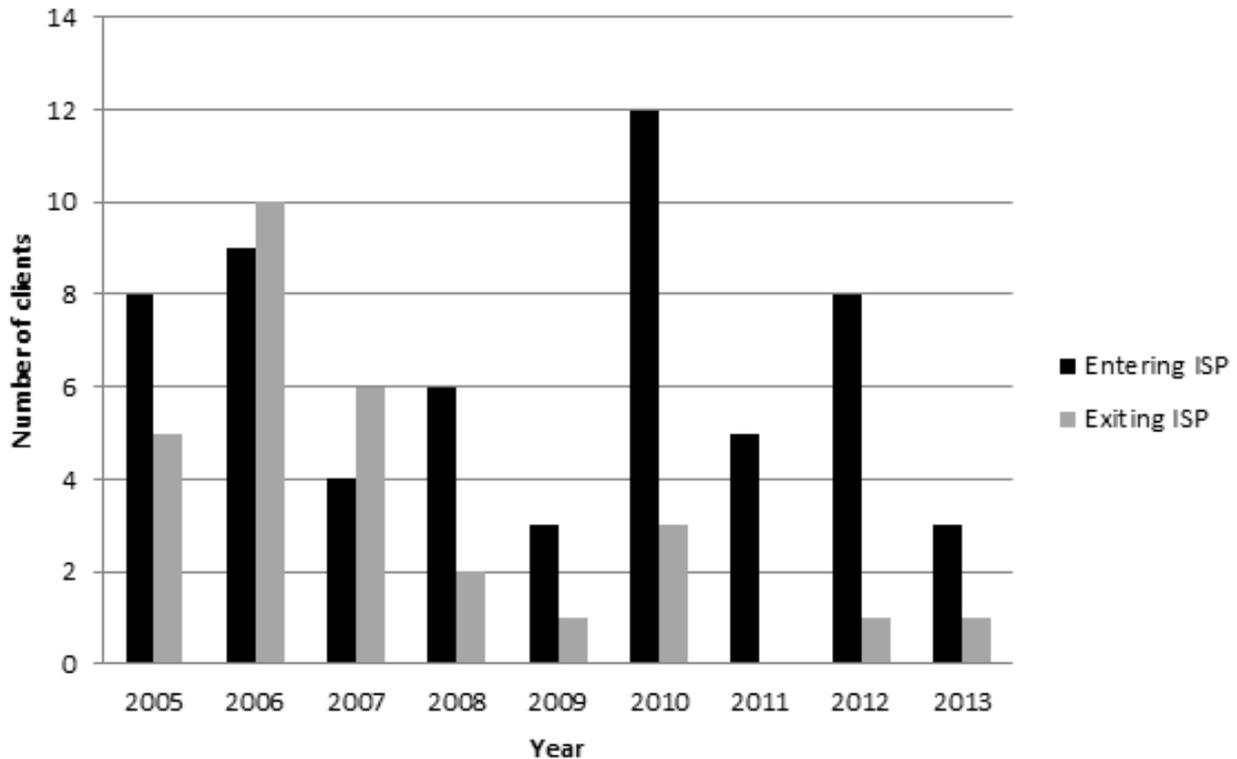
5.1 Nomination process

The majority of ISP staff and stakeholders considered the nomination process successful in identifying people for whom the Program was intended. This was consistent with the previous evaluation (McDermott et al., 2010). In the interviews and focus groups for the current evaluation, most ISP staff said that the forms and processes had improved over time so that staff were now receiving more comprehensive information at referral. Some related these improvements to the fact that the Program was better known and understood in the service sector and wider community.

Staff and stakeholders interviewed for this evaluation felt that the nomination process had slowed in the last few years, due to clients staying in the Program for longer than expected. External stakeholders said that the Program's limited intake capacity had reduced the willingness of some agencies to refer people to the ISP. This was because of the low likelihood of having a referral accepted, combined with the large amount of work necessary for preparing the referral documentation.

ISP program data shows that client intake fluctuated strongly over the years, with between three and 12 clients accepted in any one year (Figure 5.1). The last few years saw both the highest and the lowest intake numbers, with 12 clients in 2010 and three clients in 2013.

Figure 5.1 Number of clients entering and exiting the ISP by year

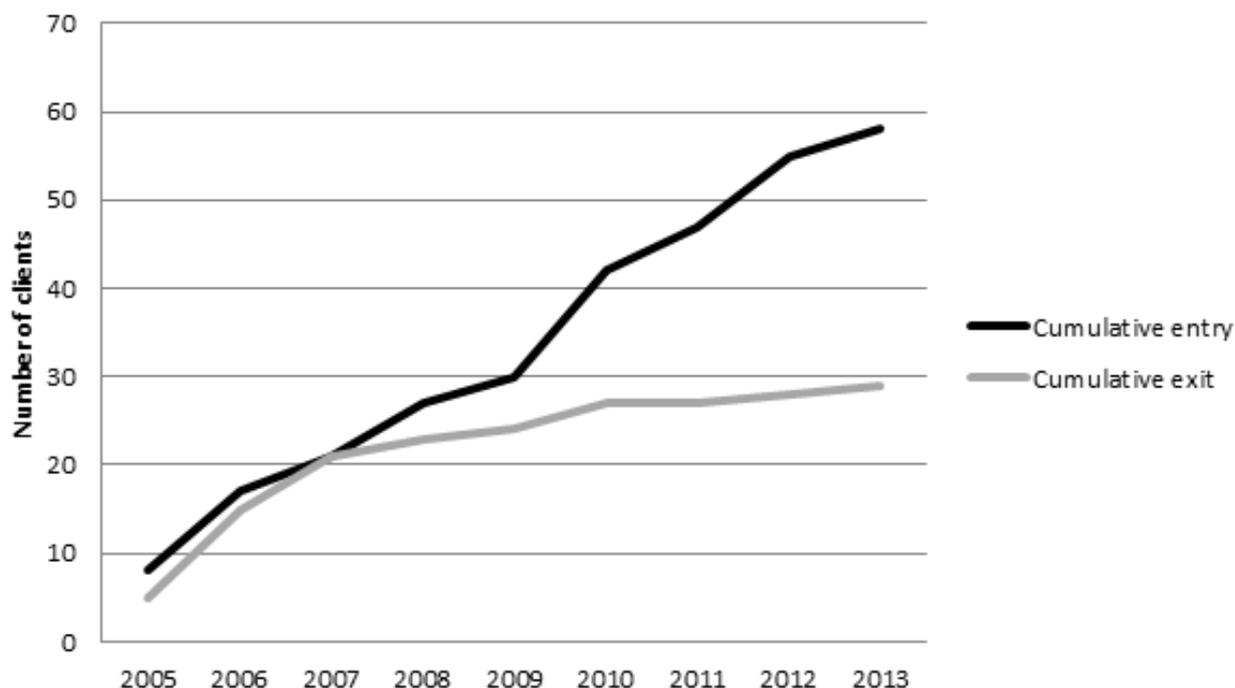


Source: ISP program data (n=58)

Client turnover in the Program reduced in the last few years (Figure 5.1). Interviewees from all groups felt that this was because the profile of people who were accepted into the ISP had changed over time. They said that in the beginning several people had entered the ISP directly from prison, but would now be unlikely to be accepted. This development was foreshadowed in the 2010 evaluation and was partly due to the establishment of the Community Justice Program (CJP), which supports people with intellectual disability and complex needs who have been in the criminal justice system. According to the interviewees, this client group was also relatively quick to exit the Program. This is reflected in the early, relatively high exit numbers in Figure 5.2.

Staff and stakeholders commented that, in recent years, more people with personality disorders were accepted into the ISP, and they tended to remain in the Program for several years. Interviewees said this was due to a shortage of suitable accommodation and support, as this group of clients fitted into neither mental health nor disability services. Figure 5.1 confirms that the number of people exiting the ISP was lower in the last few years than in the beginning. Figure 5.2 presents this data as cumulative figures. It shows that aggregate exit numbers became significantly lower than entry numbers as the Program progressed, leaving fewer spaces for new clients.

Figure 5.2 Cumulative numbers of clients entering and exiting the ISP, 2005–2013



Source: ISP client program data (n=58)

In the previous evaluation, staff and stakeholders had suggested that ISP nominations from external service providers be considered. This suggestion was not taken up, possibly due to the restricted number of vacancies in the Program.

5.2 Supporting clients in the ISP

Staff and stakeholders identified factors that helped the ISP to achieve positive outcomes for clients, but also aspects that hindered the successful implementation of the ISP support model.

Overall staff and stakeholders were positive about the Program's approach and processes in meeting the clients' complex needs. ISP clients received not only stable accommodation but usually integration and coordination of several types of support, such as therapeutic, clinical, mental health and behavioural support, as well as support with independent living skills, social and economic activities, and re-establishing personal relationships.

Interviewees attributed positive outcomes for clients to the ISP's flexible, holistic support combined with person-centred case management and planning. In addition, having a highly experienced, clinical inter-disciplinary team in-house to meet client needs and provide support and supervision to staff was identified as critical to the success of the ISP. Clear communication pathways between teams of residential staff, case managers and clinicians were seen as essential for the consistent implementation of case plans. Staff said that communication and inter-disciplinary work were facilitated through regular case review meetings, as well as systems to share information and monitor clients' progress and changing support needs. These positive assessments mirrored the 2010 evaluation.

The case studies (Appendix E) illustrate the ISP's professional, holistic and individualised approach to client support, and its effect. Just one example:

Philip initially received a high level of direct staff support and clinical support, which was reduced over time. Staff supported Philip to learn how to lead a positive life in the community. Clinical services supported Philip to engage in psychological therapy. Case management services developed a plan on how to meet Philip's needs in the present and future.

Since joining the ISP, Philip has ceased all substance abuse, is maintaining his own Department of Housing accommodation, improved his mental health and has not been charged for any offence. He also completed a therapeutic intervention program to address his offending behaviour.

Philip acknowledges the significant gains he has made in his life since entry to the Program. He states he was an angry man who was worried about accepting services, trusting others and opening up to receive help and advice. Philip now reports that persisting with him, being patient and providing unconditional support has enabled him to achieve things he never thought he could.

Since the previous ISP evaluation, the administration of the Program shifted from a multi-agency-led, stand-alone pilot project to a multi-agency program led by and incorporated into ADHC. As a consequence, since 2010 ADHC governance, quality improvement, policy and industrial conditions applied to the ISP. Therefore the supported accommodation stream underwent significant reforms, as it implemented the Community Living Award, new health care policies and competency training for all disability support workers.

There were mixed views among staff and stakeholders as to the impact of these reforms. Concerns were that the implementation changed the nature of the ISP from a flexible program able to fit around the client to one that rather made the client fit. The areas of impact identified were:

- Limited recruitment of staff with work expertise in mental health
- Flexible responses to client support need are restricted by shift lengths and budget constraints
- Difficulty to access specialist expertise on short notice.

ISP identified three distinct client groups in ISP, with different support needs and anticipated outcome trajectories. These are described here and illustrated with case study examples:

1. People who would continue to have very high support needs and would continue to require intensive, ISP-style service provision, often due to personality disorder or acquired brain injury (about 25 per cent of clients)
 - For example, Julia has been in the ISP since 2007. She has an acquired brain injury and personality disorder. She needs a high level of support, and ISP has not been able to find an adequate external funding source for her.
2. People who had improved within ISP to the extent that they could transition to other intensive support arrangements that could be provided by other agencies or NGOs after training and capacity building from ISP (about 25 per cent of clients)

- For example, Gina transitioned successfully from the ISP in 2013 to a group home run by an NGO. The ISP conducted training with the new accommodation staff and secured extra funding so the NGO could recruit specialist staff for Gina's support.
3. People who had responded well to ISP support; who had benefited from a good diagnosis and intensive support in ISP at the start and the gradual reduction in support, and could transition out of the program into stable living arrangements with some support (about 50 per cent of clients)
- For example, Lilly exited the ISP in 2010 and lives independently in an apartment. She has a support network in the community that includes a community group, a pharmacist, dentist, doctor and psychiatrist. Lilly works two days a week, attends English classes, volunteers at an elderly community group and participates in a dance group.

The client groups described above are similar to those identified in the 2010 evaluation, although the proportions differed. The clients with higher support needs, in groups 1 and 2 above, comprised lower proportions of 11 and 19 per cent respectively in 2010, while the most successful group 3 made up 70 per cent in the previous evaluation. This shift confirms that, over time, higher-needs clients accumulated in the Program due to their difficulty transitioning out of the ISP.

Every staff and stakeholder who took part in this evaluation said that the ISP was an important program that needed to be continued in some form and ideally expanded. They were concerned about the apparent lack of available accommodation and intensive support options for people with multiple and complex needs; this issue is illustrated by case studies about non-clients collated for this evaluation (people who were referred to the ISP but rejected, Appendix E). The case studies evidence a widespread shortage of service capacity, and they show how individual services in a fragmented sector – including mental health services, hospitals, prisons, disability and other community services – may focus on one need of a person without being able to address their multitude of interconnected needs. For example:

Garry has been living for years with extensive emotional needs, a brain injury, a spinal cord injury and a pressure sore and bone infection that require surgery. There has been no holistic approach to supporting him, and individual services have not been able to engage him either in treatment for his pressure sore and bone infection, or in case management for his mental illness.

Steven is currently in prison. Over the years it has been evident that his complex mental health needs cannot be adequately supported in the resource-poor rural area where he lives. He is considered at great risk of continuing in the cycle of custodial sentences – release to community without appropriate supports – deterioration of his mental health – resulting in re-offending behaviour and reengagement with the criminal justice system.

Debbie is homeless and abuses drugs and alcohol. Since her failed ISP nominations, she has had several longer admissions to mental health facilities. Back on the streets, she is no longer able to access emergency accommodation due to her reputation.

Debbie presents to hospital emergency at least three times per week, often brought in by police who find her naked and assaulted. The hospital has a response plan where they admit her once per month for one week to stabilise her health and her mood.

5.3 Transitioning clients out of the ISP

Transitioning clients out of the ISP within the Program's intended 18-month timeframe proved a key challenge. This was apparent in the previous evaluation and has continued since. At the time of this evaluation in 2013, 76 per cent of all current and former ISP clients had been in the Program for more than two years (Figure 3.5 above).

Reasons for the transitioning difficulties related to client support needs and availability of appropriate support options outside the ISP. Regarding the first point, the ISP was designed for people whose multiple and complex support needs had not been met by the existing service system. As described above, clients typically entered the ISP with histories of early trauma, long-established drug use and multiple mental health needs. The ISP experience shows that the complexity and inter-relatedness of client needs often requires longer timeframes than originally anticipated to be addressed and stabilised. For example, Scott (see case study in Appendix E) was in the ISP for six years, from 2006 till 2012, and then transitioned successfully to supported accommodation and community-based services.

Regarding the second point, ISP staff and stakeholders were unanimous that there was ongoing shortage of options to transition clients out of the Program. Interviewees mentioned the following reasons:

- limited capacity within community and government services to appropriately support clients with complex needs (including accommodation, experienced staff and holistic service options according to individual need)
- difficulty securing collaborative agreements with agencies and services that might support clients
- clients' attachment to ISP support, especially if they had been in the Program for several years.

The same issues were raised in the previous evaluation report. The case studies in Appendix E provide examples of the shortage of suitable accommodation and intensive services to support people with complex needs, such as:

Rick is ready for transition from the ISP. Funding has been secured for dedicated support at key times, but a placement has not yet been found. ISP has provided Rick's profile to several NGOs; however all have deemed him not suitable due to the complexity of his needs.

Jane exited the ISP in 2009. Her support was transferred to the ADHC Community Support Team while she received accommodation services from an NGO. In 2011 the NGO service deemed they could no longer support Jane due to the severity of her behaviour, which included an increase in property damage. At this time Jane briefly returned to custody and was then accepted into the ADHC Community Justice Program, where she has continued to receive specialist accommodation and behaviour support.

Petra transitioned from the ISP to an NGO service in 2007. Petra set fire to her room and is currently in prison. Suspected contributing factors are reduced clinical support at the NGO compared to ISP; and not engaging Petra in positive activities such as further education and work.

In the focus groups and interviews for this evaluation, ISP listed strategies that they had implemented to address transition barriers. Strategies included:

- involvement of external services in supporting ISP clients during their time in the Program
- introducing clients to the new service over a longer period of time
- capacity building in external services, including ISP clinical staff assisting in the implementation of clinical care plans
- recently, identifying possible exit pathways at the time of clients entering the ISP and coordinating exit planning from an early stage.

Staff experienced more success with transitioning clients who had disorders that aligned with existing resources of services, in particular schizophrenia, rather than borderline personality disorder. Staff also found that community services working within a mental health framework were more flexible to develop support around clients' needs. Finally, transitions worked better in services to which ISP had successfully transitioned clients in the past and where ISP staff had established good working relationships, for example with some HASI providers, and some NGOs that were working within a mental health paradigm.

The case studies in Appendix E show how the ISP has managed transitions successfully. For example:

Sara was discharged from a psychiatric hospital to live with her partner in 2013. The ISP developed a service agreement with the couple and provided drop-in support. Sara and her partner had weekly meetings with the ISP case manager, clinical consultant and/or team leader supported living, to discuss staff and support provided and to solve problems. Sara is also under the care of the Public Guardian and financial management. Sara's activities of daily living and engagement with community increased significantly. She also takes her medications and, as a result, has not relapsed. In 2014 the couple transitioned to a local service providing ongoing support to people with intellectual disability.

Lilly moved into a shelter for homeless women while still in the ISP. The ISP provided clinical and case work support to the staff working with Lilly, and ISP recruited support workers from a Chinese NGO for regular drop-in support. When Lilly's independent living skills increased, the ISP obtained an apartment for Lilly adjacent to the Chinese NGO that had been providing drop-in support. In 2010 Lilly exited the ISP and remained in her unit. She had successfully established a support network within the community.

Scott transitioned from the ISP into supported accommodation provided by an NGO. The transition was a collaborative endeavour over seven months, with ISP working closely with the NGO and ADHC region. A comprehensive transition plan was developed, and regular meetings were held to track the progress of transition actions.

This ensured a continuation of Scott's support by a private psychiatrist and a local GP, and a transfer of mental health services to the local mental health team.

5.4 Suggestions for program development

Overall, the perception of staff and stakeholders was that the ISP was well set up to meet the needs of their target group. They identified ways to strengthen and improve the Program in the future, as below. If the ISP does not continue in its current form under the NDIS, these suggestions would apply to any replacement program:

- extend client support timeframes to be responsive to the time each individual needs
- increase the intake capacity of ISP and extend its geographical area
- fill gaps in staff skills and training
- develop options for clients who will require ongoing, intensive support
- establish transition planning as an integral part of the support model from the beginning.

5.5 Summary of processes for supporting clients

- ISP staff and agency stakeholders considered the nomination process effective in identifying clients for whom the ISP was intended. They found that intake information was more comprehensive than in the past because the Program was better known.
- Interviewees observed that the ISP client profile had changed over time, so there were now more people with personality disorders and fewer referred directly from prison. This change reduced client turnover in the ISP, leaving fewer spaces for new clients.
- The ISP approach was considered effective in meeting clients' complex needs. Staff and stakeholders credited the holistic, flexible and integrated service provision in ISP, as well as regular communication among staff, with achieving positive client outcomes.
- ISP interviewees had mixed views about governance changes that brought ISP under ADHC workplace regulations. They felt that the variety of staff experience was restricted and staff training was sometimes delayed, which reduced to some extent the capacity and flexibility of ISP to respond to client needs.
- Due to their multiple and complex needs, many clients need longer than the intended 18-month timeframe for ISP to be ready for transition into other support options. ISP management estimates that about 25 per cent of clients will need intensive, ISP-type support in the long term.
- Finding adequate support for clients outside of the ISP was a major challenge. ISP staff and stakeholders felt that the wider service sector needed further assistance to develop capacity to support people with multiple and complex needs.
- Interviewees were unanimous that the type of support from ISP needed to be continued in some form and ideally expanded to meet the unmet demand to enter

the Program and appropriate options for sustained support to exit the Program. At the same time, sector capacity needed to be increased through training, additional funding and involvement of services with clients while they were still in the ISP.

6 Governance and service system impact

As detailed in section 1.2 above, the ISP is a partnership program led by ADHC and managed together with NSW Health and NSW Housing. A larger Interagency Reference Group (IRG) provides advice to the Program, and accommodation and clinical support staff report to the Program's Director. The detailed governance structure of the ISP is illustrated in Appendix B. This section reports on staff and stakeholder perceptions of the effectiveness of ISP in engaging stakeholders, managing the Program and informing changes to the service system for people with complex needs. It also discusses considerations for the future of the ISP.

6.1 Governance arrangements

At the time of the previous evaluation, staff and stakeholders believed that all relevant government agencies were involved and engaged in the ISP at appropriate levels, and that management and interagency groups were effective overall due to good communication and strong partnerships. The management group benefited from consistency in membership, while some staff turnover in the interagency group reduced the commitment of some agencies.

The current evaluation found that the role of the ISP management committee comprising ADHC, NSW Health and NSW Housing appears to have remained stable. Stakeholders found that this committee, together with the input from ADHC as the main agency and funding body of ISP, was still crucial to the effective operation of the Program and to the development, implementation and monitoring of guidelines and policies.

In the past evaluation, the IRG was seen as central to guiding Program implementation and referrals in and out of the ISP. It appears that the group's involvement has reduced since then. Among the reference group members consulted for this evaluation, many appreciated learning about ISP through case studies of ISP clients discussed at reference group meetings. At the same time, some were unclear about their role in the Program, and they felt they received too little information about the ISP – for example, what it was achieving for which people – to be able to contribute their expertise. This may be partly due to turnover of agency representatives on the reference group.

Some felt that NSW Housing was less involved in the reference group than it had been in the past, mainly because it could not provide clients with priority pathways to accommodation after exiting the Program. At the time of writing this report, the issue is being addressed and NSW Housing and ISP partnerships have resulted in the provision of a unit in Western Sydney and two permanent homes for ISP clients under the 'place to call home' program.

Interviewees also felt that criminal justice agencies had reduced their engagement because the ISP focus had shifted to other client groups (see 5.1 above), and that all agencies had

lost enthusiasm because of the limited opportunities for referral into the ISP. Some noted that the ISP was no longer perceived as a true interagency program since it had been incorporated into ADHC.

Interviewees said that any barriers to effective involvement of external agencies were further heightened by uncertainty about the continuation of the ISP into the future, in the context of the NDIS rollout.

ISP considered the reference group important for ensuring pathways in and out of the Program. This work had been constrained because NSW Government agencies on the reference group had at times not prioritised ISP clients for vacancies in the mental health and disability service systems. Their large agencies had competing demands and saw the clients as non-urgent as their immediate needs were being met by the ISP. Program stakeholders had the impression that the ISP was often seen as a solution rather than a transitional pathway.

A review of the group's Terms of Reference was planned to effect better engagement of the agencies with client development in the ISP. Interim measures might include increased engagement with the group, clarifying its role with the members and providing them with more information about the ISP.

6.2 Informing systemic change

The ISP aims to contribute to changes in the existing service system so that more people with complex needs can be adequately supported outside specialist programs like the ISP. At the time of the previous evaluation, the ISP had contributed to improved coordination between existing agencies, promoted the Program's holistic approach among high-level government staff and advocated for greater flexibility in other government programs' eligibility criteria.

The current evaluation found that the ISP had continued its advocacy activities and engaged in capacity building for NGOs. Examples included:

- lobbying other government agencies to prioritise people with complex needs for available funding packages
- providing specialist training to community-based services and professionals to support clients during and after exit from the ISP
- the ISP's capacity-building initiatives: working in partnership with services to facilitate appropriate client support, e.g. working with hospital staff to develop treatment protocols for particular clients.

The case studies show examples of capacity building in NGOs, such as:

Gina exited the ISP to a group home run by an NGO. ISP conducted training with the new accommodation staff and secured extra funding so the NGO could recruit staff with specialist skills for Gina's model. One year later it was decided that there was no more need for the Public Guardian to be appointed. Gina was settled in her accommodation and with support had increased her independent living skills.

Charlotte transitioned from the ISP to an NGO. Shortly afterwards, concerns emerged

regarding the NGO's capacity to adequately meet client needs, including lack of staff experience, case planning and record-keeping. Charlotte's high-risk and offending behaviours increased again. The Public Guardian supported the NGO to address these issues. Also, staff stability at the house improved, and Charlotte's behaviours settled. She started working five half days a week and attended counselling for absconding and occasional criminal offences.

According to staff and stakeholders, the main barriers to more significant influence of the ISP on systemic change were a shortage of skills and funding within NGOs to support clients with complex needs, and restrictions on sharing information across sectors and services. An example mentioned to illustrate the latter point was that a client might be sentenced to a jail term, and their Public Guardian would find out only by accident that the person was also an ISP client.

6.3 Considerations for the future of ISP under the NDIS

All stakeholders consulted for this evaluation were concerned about the future of ISP in the transition to the NDIS. Interviewees saw the ISP as a unique program whose combination of safe accommodation, therapeutic treatment and life skills training for people with complex needs was essential in filling a gap in the service system. Their concern was that ISP might not continue in its current form, but all interviewees were unanimous that a comparable program was needed – after all, clients had been referred to the ISP because they had not received adequate support elsewhere.

ISP recognised that individual funding provisions under the NDIS would assist with the flexibility of support services for people with complex needs, but they anticipated that the cost would be above NDIA benchmarks. Also, the limitations around housing provision under the NDIS would need to be addressed. Stakeholders felt a program was required that, in whichever form, provided people with complex needs with:

- transitional, high-level support
- pathways to sustainable living arrangements
- long-term, adequate support services tailored to individual need.

According to the interviewees, this would require modified approaches and additional capacities within service provider organisations including:

- multidisciplinary team approaches
- organisational capacity to work with clients with complex needs
- highly skilled staff including trained support workers and clinical specialists
- experienced case managers
- access to suitable accommodation.

Suggestions were to allocate additional funding for people with complex needs, and for capacity building within service provider organisations. Interviewees acknowledged this was expensive, but they considered it less costly than sending clients back into an inadequate service system where, as one interviewee put it, they 'continue to cycle in and out of jail,

emergency departments and transitional housing'. The case studies about non-clients in Appendix E demonstrate this point. Some interviewees recommended setting up separate organisational entities to take over established ISP group homes and continue to work with the clients.

6.4 Summary of governance and system impact

- Compared to the last evaluation, during the timeframe of this evaluation (2011 to 2014), there appeared to be less involvement of the Interagency Reference Group in ISP implementation and in referrals into and out of the Program. Staff and stakeholders said this was due to limited intake capacity of the ISP at the time, restricted options within agencies for offering support to clients after exit, and uncertainty about the future of the ISP under the NDIS.
- Interviewees said the ISP had continued its advocacy and capacity-building activities within the sector. The Program's influence on systemic change was limited by skills and funding shortages within NGOs and restrictions on sharing client information.
- Staff and stakeholders argued that, under the NDIS, the NSW Government needs to consider how to provide adequate support to people with multiple and complex needs. Suggestions included an ISP-style program; additional funding for people with complex needs; enhanced capacity building initiatives in the sector; and continuing ISP accommodation options. After the evaluation ended, new government funding improved resources and system capacity for ISP clients to move on to permanent support options.

7 Economic analysis

The economic analysis of the ISP determined the cost of the Program and compared this cost with the client outcomes achieved. Financial data was provided by ADHC. Data for the previous evaluation covered three quarters, July 2007 to March 2008. The data for this evaluation was from 11 consecutive quarters, including two financial years, 2011–12 and 2012–13, as well as three quarters for 2013–14, up to March 2014. Costs for both current and former clients were included. All figures are presented in 2014 dollars, and values from the previous report have been indexed using the Consumer Price Index (CPI). As the ISP is Sydney-based, the Sydney CPI index was used (ABS 2014).

7.1 Cost

Direct and indirect costs for delivering the ISP included the following categories:

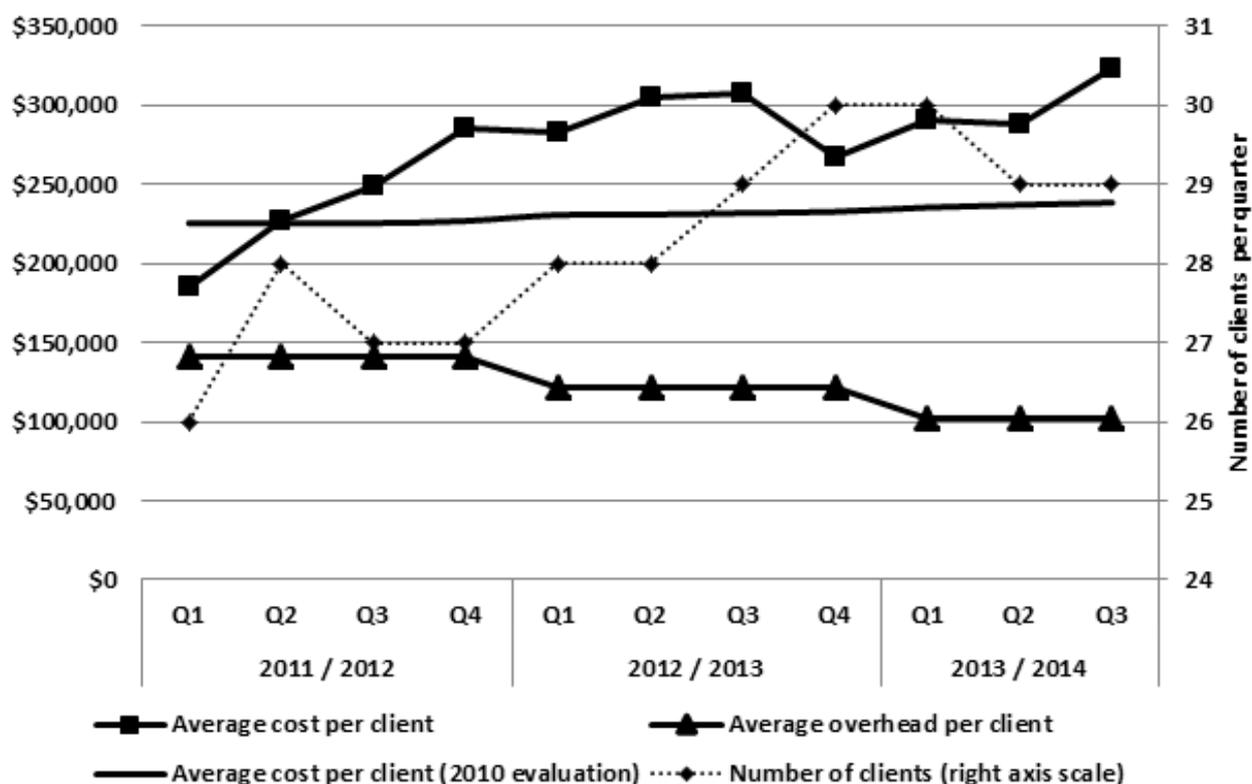
- Operating cost – administration costs for each unit in the Program
- Operating maintenance – property maintenance costs
- Operating rent – property rental costs
- Employee cost
- Program management – administration of the Program, employee and operating costs
- Support services – clinical and case management team
- Supported living management – administration of the supported accommodation stream, includes employee and operating costs.

As in the previous evaluation, client costs included revenue comprising 55 per cent of the clients' disability support pension. This was recorded as a cost offset, but is a minor component, representing approximately three per cent of average support costs.

Average Program cost is presented as cost per client per year, with quarterly figures annualised to make them comparable across the evaluation period. The previous evaluation determined the average cost per client to be \$238,377 per year for the 2007–08 financial year, as presented for comparison in Figure 7.1, with a slight increase over time due to indexation. For the current evaluation period, the average client cost per year was \$273,686 (Figure 7.1), ranging from \$184,650 to \$323,330 per year across the comparative quarters.

Between the two evaluations, average client cost grew by 14.8 per cent. This is likely due to an increase in clients with high support needs, examined below.

Figure 7.1 Average cost per client per year



Source: ISP program financial and client data

In addition to direct support costs, ISP incurred program management costs, including for accommodation operation and maintenance as well as head office staff. Because of the irregular timing of maintenance funding in particular, the average overhead cost per client is presented as an annual average across each year. Figure 7.1 shows that program management costs have decreased year on year, from \$140,497 per client in 2011–12 to \$102,036 in 2013–14. This reflects significant maintenance costs in 2011–12.

The support needs of ISP clients vary significantly, and this is reflected in the cost of their support. Although the support costs for individual clients were not available, the financial data provided indicates in broad terms which clients were relatively high, medium or lower cost, based on their levels and types of support. Cost categories were broadly defined by ISP as follows:

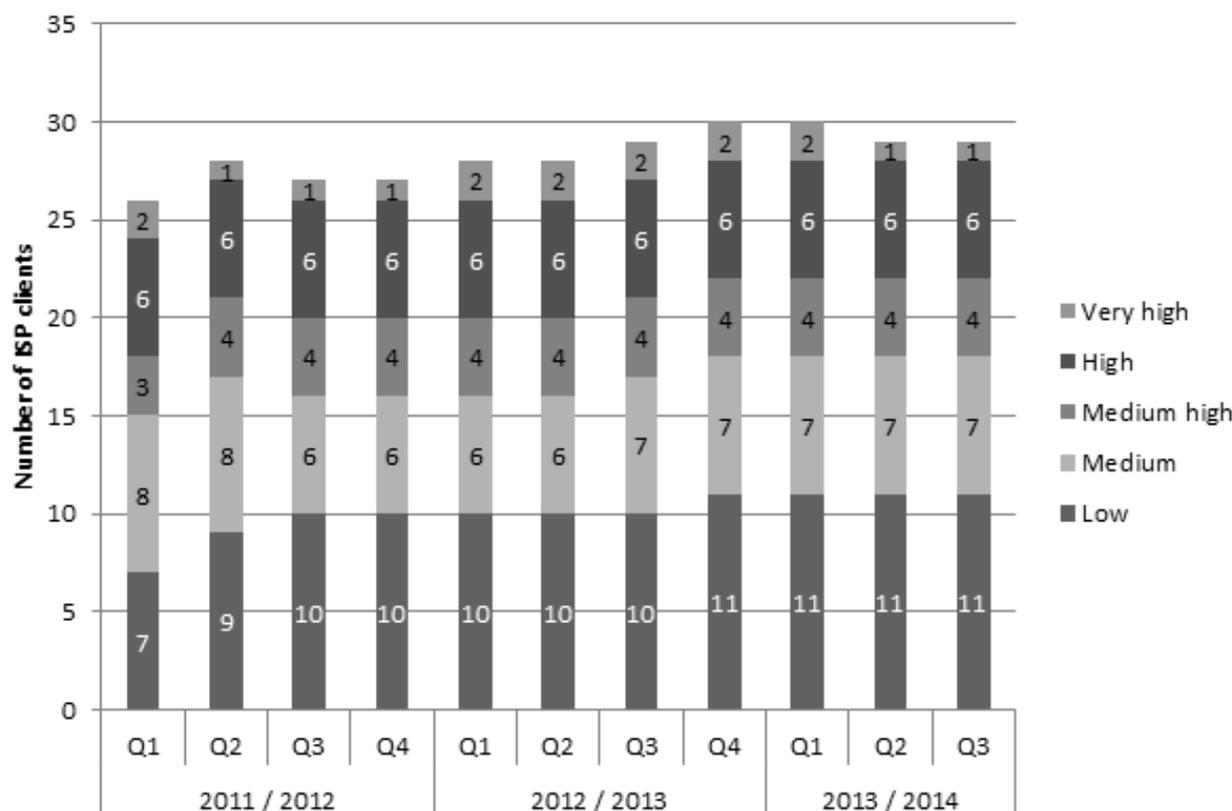
Low cost:	Predominantly drop-in or lower-level group support client
Medium cost:	Client shares support staff
Medium high cost:	Mix of shared and individual support
High cost:	Client receives 1:1 support 24/7
Very high cost:	Client receives more than 1:1 support 24/7

The implication of large cost differences between clients is that small numbers of higher-cost clients can skew the overall program cost and the associated average cost per client upwards.

Figure 7.2 shows the distribution of clients by cost categories. During the 11 quarters

included in this evaluation, the ISP supported two very high-cost clients more than half the time. This may plausibly represent around 20 per cent of direct program costs, and several times the average cost of relatively lower-support clients. The proportions of medium high and high-cost clients were stable, but with consistently more high-support clients, while the medium and low-cost groups partly offset each other, with a slight increase in low-cost clients over the study period.

Figure 7.2 Number of clients by level of cost, July 2011 to March 2014



Source: 2014 ISP program financial and client data

Program costs for non-clients or former clients were not available, but the previous evaluation estimated that support packages for clients post ISP were about one-third lower than during the ISP.

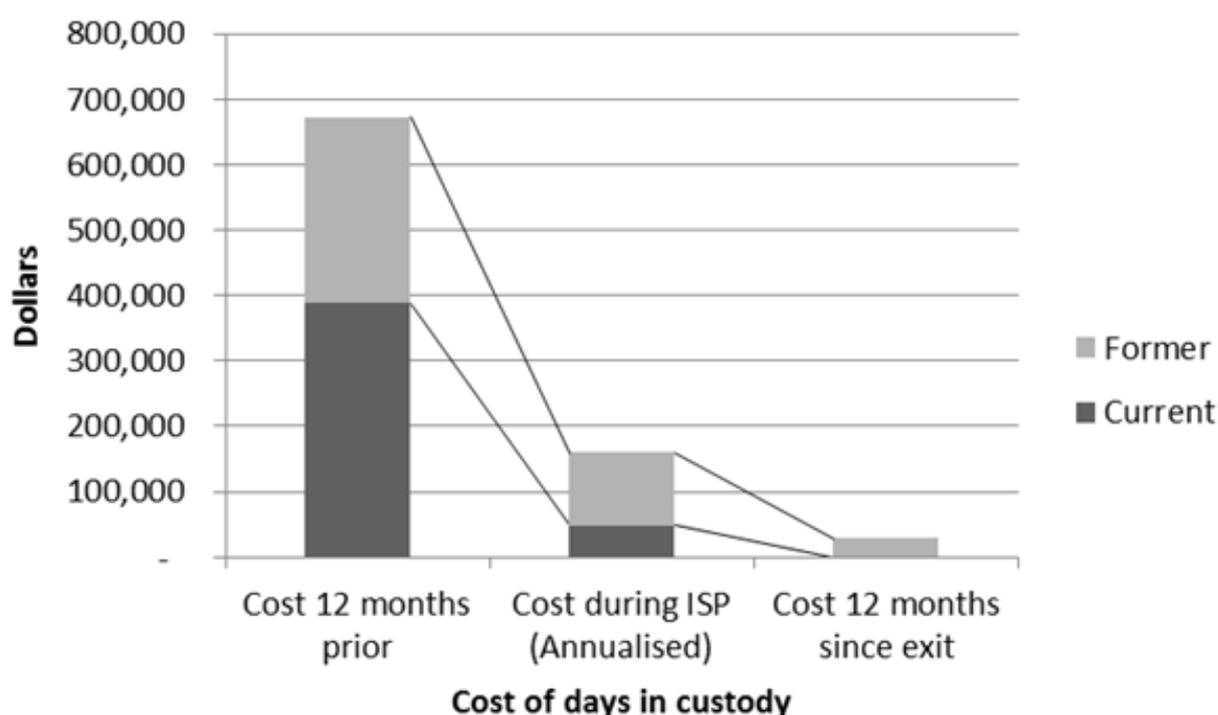
7.2 Outcomes

The ISP intends to address the multiple and complex needs of clients comprehensively so they can exit the Program into stable accommodation and lower intensity support arrangements that ideally involve independent living with mainstream, community-based support services. This outcome generally implies significantly lower service cost than before or at the start of clients' ISP involvement. Experience indicates that ISP reaches positive outcomes for the majority of clients (section 5.2), which is further illustrated by the case studies in Appendix E about former clients. The data analysed in this evaluation has shown that the estimated average yearly cost per client of \$273,686 has resulted in positive client outcomes, summarised below.

The only financial outcomes data available for this evaluation was the cost of ISP clients to corrective services, indicated by days spent in custody. The 2010 evaluation had additional financial data about clients' health service use, but as explained earlier, comparable data was not available for the current evaluation.

As reported in section 4.3, days spent in custody reduced substantially once clients joined the ISP and dropped further after they exited. Department of Corrective Services financial data combined with average cost in custody figures showed a corresponding substantial reduction in cost (Figure 7.3). The estimated cost of days in custody of all ISP clients decreased from \$672,766 in the 12 months prior to entering the ISP to \$159,624 on average per year while in the Program. This was a net saving of \$631,225 per year, or 76 per cent of costs. For the 12 months after former clients left the ISP, there was a further drop in the estimated cost of days in custody to \$29,267.

Figure 7.3 Change in total cost to corrective services



Source: Department of Corrective Services

Note: These estimated costs are based on the average cost per person of one day in custody, which the Productivity Commission Report on Government Services stated as \$188 for 2013–14.

ISP cost outcomes could be further quantified by obtaining service data about former clients that was not available for this evaluation. The secondary health care data from NSW Health that ADHC was applying for at the time of this report (section 2.4) will likely show savings across hospital admissions, emergency departments and community care services, corresponding to reduced health service use while in the ISP (section 4.2). The previous evaluation established that hospital costs reduced by 60 per cent after clients entered the ISP.

As detailed in the previous sections, this evaluation found positive client outcomes in all areas examined. Improvements were consistent with those in the previous evaluation and are summarised in Table 7.1:

- reduced incidents of high-risk behaviour
- reduced contacts with health services
- reduced use of criminal justice services
- increased living skills
- increased social contacts
- slightly increased economic participation
- improved self-assessed health.

Table 7.1 Quantitative outcome data for ISP clients

Outcome type	Data description	Client outcome
High-risk behaviour	Number and severity of incidents	Overall number of incidents declined while in the ISP, number of severe incidents remained stable at a low level
Health service use	Contacts with health services	Number of contacts declined while in the ISP, especially with GPs, psychiatrists and community mental health services
Criminal justice service use	Days in custody	Former clients: 90% decrease of days in custody from pre to post ISP Current clients: 88% decrease from pre ISP
	Probation days	Reduction from 62 per year to 0 (during first 4 years in the ISP)
	Police contacts	Reduction from 10 to 2 per year (during first 4 years in the ISP)
	Days in other diversional programs	Reduction from 5 to 0 (during first 4 years in the ISP)
	Community service days	Reduction from 4 to 0 (during first 4 years in the ISP)
Living skills	Proportion of former clients who increased living skills	Increases during ISP (3 highest percentages only): 41% doing laundry 37% house cleaning 32% cooking
Social contacts	Proportion of former clients who improved social contacts (limited data)	About one-half improved social contacts with parents and siblings
Economic participation	Proportion of clients who commenced paid work, volunteer work, education or training	Between 0% and 28% participation across activities and current/former clients
Health	Proportion of current clients whose self-assessed health improved (limited data)	87% felt their health had improved or remained the same, compared to one year ago

Additional outcomes data available to the previous evaluation in 2010 related to:

- former clients' housing situation – 89 per cent were living in stable accommodation, 81 per cent had a well-maintained physical environment, and 72 per cent paid their rent on time
- personal wellbeing – statistically significant increases were recorded in all areas of personal wellbeing for current clients since entry to the ISP.

Other data presented in the outcomes section of this report is not included in the table above because it is descriptive. It relates to current clients' health and criminal justice service use, and their self-assessed wellbeing.

To assess the long-term effectiveness of the ISP, it would be important to obtain outcome data about former clients at intervals after their exit from the ISP. This data would show whether outcomes are maintained or even improved, and what the associated recurrent cost savings are, thus indicating ongoing benefits from ISP investment.

7.3 Summary of economic analysis

- Over the three years 2011 to 2014, average Program cost per client per year was \$274,000. This was a 15 per cent increase compared to the previous evaluation, probably due to more clients with high support needs in the ISP. Overhead costs decreased during the same three-year period.
- This evaluation found that Program expenditure has resulted in positive outcomes for many clients, including: reduced risk behaviour and use of health and criminal justice services; increased living skills and social contacts; slightly increased economic participation; and improved self-assessed health. Positive outcomes were consistent with the previous evaluation.
- Corrective Services financial data showed substantial cost savings once clients entered the ISP, due to fewer days spent in custody. Total costs for days in custody decreased by an estimated 76 per cent, a net saving of \$631,000 per year.
- All client outcomes were quantified where possible throughout this report, and were illustrated with case studies.

8 Implications

The ISP is an interagency program supporting people with multiple and complex needs that have not been adequately addressed by the service system. This evaluation analysed program and financial data, incident reports, case studies, interviews and focus groups to examine the longer term client outcomes achieved by the ISP and to inform policy makers about effective models of service provision for people with complex needs. It extends a previous evaluation conducted by the SPRC in 2008–09.

This section discusses implications of the findings in relation to the evaluation aims (section 2.1): assessing client outcomes, costs, and processes and governance arrangements of the ISP. It concludes with implications for the service system.

8.1 Client outcomes

The findings establish longer term trends observed in the previous ISP evaluation. Data shows that the ISP achieves a range of positive outcomes for many clients while they are in the Program. Outcomes include: reduced risk behaviour and use of health and criminal justice services; increased living skills and social contacts; and improved self-assessed health. Economic participation outcomes appear more difficult to achieve.

At present there is no systematic data to indicate whether these outcomes are sustained. Longitudinal follow-up of clients after exiting the ISP seems essential to determine whether the Program is effective in improving clients' lives in the long term. Comparable data could be collected about non-clients (those who are referred to the Program but not accepted) to confirm which outcomes can be attributed to the ISP.

8.2 Costs

Program costs are about \$274,000 per client per year. This covers housing, intensive accommodation support, clinical and other support as needed, and case management. Cost effectiveness could not be fully determined as comparable costs for non-clients or former clients were not available. The previous evaluation estimated that support packages for clients post ISP were about one-third lower than during the ISP. This evaluation showed a 76 per cent reduction in costs for days spent in custody after clients entered the ISP and a further reduction after clients left the Program.

Case studies about former clients and non-clients indicate that clients who exit the ISP can live in the community with adequate support and considerably lower cost on the service system compared to before they entered the ISP, and compared to non-clients, who continue to cycle through hospitals, jails and community services that cannot address their complex needs.

Similar to the follow-up for client outcomes discussed above, it seems essential to follow-up service costs for former clients and cost data about non-clients to quantify cost savings to the service system achieved by the ISP.

8.3 Processes and governance

Staff and stakeholders were clearly committed to the ISP. They considered the Program effective in meeting clients' complex needs, and they credited the ISP approach involving holistic, individualised, coordinated and expert support with achieving positive outcomes for many clients.

The main challenges for the ISP have not changed since the previous evaluation. The majority of clients need longer than the intended 18 months to be ready to leave the Program; and once clients are ready to leave, adequate support outside the ISP is difficult to find.

In the last few years, delays in exiting clients have reduced the Program's capacity to accept new clients. Referring agencies have become somewhat less involved in the ISP. At the same time, the Program has undergone significant reform and restructure as it was incorporated into ADHC, causing concerns about the loss in flexibility to respond to client need and to recruit different types of expertise to the Program.

These findings indicate that in the future the ISP, or any similar program, needs to monitor its governance arrangements regularly, to ensure sustained input and commitment by all agencies involved. Within the Program, staff expertise and flexibility of support need to be continually assessed, and training and support arrangements revised if necessary.

Since the barriers to transitioning clients into alternative support persist, the future of the ISP needs to be considered in conjunction with the service system as a whole.

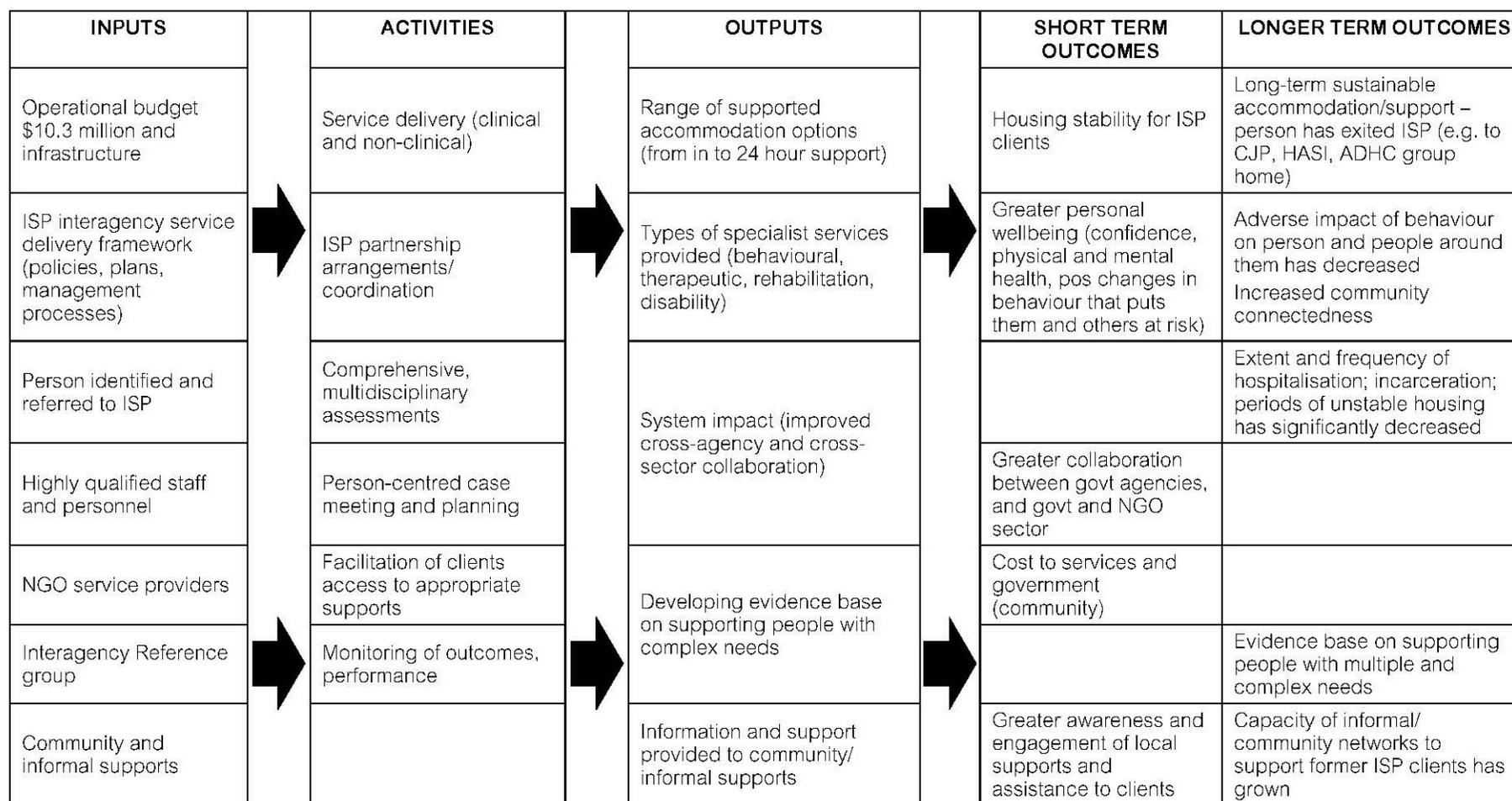
8.4 Service system

The findings presented in this evaluation consistently indicate that the ISP fills a gap in the NSW service system: client outcome data shows that clients' quality of life has improved in the ISP, compared to support they received previously; cost data gives some indication of savings to the service system achieved through ISP support; case studies provide examples of positive client trajectories, compared with people with similarly complex needs who were not accepted into the ISP and continue to be inadequately supported; and ISP staff and stakeholders report ongoing shortage of suitable, alternative support for ISP clients.

The service sector outside the ISP seems to have limited accommodation options and few intensive support services for people with multiple and complex needs. ISP has provided some advocacy and capacity building, but it appears funds and skills within service organisations have been too restricted to effect widespread change.

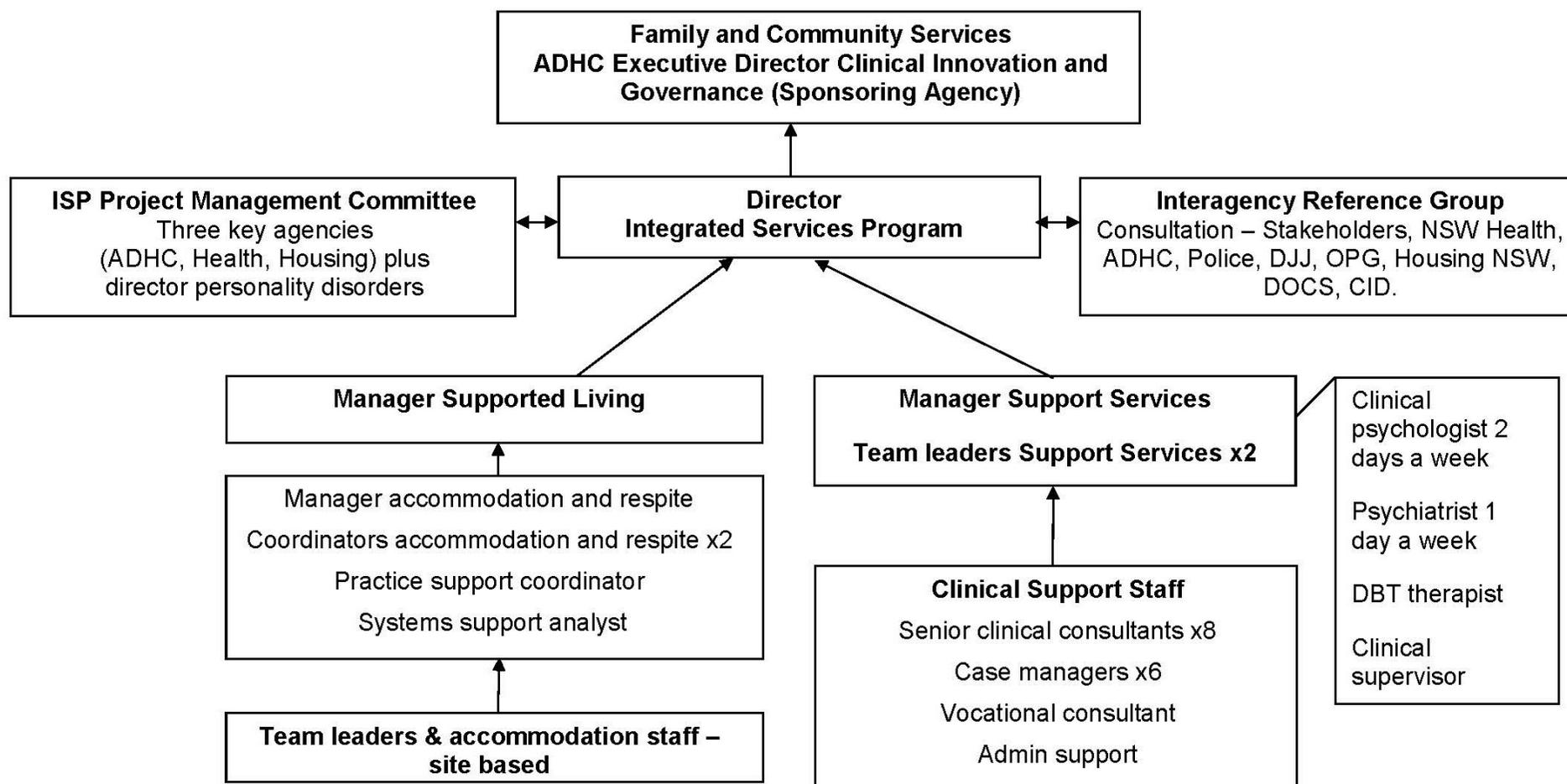
Appendix A

ISP program logic



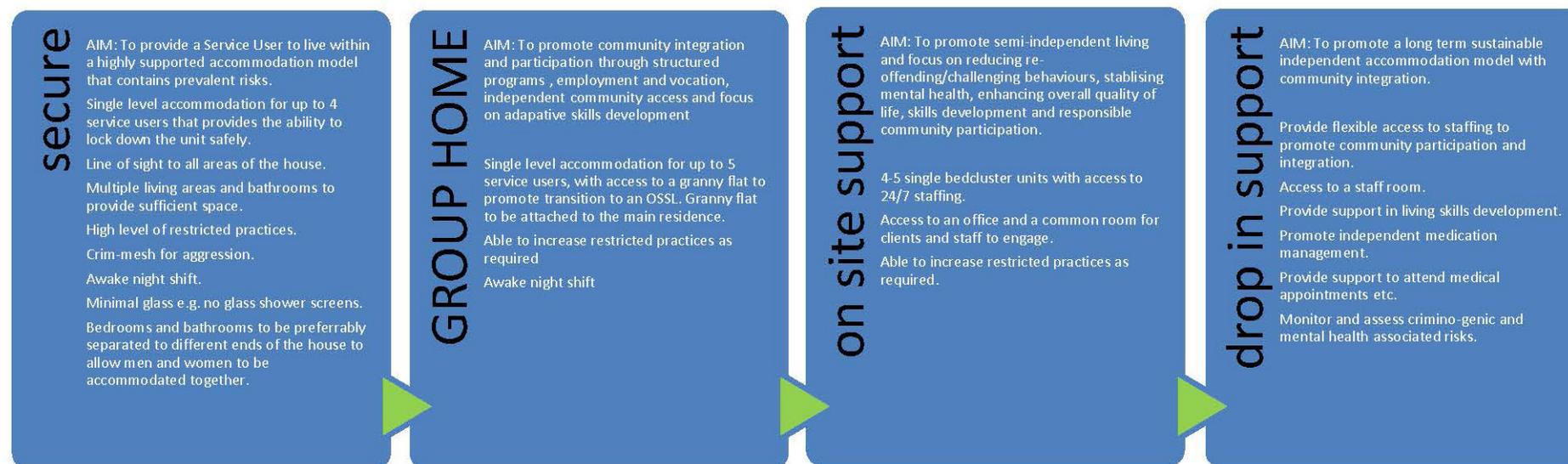
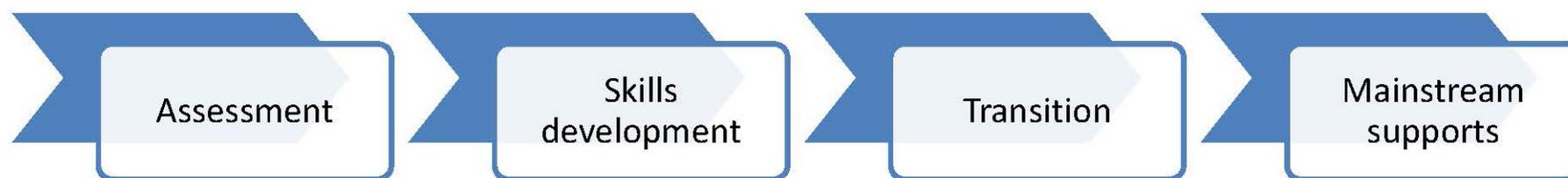
Appendix B

ISP governance structure



Appendix C

Model of ISP accommodation and support services



Appendix D

Data collection tools

Data collection template for current clients

Client information to be collected by ISP – CURRENT CLIENT

Section 1 - Background	
Please answer the following background questions about yourself and the client.	
Person responsible for completing this form	
Unique client record number	
Client date of birth	
Date form was completed	
And how long have the client been involved with ISP services?	(Number of months)
Date moved out or planning to move out of ISP	

Section 2 - Mental health and disability					
Please answer the following mental health, disability and core restriction questions about the client. Please describe in the diagnosis column the type of disability exhibited (if applicable).					
	Level of core restriction (see next page)				
	N/A	Mild	Moderate	Severe	Profound
Primary mental health diagnosis: (put diagnosis here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secondary mental health diagnosis: (put diagnosis here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical disability: (put diagnosis here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual disability: (put diagnosis here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug and or alcohol disorder: (put diagnosis here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acquired brain injury or similar impairment: (put diagnosis here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other physical or cognitive impairment: (put diagnosis here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Disability as core-activity restriction - definitions*Core activities*

The core activities in this schema are communication, mobility and self care.

Levels of restriction in core activities

Four levels of core-activity limitation are determined based on whether a person needs help, has difficulty, or uses aids or equipment with any of the core activities (communication, mobility or self care). The four levels of limitation are:

Profound: the person is unable to do, or always needs help with, a core-activity task.

Severe: the person sometimes needs help with a core-activity task has difficulty understanding or being understood by family or friends.

Moderate: the person needs no help but has difficulty with a core-activity task.

Mild: the person needs no help and has no difficulty with any of the core-activity tasks, but [has minimal restriction(s) and may use] aids and equipment [or other support].

This schema is used by the Australian Bureau of Statistics (e.g. 2003 Disability, Ageing and Carers Summary of Findings, 4430.0)

Section 3 – Health care

From **1 January 2013 – 30 September 2013**, how many times has the client used each of the following health services:

	Number of times used from 1 January 2013 – 30 September 2013
General practitioner/medical officer (# of appointments)	
Psychiatrist (# of appointments)	
Psychologist (# of appointments)	
Drug and alcohol services (# of appointments)	
Other specialists (# of appointments)	
Community mental health services (# of appointments)	
Emergency hospital services (# times visited ER)	
Other hospital services (# of days)	
Allied health services (physiotherapy, dental, occupational therapy, rehabilitation) (# of appointments)	
Other (describe)	

Please describe how the client's service use has changed from **1 January 2013 – 30 September 2013**:

Section 4 – Criminal justice	
From 1 January 2013 – 30 September 2013 , how many times has the client been involved in the following elements of the criminal justice system:	
	Number of services used from 1 January 2013 – 30 September 2013
Police (# of contacts)	
Courts (# days)	
Corrective services (# days in gaol)	
Community service (# days)	
Compulsory drug and alcohol programs (# appointments OR # of days)	
Other diversional programs (# days)	
Probation service (# days)	
Other (describe)	
Please describe how the client's service use has changed from 1 January 2013 – 30 September 2013 :	

Section 5 – Living skills					
Thinking about the client now, how would you rate their level of independence in each of the following self care tasks ? (please tick ✓)					
	(1) = Independent	(2) = Supported less than half the time	(3) = Supported more than half the time	(4) = Fully dependent	(5) = Don't know
Bathing/showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please describe how the client's service use has changed from 1 January 2013 – 30 September 2013 :					

Section 6 – Activities of daily living					
Thinking about the client now, how would you rate their level of independence in each of the following activities of daily living ? (please tick ✓)					
	(1) = Independent	(2) = Supported less than half the time	(3) = Supported more than half the time	(4) = Fully dependent	(5) = Don't know
Cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting to places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using public transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Banking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Budgeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of community services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please describe how the client's service use has changed from 1 January 2013 – 30 September 2013 :					

Section 7 – Social and community participation									
At the moment how often would you say the client has contact with each of the following people? (please tick ✓)									
	(1) = Daily	(2)=More than once a week	(3)=Weekly	(4)=Every couple of weeks	(5) = Monthly	(6) = Every couple of months	(7)=Yearly	(8)=Every couple of years	(9)=Never or NA
Parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings or other relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please describe how the client's service use has changed from 1 January 2013 – 30 September 2013 :									

Please tick (✓) the corresponding boxes relating to the clients social and community participation:

a) What is the client's marital status now?

Married/de facto

Single (never married)

Divorced/separated

Widowed

b) Is the client in an intimate relationship at the moment?

Yes

No

Don't know

c) Has the client made any new friends or renewed relationships with families and friends since 1 January 2013?

Yes

No

Don't know

Why or why not?

d) On the whole does the client get on with the neighbours?

Yes

No

N/A

Don't know

Why or why not?

e) Has the client become involved in any social/community activities (e.g. sporting clubs, local events, bush care, church activities) since 1 January 2013?

Yes

No

Why or why not?

f) Other comments:

Section 8 – Employment, training and education

Please tick (✓) the corresponding boxes relating to the client's employment, training and education:

- a) Is the client doing any paid work?
- Yes
- (If Yes, what type of work?)
- No
- b) Average number of hours per week:
- c) What type of work is it?
- N/A
- Casual/temporary
- Permanent
- Don't know
- d) Is the client currently doing any volunteer work?
- Yes
- (If Yes, what type of work?)
- No
- Don't know
- e) Average number of hours per week:
- f) Has the client currently enrolled in education or training (e.g. TAFE, community course)?
- Yes
- (If Yes, what course is it?)
- No
- Don't know
- g) Average number of hours per week:
- h) Have any of these work or education activities changed since 1 January 2013?
- Yes
- No

Why or why not?

Section 9 – Case summary

Please write a short case summary of the client addressing the following three questions:

From **1 January 2013 – 30 September 2013**, briefly describe the achievements experienced by the client in relation to their progress within ISP.

From **1 January 2013 – 30 September 2013**, briefly describe any setbacks experienced by the client in relation to their progress within ISP.

From **1 January 2013 – 30 September 2013**, how have the future goals and prospects of the client changed or been achieved?

e) How satisfied are you with your personal relationships?

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>										

Completely dissatisfied

Mixed

Completely satisfied

f) How satisfied are you with how safe you feel?

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>										

Completely dissatisfied

Mixed

Completely satisfied

g) How satisfied are you with feeling part of the community?

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>										

Completely dissatisfied

Mixed

Completely satisfied

h) How satisfied are you with your future security?

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>										

Completely dissatisfied

Mixed

Completely satisfied

10.2: Self assessed health

Please ask the client the following questions about health as used by the Australian Bureau of Statistics. We will use this information so we can compare the client to other people and measure change in the person's well being while in ISP. If the client cannot complete this with you, please tick (✓) the appropriate box for him/her:

- a) How do you feel about your life as a whole, taking into account what has happened in the last year and what you expect to happen in the future? Please tell me the number that most corresponds to how you feel.

Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
<input type="checkbox"/>						

- b) In general, would you say that your health is excellent, very good, good, fair or poor?

Excellent	Very good	Good	Fair	Poor
<input type="checkbox"/>				

- c) Compared to 1 year ago, how would you rate your health in general now? Would you say it was much better, somewhat better, about the same, somewhat worse or much worse than 1 year ago?

Much better	Somewhat better	About the same	Somewhat worse	Much worse
<input type="checkbox"/>				

- d) Do you consider yourself to be acceptable weight, underweight or overweight?

Acceptable weight

Underweight

Overweight

Data collection template for former clients

Client information to be collected by ISP – FORMER CLIENT

Section 1 - Background	
Please answer the following background questions about yourself and the client.	
Person responsible for completing this form	
Unique client record number	
Client date of birth	
Date form was completed	
And how long had the client been involved with ISP services?	(Number of months)
Date moved out of ISP	

Section 2 - Mental health and disability					
Please answer the following mental health, disability and core restriction questions about the client. Please describe in the diagnosis column the type of disability exhibited (if applicable).					
	Level of core restriction (see below)				
	N/A	Mild	Moderate	Severe	Profound
Primary mental health diagnosis: (put diagnosis here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secondary mental health diagnosis: (put diagnosis here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical disability: (put diagnosis here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual disability: (put diagnosis here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug and or alcohol disorder: (put diagnosis here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acquired brain injury or similar impairment: (put diagnosis here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other physical or cognitive impairment: (put diagnosis here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Disability as core-activity restriction - definitions

Core activities

The core activities in this schema are communication, mobility and self care.

Levels of restriction in core activities

Four levels of core-activity limitation are determined based on whether a person needs help, has difficulty, or uses aids or equipment with any of the core activities (communication, mobility or self care). The four levels of limitation are:

Profound: the person is unable to do, or always needs help with, a core-activity task.

Severe: the person sometimes needs help with a core-activity task has difficulty understanding or being understood by family or friends.

Moderate: the person needs no help but has difficulty with a core-activity task.

Mild: the person needs no help and has no difficulty with any of the core-activity tasks, but [has minimal restriction(s) and may use] aids and equipment [or other support].

This schema is used by the Australian Bureau of Statistics (e.g. 2003 Disability, Ageing and Carers Summary of Findings, 4430.0)

Section 3 – Health care	
For the selected quarter each year, how many times has the client used each of the following health services:	
	Number of times used by year
General practitioner/medical officer (# of appointments)	
Psychiatrist (# of appointments)	
Psychologist (# of appointments)	
Drug and alcohol services (# of appointments)	
Other specialists (# of appointments)	
Community mental health services (# of appointments)	
Emergency hospital services (# times visited ER)	
Other hospital services (# of days)	
Allied health services (physiotherapy, dental, occupational therapy, rehabilitation) (# of appointments)	
Other (describe)	
Please describe how the client’s service use has changed over time:	

Section 4 – Criminal justice	
For the selected quarter each year, how many times has the client been involved in the following elements of the criminal justice system:	
	Number of services used by year
Police (# of contacts)	
Courts (# days)	
Corrective services (# days in gaol)	
Community service (# days)	
Compulsory drug and alcohol programs (# appointments OR # of days)	
Other diversional programs (# days)	
Probation service (# days)	
Other (describe)	
Please describe how the client's service use has changed over time:	

Section 6 – Activities of daily living					
For the selected quarter each year, how would you rate the client's level of independence in each of the following activities of daily living ? (please tick ✓)					
	(1) = Independent	(2) = Supported less than half the time	(3) = Supported more than half the time	(4) = Fully dependent	(5) = Don't know
Cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting to places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using public transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Banking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Budgeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of community services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please describe how the client's service use has changed over time:					

Section 7 – Social and community participation									
For the selected quarter each year, how often would you say the client had contact with each of the following people? (please tick ✓)									
	(1) = Daily	(2)=More than once a week	(3)=Weekly	(4)=Every couple of weeks	(5) = Monthly	(6) = Every couple of months	(7)=Yearly	(8)=Every couple of years	(9)=Never or NA
Parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings or other relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please describe how the client's service use has changed over time:									

Please tick (✓) the corresponding boxes relating to the clients social and community participation:

- g) What was the client's marital status?
- Married/de facto
- Single (never married)
- Divorced/separated
- Widowed

Did this change since entering your service? If so please explain:

- h) Was the client in an intimate relationship?
- Yes
- No
- Don't know

Did this change since entering your service? If so please explain:

- i) Has the client made any new friends or renewed relationships with families and friends since entering your service?
- Yes
- No
- Don't know

If yes, please explain:

j) On the whole did the client get on with the neighbours?

Yes

No

N/A

Don't know

Has this changed since the client entered your service? If so please explain:

k) Did the client participate in any social/community activities (e.g. sporting clubs, local events, bush care, church activities)?

Yes

No

Has this changed since the client entered your service? If so please explain:

Section 8 – Employment, training and education

Please tick (✓) the corresponding boxes relating to the clients employment, training and education while in the ISP:

- i) Did the client do any paid work?
 Yes
 (If Yes, what type of work?)
 No
- j) Average number of hours per week:
 k) What type of work was it?
 N/A
 Casual/temporary
 Permanent
 Don't know
- l) Did the client do any volunteer work?
 Yes
 (If Yes, what type of work?)
 No
 Don't know
- m) Average number of hours per week:
 n) Was the client enrolled in education or training (e.g. TAFE, community course)?
 Yes
 (If Yes, what course was it?)
 No
 Don't know
- o) Average number of hours per week:

Section 9 – Case summary

Please write a short case summary of the client addressing the following three questions:

From **1 January 2013 – 30 September 2013**, briefly describe the achievements experienced by the client in relation to their progress since entering your service.

From **1 January 2013 – 30 September 2013**, briefly describe any setbacks experienced by the client in relation to their progress since entering your service.

From **1 January 2013 – 30 September 2013**, how have the future goals and prospects of the client changed or been achieved?

10.2: Self assessed health

Please ask the client the following questions about health as used by the Australian Bureau of Statistics. We will use this information so we can compare the client to other people and measure change in the person's well being while in ISP. If the client cannot complete this with you, please tick (✓) the appropriate box for him/her:

- e) How do you feel about your life as a whole, taking into account what has happened in the last year and what you expect to happen in the future? Please tell me the number that most corresponds to how you feel.

Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
<input type="checkbox"/>						

- f) In general, would you say that your health is excellent, very good, good, fair or poor?

Excellent	Very good	Good	Fair	Poor
<input type="checkbox"/>				

- g) Compared to 1 year ago, how would you rate your health in general now? Would you say it was much better, somewhat better, about the same, somewhat worse or much worse than 1 year ago?

Much better	Somewhat better	About the same	Somewhat worse	Much worse
<input type="checkbox"/>				

- h) Do you consider yourself to be acceptable weight, underweight or overweight?

Acceptable weight

Underweight

Overweight

Personal Wellbeing Index for people with intellectual disability

Instructions: Ask client how happy they feel about the following topics. Have them point to the face that best represents how they feel.

Very dissatisfied	Dissatisfied	Mixed	Satisfied	Very Satisfied
0	1	2	3	4
--	-	0	+	++
				

How happy do you feel about:

Respondent rating (0-4):

1. your life as a whole?
2. the things you have? Like the money you have and the things you own?
3. how healthy you are?
4. the things you make or the things you learn?
5. getting on with the people you know?
6. how safe you feel?
7. doing things outside your home?
8. how things will be later on in your life?

Topic guide for focus groups and interviews with ISP staff and other agency stakeholders

The topics cover the processes and outcomes of ISP. Only questions relevant to the group participants will be asked.

Governance

1. Are all relevant agencies represented at appropriate levels in the current governance arrangements?
2. What are the critical factors or barriers to engaging relevant stakeholders?
3. How effective are current processes for planning, monitoring and reviewing the project? What could be improved?
4. Has the ISP been successful in affecting system-level change in service provision for the target group? (e.g. more coordination, flexibility, integration with NGOs, advocacy groups and community services?)

Operation/management of support provided

5. What works and does not work so well in the operation of the ISP?
 - a. nomination and referral processes
 - b. service model (flexible, individualised, multidisciplinary)
 - c. level of funding and support provided (adequacy)
 - d. program management (communication, service integration)
 - e. staffing (levels, skills, consistency)
 - f. transitioning clients out of the program
 - g. other issues?
6. Has the ISP changed over time and why?
7. Do current management arrangements support leadership and accountability?
8. Are there any legislative or industrial factors assisting or inhibiting provision of services to ISP clients?

Outcomes

9. What are the main benefits of ISP for clients (e.g. housing stability, health, wellbeing, social connections)? Can you give examples?
10. Are these benefits sustained in the longer term?
11. What are the main downsides of ISP for clients (e.g. loneliness, isolation, vulnerability, hospitalisations)? Can you give examples?
12. Do some types of clients benefit from ISP more than others?
13. Does the program reach its target group? Are any groups of people missing out?
14. Why have clients left the ISP? What happened to the resources – housing, furniture & funding?
15. Has adequate data been available to monitor client progress and outcomes?

Overall

16. What ISP support could be provided in the context of NDIS packages?
17. Are there any other experiences or issues with the implementation of ISP that you'd like to be reflected in the evaluation?

Personal Wellbeing Index (PWI) qualitative questions

Process

- A. Team Leader to identify most appropriate staff to discuss the questionnaire with each client.
- B. This questionnaire is to be offered to all clients to complete on a voluntary basis. The Team Leader will have discretion as to whether it is helpful to present to this adapted questionnaire to clients who have completed the previous questionnaire.
- C. Team Leader to work with identified staff around the best method of delivery or discussion depending on the individual client’s known interaction style and preferences.
- D. Please record your client’s response to engaging in the process by completing the questions at the bottom of this form.
- E. The forms are to remain de-identified for SPRC. Please identify the client by the Evaluation code only. Their code is provided to you with this form.

Topic	Question	Response/Comments
Satisfaction with life as a whole	Are there any good things happening for you in your life at the moment?	
	If yes, could you please tell us what they are?	
	If no, what do you think would help you?	
Health Satisfaction	Do you feel healthy at the moment?	
	If yes, what had made you feel healthy?	
	If no, what do you think would make you feel healthy?	
Goals/Achievements	Do you have goals or specific things you want to achieve at the moment?	
	If yes, are you how are you going with them?	
	If you have goals but are not achieving them, what do you think is getting in the way?	
Standard of Living	Are you happy with where you live at the moment?	
	If yes, what is making you feel this way?	
	If no, what is making you feel this way?	

Relationships	Are you happy in your relationships with? <ul style="list-style-type: none"> • Staff • Co residents (if applicable) • Family • Friends • Significant others 	
	If yes, what has contributed to you feeling happy in your relationships?	
	If no, what has affected your relationships?	
Community	Do you feel you are part of your community?	
	If yes, what has contributed to this feeling?	
	If no, would like to be part of your community and what help do you think you need to feel this way?	
View of the Future	Do you have plans for your future e.g. where you would like to live, career, health, relationships	
	If yes, do you think you are on your way to achieving your plans and what has facilitated this?	
	Are you hopeful about your future?	

Staff questions.

Did the client voluntarily engage in the process?

Please describe the setting which facilitated their engagement? (eg, client meeting, community outing etc)

How did the client feel about completing the questionnaire? (Was this based on their express views or your observations?)

Thank you for facilitating the completion of this questionnaire with your client.

Appendix E

Case studies

Claire (current client)

Claire is a middle-aged woman and has mild intellectual disability, severe borderline and anti-social personality disorder, and she experiences psychotic hallucinations during extreme stress. Claire also has a history of poly-substance abuse, including alcohol, cannabis and amphetamines, and she shows impulsive and aggressive behaviour while under the influence of alcohol. Claire reports hearing voices that command her to harm herself and others.

She was incarcerated repeatedly from the age of 16 following convictions for stealing, malicious injury, armed robbery and assault. Since receiving support from the ISP, Claire has not had any formal criminal charges.

Claire is a long-stay resident with ISP (more than three years), where she receives support to manage the risks she presents to herself and others. This includes restricted access to household items she may use to self harm and support to access the community. She has made significant gains around managing her risk and developing her independence, including a reduction in self harm and hospital presentations, gains in emotional regulation, and increased adherence to treatment. Claire now has reduced supervision in the community for leisure activities and grocery shopping.

Factors that have contributed to Claire's progress and improved emotional stability include a highly-structured therapeutic setting in a low-stimulus environment, and daily and weekly routines involving a mix of skill development activities, daily living activities, individual therapeutic sessions and recreation. Claire has been supported by the ISP to control her diabetes through diet rather than medication, and she manages ongoing issues after surgery for constipation with the support of the local hospital.

There have been differences of opinions with significant others in Claire's life regarding the ongoing medical care and support needs for Claire. This has created an internal conflict for Claire, often making her feel as though she needs to choose between her service provider and significant others. The Public Guardian has identified roles and responsibilities around Claire's care.

Claire's goal is to find suitable long-term support. The ISP has identified a service provider and is negotiating appropriate services for Claire so that she can maintain the significant gains she has made while with the ISP.

Graham (current client)

Graham is a 37-year-old man with treatment-resistant schizophrenia, borderline intellectual functioning and a long history of poly-substance abuse including amphetamines and alcohol. Graham has had several hospital admissions due to drug-induced psychosis.

His relationship with his family broke down when he was 19 years old and he became homeless. He led a transient lifestyle, residing in a number of mental health facilities and boarding houses until early 2009, when he entered a psychiatric hospital. In March 2010 he transitioned into the ISP.

Initially in ISP, and as a consequence of his mental illness, Graham misused multiple substances, left frequently, behaved aggressively, did not take medication and engaged poorly with support staff. ISP provided 24/7 staff support, organised a clinical consultant through NSW Mental Health, and provided case management to support Graham to access appropriate services, maintain his family contact, manage his emotions, and to seek employment and enrol in TAFE courses of his interest.

ISP staff have supported Graham to budget and cook his own meals, access the community independently with public transport and take his medication daily. His aggression and leaving the accommodation have reduced. He does not take drugs and reports that he drinks two 2 bottles of beer once or twice weekly. Since coming into ISP, he has reconnected with his mother and his own teenage child.

In order to gain further independence, Graham was recently transitioned into an ISP step-down model, a small group home with 24/7 staff support but fewer restrictions and the option of reduced staff support as clients develop their skills for independent living. Graham would like to move out of ISP to live in a social housing unit so that he is able to invite his friends and family and have his teenage child stay on weekends.

Julia (current client)

Julia is 31 years old and at age 11 moved to Australia with her family. She contracted encephalitis at age 14, resulting in a brain lesion, and she has schizoaffective disorder and a personality disorder.

Julia used various drugs (amphetamines, cocaine, marijuana, heroin, methadone and benzodiazepines), was repeatedly hospitalised for drug-induced psychosis and has had long-term rehabilitation stays in mental health facilities. Julia has not been able to sustain tenancies.

Julia is a long-stay client in ISP and is not ready to leave. She receives case management and clinical support and vocational case management. Julia has also engaged in direct therapy throughout her time in ISP, but this has been difficult due to her limited concentration and impulsivity. Julia's mental illness causes behaviours such as substance abuse, impulsivity, poor emotional regulation, seeking admission to hospital or interaction with emergency services, inability to foresee consequences of actions, self harm and seeking sexual relations and affection from strangers.

Her progress in ISP has recently deteriorated, and ISP is working with NSW Health to identify the cause and appropriate treatments. Meanwhile Julia is receiving a higher level of support.

At this point, ISP has not been able to identify a funding source that would provide Julia the opportunity to exit to an appropriate model of support. She is not eligible for direct services provided by Ageing, Disability and Home Care. Community Mental Health have deemed that mental health services may not be appropriate because her challenges primarily result from brain injury and personality disorder. ISP is continuing to look for a funding source.

John (current client)

John is 38 years old, has mild intellectual disability, psychosis, borderline personality disorder with dependent personality traits, schizophrenia and complex post-traumatic stress syndrome. John came to ISP after a long stay in a mental health unit. He has displayed high-risk behaviours including absconding, physical aggression towards others (including ISP staff and his extended family), fire-setting and damaging property. He often acts impulsively and erratically when experiencing psychotic episodes; and he frequently has explosive outbursts of anger towards objects.

After entering the ISP, John resided in a 24/7 group home for two years, but then his mental health deteriorated, and he has benefited from a long stay in a mental health unit to stabilise. Since then John's behaviour has improved, through structured routines involving skills-building and pleasurable recreational activities. His psychosis is managed through medication and grounding techniques to reduce his anxiety. Further, John receives ongoing psychological support from a clinical psychologist, building his distress tolerance and increasing his ability to recognise and manage his mental health symptoms.

Over recent months John has received support from the ISP to explore education and employment opportunities. He attended a philosophy class at a local mental health day centre, and he has secured work in a supported employment placement.

Sara (current client, ready to transition)

Sara is 23 years old, has moderate intellectual disability and schizophrenia, and had bipolar affective disorder in the past.

When accepted into the ISP, Sara needed and agreed to ISP support. However she insisted on living with her partner rather than in a group home. The ISP developed an outreach program with Sara and her partner and provided drop-in support and implementation of skill development and behaviour support. This initially consisted of two staff for 4 hours per day and later increased to one staff 6-8 hours per day. Following the increase of support hours, Sara's activities of daily living and engagement with community increased significantly. Sara also takes her medications and as a result has not relapsed since her discharge from hospital.

Sara and her partner had weekly meetings with the ISP case manager, clinical consultant and/or team leader supported living, to discuss staff and support provided and to solve problems.

A local service providing support to couples with intellectual disability was sourced to provide ongoing support to Sara and her partner. The couple were referred and accepted into this program in February 2014 and transitioned to the new support.

Philip (current client, ready to transition)

Philip is a middle-aged man. He has a mild intellectual disability acquired at birth, experienced significant physical and sexual abuse throughout childhood and has had poor mental health throughout his adult life. He was in prison repeatedly and otherwise lived an itinerant lifestyle, doing whatever it took to survive. He experienced significant substance abuse issues, was predominantly homeless and had no support from family or friends.

Upon entry to the ISP, Philip initially received a high level of direct staff support and clinical support, which was reduced over time. Staff supported Philip to learn how to lead a positive life in the community, through role modelling, practising problem-solving skills and promoting community integration.

Clinical services supported Philip to engage in psychological therapy and supported the model of behaviour intervention that direct support staff used in their interaction with Philip. Case management services developed a plan on how to meet Philip's needs in the present and future. This included sourcing a long-term service provider and finding stable accommodation for Philip.

Since joining the ISP, Philip has made substantial progress in developing his skills and leading a crime-free life. Philip has ceased all substance abuse, is maintaining his own social housing, improved his mental health and has not been charged for any offence since entering the ISP. He also completed a therapeutic intervention program to address his offending behaviour.

Philip is pleased with the significant gains he has made in his life since entry to the Program. He reports that ISP persisting with him, being patient and providing unconditional support has enabled him to achieve things he never thought he could. Philip has a determination to do well, improve his situation and stay out of trouble. He is appreciative of the opportunity and new start ISP has assisted him with.

Philip was due to transition out of the ISP in 2014. He will continue to reside in the social housing he found while in ISP and receive drop-in support funded through ADHC.

Louise (current client, ready to transition)

Louise is a middle-aged woman who has Asperger's syndrome, anxiety and obsessive compulsive disorder. Louise has for a long time used behaviours that put her at risk. Prior to entering the ISP, there were daily incidents resulting in admissions to hospital, psychiatric care and frequent use of emergency services.

When Louise entered the ISP, she received 24/7 support involving a detailed transition plan to support her move. A comprehensive clinical assessment was completed to inform an individualised behaviour support plan to manage Louise's behaviours of concern. Louise also met weekly with a senior clinical consultant to learn structured problem solving.

Since being with the ISP, Louise's incidents have vastly diminished due to consistent care by the support staff and Louise's efforts to engage with the program. Louise has indicated she now feels validated, has awareness of her behaviour and can better manage her anxiety. Louise enjoys more independence, trust, living skills such as budgeting, cooking and cleaning, communication with others and closer family connections.

Louise has been ready to return to her local region for some time and has been engaged in services in that area. This is in line with her personal goal to return to where she grew up, closer to her family. Louise will need supported accommodation with access to 24 hour staffing (awake night shift), a consistent staff team, a thorough client compatibility assessment and a slow transition, with service capacity for Louise to return to her high support model if required.

Rick (current client, ready to transition)

Rick is in his thirties. He has schizophrenia, acquired brain injury and mild intellectual disability. Rick was neglected and abandoned and made a ward of the state at 13 weeks.

At 14 months old Rick was adopted. As a child, he showed behaviours that put himself and others at risk, including uncontrollable outbursts of anger. His adoptive family asked Rick to leave when he was 13 years old. For the next two years Rick attended a special boarding school, from where he was expelled at the end of Year 8 due to his behaviour.

From that time until he entered the ISP, Rick received little support from services and had unstable accommodation. Due to behaviours, including self harm, soliciting prostitution, weapons possession and arson, all accommodation or supports that were arranged for him broke down. Rick had an extensive offending history (116 convictions between July 1993 and June 1997) and regularly used heroin, marijuana and amphetamines. He stole cash to pay for drugs and to survive.

Since joining the ISP, Rick has developed strategies to manage his behaviour and has learned independent living skills. He has engaged in treatment for his heroin addiction and receives ongoing psychiatric support from his local community mental health team. Rick regularly and voluntarily takes prescribed psychotropic medication for the management of his schizophrenia.

Rick has not displayed any risk behaviours since receiving support from the ISP, and his offending has practically stopped. There has been one recorded offence (theft), which was dismissed due to his mental illness.

Rick has secured a supported employment placement, where he has worked for six years for four half-days per week. He has taken on responsible roles in his workplace in addition to his core work.

His independent living skills include tidying, cleaning, using the washing machine, mopping and vacuuming floors, making beds, washing and drying dishes, meal planning, cooking and making relevant phone calls. He also uses public transport and independently attends medical appointments at Community Mental Health. Rick can access the community without staff support, although behavioural concerns still exist.

Rick is ready for transition from the ISP. Funding has been secured for dedicated support at key times, but a suitable placement has not yet been found. ISP has provided his profile to several non-government organisations; however all have deemed him not suitable due to the complexity of his needs.

Jane (former client)

Jane is in her thirties and has mild intellectual disability and personality disorder, probably with borderline and histrionic traits. Due to the complex presentation of her symptoms, her diagnoses have been questioned by various psychiatrists. She also has cerebral palsy, reduced muscle tone, impaired renal function, vision and hearing deficits, and difficulty discriminating background noises.

Jane has had a complex history of abuse and trauma. She experienced four periods of imprisonment due to aggression, public nuisance, nudity in public places, and entering enclosed lands. Prior to entering the ISP, Jane had been formally charged with 48 offences and spent 14 occasions in custody.

The ISP assessed that the service providing support to Jane at the time did not have the capacity to meet her complex needs. Jane moved to an alternative residential placement operated by an NGO, a group home with 24 hour staffing support. Jane received support from the ISP to address the behaviours that were putting herself and others at risk: aggression, stripping in public, running away and contacting emergency services. The support included ongoing access to a psychiatrist, identifying Jane's goals and developing suitable pro-social strategies.

There was a marked decline in Jane's risk behaviours, with five recorded offences during her involvement with ISP. Jane wanted to build a life for herself, which included returning to the area where her family lived, participating in leisure and vocational activities, and taking care of herself.

When Jane exited the ISP, it was unclear whether the Program was going to continue, and her support was transferred to the ADHC Community Support Team while she continued to receive accommodation services from the NGO. In 2011 the NGO service deemed they could no longer support Jane due to the severity of her behaviour, which included an increase in property damage. At this time Jane briefly returned to custody and was then accepted into another specialist program, where she has continued to receive specialist accommodation and behaviour support.

Gina (former client)

Gina is a middle-aged woman. She has obsessive compulsive disorder, mild developmental delay, Tourette's Syndrome, possibly borderline personality traits, and she reports an acquired brain injury. Her father was allegedly verbally and physically abusive towards her mother. Between 21 and 41 years of age, Gina had unstable accommodation due to verbal aggression, property destruction and her inability to manage daily tasks. She did not have adequate mental or physical health care.

In her initial placement with ISP, Gina did not engage with support. Another ISP accommodation option was identified to respond better to Gina's needs, with staff who had more experience, but she frequently left her accommodation, was verbally aggressive, destroyed property and set part of the house alight.

By the end of 2010 Gina attempted to live with her sister, but this arrangement broke down. Gina was charged with malicious damage at her mother's and sister's houses, placed in custody, and her mother and sister took an Apprehensive Violence Order (AVO) against her. Following this, Gina was admitted to a psychiatric hospital, after presenting with psychiatric symptoms and declining treatment while in custody. During Gina's 12-month admission the ISP remained in place, providing her with consistent drop-in support. ISP also identified and secured a suitable accommodation model.

Gina formally exited the ISP and transitioned successfully to a group home run by an NGO. ISP conducted training with the new accommodation staff, and this was reported to be useful for the staff. Extra funding secured by the ISP allowed the NGO to recruit staff with specialist skills for Gina's support needs.

The Public Guardian conducted a client visit with Gina, where there appeared to be no issues of concern. Gina had been taking her medication, was in contact with her sister, managed domestic tasks and attended outings. She was settled in her accommodation, and there were no restrictions in place. It was decided that there was no need for the Public Guardian to be appointed. Gina had been progressing well and was regularly attending activities at two community centres. She stayed at her mother's every second to third weekend with no issues or concerns. The service had successfully completed travel training with Gina to two different locations and in the process supported Gina to manage issues that were unsettling for her.

Lilly (former client)

Lilly is a middle-aged woman who has schizophrenia with secondary depression. Lilly was a child refugee, displaced from her immediate family and eventually abandoned by her extended family in Australia. Prior to ISP, she appeared withdrawn, timid and declined to engage with service providers. For a long time, her native language was not identified, which compounded the difficulties engaging with her. No diagnosis or assessments were made, leaving Lilly ineligible for funded disability services and most supported accommodation options. Lilly displayed symptoms of deteriorating mental health, which included eating out of garbage bins, hoarding food scraps and rubbish in her room, and bad hygiene.

Once in the ISP, Lilly went to a psychiatric hospital, and with the support of psychotropic medications she became more communicative and informed staff of the symptoms she experienced. An ISP clinical consultant visited Lilly weekly to build rapport and communicate with her using her home language. The clinician also helped with communication with other service providers. ISP aimed to ensure Lilly's basic needs such as safety were met and then worked with her to regain essential living and self-care skills lost due to years of displacement.

In June 2008, when Lilly's mental health appeared to have stabilised, ISP negotiated for Lilly to transition to a shelter for homeless women. ISP then provided clinical and case work support to the staff working with Lilly, and ISP recruited support workers from a culturally relevant NGO for regular drop-in support.

With the help of the support workers, Lilly rapidly regained most daily living, self-care and community living skills. As she had access to fresh food, she gained cooking skills and ceased eating out of the bin. Lilly independently accessed the bank to collect her pension money three times a week, and with a regular income her hoarding behaviour diminished.

The ISP obtained a two-bedroom unit for Lilly, adjacent to the NGO that had been providing drop-in support. At the same time, Lilly began to visit a private psychiatrist for medication reviews and was compliant with her medication regime.

Lilly exited the ISP and remained in her unit. She had successfully established a network of support within the community that included attending a community group and accessing a pharmacist, dentist, doctor and psychiatrist. Most of these service providers were able to communicate with her using her language. Lilly had also established an active weekly schedule, including working two full days, attending a community English class, volunteering at an elderly community group and participating in a dance group.

Scott (former client)

Scott is in his thirties and has intellectual disability. He attended mainstream local schools until age 8 and completed his education at a special school. Scott lived with his family until his parents' separation, due to his father's alcoholism and abuse, when Scott was 20 years old. Due to Scott's own aggression and alcohol abuse, he moved into a boarding house at the age of 23 years. Scott continued to misuse alcohol and other drugs, often resorting to prostitution to earn money. His functioning deteriorated, and after coming into contact with the criminal justice system, he was placed in a large residential centre for people with intellectual disabilities. Shortly after that he entered the ISP.

Following an assessment and implementation of a behaviour support plan, all of Scott's risk behaviours reduced. This was achieved through providing a stable, structured and consistent environment where Scott felt supported and safe. Scott had opportunities to engage in meaningful pro-social activities, which facilitated access to the wider community and social contacts. He was also supported to access psychiatric services through his local community mental health team.

Scott moved through three accommodation settings while in ISP, each move preparing him for his transition back into the community. As no suitable places outside the ISP were found in the area where he wanted to live, Scott exceeded the planned period in the ISP by four years.

In November 2012, Scott transitioned into supported accommodation provided by an NGO. The transition was a collaborative endeavour over seven months, with ISP working closely with the NGO and the ADHC region. A comprehensive transition plan was developed, and regular meetings were held to track the progress of transition actions. This ensured a continuation of Scott's support by a private psychiatrist and a local GP within his area, and a transfer of mental health services to the local community mental health team.

Charlotte (former client)

Charlotte is in her thirties and from a non-English speaking background. She has moderate intellectual disability, borderline personality disorder and significant communication and language delay. Charlotte grew up in a large extended family. When she was 6 years old, her immediate family moved while she remained with her grandmother. From a young age she showed oppositional behaviour and repeatedly left home, which her family attempted to manage through strong discipline.

From the age of 13 years Charlotte engaged in high-risk and criminal behaviours, including prostitution, drug use and stealing. At the age of 15 years she received her first criminal charges, and from then on she was in and out of accommodation services and prison.

When Charlotte entered the ISP, her model of support involved a high level of restrictions regarding community access and alcohol, as well as room, bag and personal searches. For example, Charlotte was allowed to access the community only with two support workers, as there were concerns about her vulnerability to sexual exploitation, and because she had been involved in stealing and breaking into houses.

Charlotte began working 3 days a week and attended TAFE to increase her skills in numeracy and literacy. Through ISP support, Charlotte's offending behaviour decreased over time, and her engagement in work and social and recreational activities improved.

Charlotte transitioned to an NGO placement. One year later, concerns emerged regarding the NGO's capacity to adequately meet her needs, including lack of staff experience, case planning and record-keeping. Charlotte's high-risk and offending behaviours increased again. The Public Guardian supported the NGO to address capacity issues and monitor Charlotte's wellbeing as there were some ups and downs. The placement finally stabilised. A family member was appointed as a private guardian, and Charlotte's current circumstances are unknown.

Petra (former client)

Petra is a 40-year-old Aboriginal woman who has suffered multiple trauma and severe anxiety. She lived in numerous foster homes from the age of 2 years and experienced physical and sexual abuse. She has a history of drug and alcohol abuse, admissions to psychiatric facilities for self harm and anti-social acts, and she has a criminal record with serious offences. Just prior to entering the ISP in September 2005, Petra had been released from a 6-year prison sentence.

The ISP support included restricted access to the community, fire lighting equipment and other dangerous items, buses, alcohol, as well as room, bag and personal searches. Under the Positive Sanction Model Petra had to demonstrate appropriate behaviour to reduce restrictions. She also received clinical and therapeutic support to manage her fears and her obsession with buses.

Over her time with the ISP Petra's anxiety symptoms and behaviours decreased. She achieved partial independent access to the community, such as walking to the local community radio station, attending TAFE and the gym, going to the local pub and going to church services with staff assistance. Petra succeeded in TAFE's remedial literacy and numeracy classes and enjoyed vocational experience at the community radio station, which also helped her establish contacts with her Aboriginal culture.

However Petra's leaving the accommodation increased and other symptomatic behaviours remained, probably because accessing the community also exposed her to potentially anxiety-provoking situations.

When Petra exited from the ISP to an NGO service, the accommodation and service model remained the same. It was regularly reviewed by clinicians, given the high restrictions inherent in the approach, and it was upheld because Petra left the accommodation at every opportunity. Some years later Petra again left her group home and, although body searches had been carried out, was able to hide a lighter and set fire to her room. The group home was severely damaged and the other resident and staff were at significant risk. Petra was charged by police with arson and intent to harm, and she is currently in prison.

Contributing factors may have been reduced clinical support at the NGO compared to ISP, less group home staff training and fewer case management meetings; and a lack of engaging Petra in positive activities such as further education and work.

Petra was referred to an appropriate support program, but the application was rejected. An appeal is being considered.

Garry (non-client)

Garry is a middle-aged man. He has acquired brain and spinal cord injuries from a motorbike accident, and he has osteoporosis. After the death of his father, Garry began abusing alcohol and stopped his vocational and leisure activities and has come into contact with the criminal justice system. His disabilities have not been well supported in custody.

Although he has been able to live in his own home, the support available did not address his complex physical and mental support needs. He became socially isolated, suspected to misuse alcohol and be involved in criminal activity. Garry declined to engage with services, was verbally and physically aggressive to service providers, and threatened to become homeless and commit suicide. Garry showed extensive emotional needs and the effects of a brain injury that reduced his ability to link actions and consequences. He also developed significant health issues for which treatment broke down due to behavioural problems.

Garry was not accepted to ISP as the panel considered him 'at lower priority on the basis of ... homelessness, timeliness, immediacy of need and placement availability'.

Since then there has been no progress in addressing Garry's complex support needs.

Garry says he is dissatisfied with the services he has received over the years. Services have not been able to engage him either in treatment for his pressure sore and bone infection, or in case management for his mental illness. Garry requires surgery for his wound, but before this can happen he needs suitable supported accommodation, potentially in a group home.

Hypothetical ISP support: ISP would consider the impact of Garry's brain injury on his emotions and behaviour. An ISP clinician would work with Garry to explore his views around his surgical needs and develop strategies that would help Garry tolerate the requirements of successful treatment. An assessment of Garry's alcohol and drug use would include the emotional impact of the death of his father. Grief and loss – relating to the death of his father and his motorbike accident – would be explored and appropriately treated.

Ian (non-client)

Ian is a middle-aged man. He has a moderate intellectual disability and a severe personality disorder with borderline and anti-social features. Schizophrenia has been diagnosed at various times, and repeated self harm has been a major concern. Ian has misused multiple substances over many years. He has chronic pain issues that have exacerbated opioid abuse.

Due to family instability and trauma he grew up in a series of foster placements, at times unsuccessfully returning to his family of origin. His childhood experiences have resulted in poor emotional regulation, instability in relationships, fragile self-image and impulsivity.

Ian has long been involved with the criminal justice system. His first charge was at the age of 11 years, and his record has included serious offences. As an adult he spent much more time in prison than in the community.

Ian was not accepted by the ISP but referred to another specialist program where he was supported in specialist accommodation that included restrictions. He was eventually transitioned to an independent living model with 24-hour support from an NGO. Ian appeared relatively settled for 12 months; he found work and had reduced hospital admissions. His ongoing reliance on opioids remained problematic.

One year later Ian decided to leave his supported accommodation following the development of a relationship. Shortly after the move Ian was involved in offences including property damage and assaulting police. Ian's relationship broke down due to drug abuse, domestic violence and financial strains. His mental health deteriorated, and he was referred to a psychiatric hospital. After a short stay, Ian was discharged without consultation with his guardian or service provider to a friend's house. Since then Ian has committed several offences. He spent a month in jail before being released into supported accommodation with an NGO. Ian left the accommodation to reside elsewhere, without support.

Hypothetical ISP support: ISP would offer secure supported accommodation initially and more independent living in the future. Ian's emotional needs would be addressed with a combination of behaviour support and family therapy, the latter focusing on the attachment to his mother and grief about her death. Individualised support for Ian would be coordinated with the police, the local community mental health team and local hospital. ISP would establish a cross-agency partnership to sustain the case coordination needed to support Ian when he hits a crisis.

Steven (non-client)

Steven is a young Aboriginal man who has schizophrenia, drug-induced psychosis, poor memory and a conduct disorder. Following family instability and trauma he was placed in care of his extended family. He has an extensive criminal history and often does not comply with medical appointments and medication.

Steven was nominated for the ISP in 2009 but not successful as he was out of the metropolitan area.

At present, Steven is in prison with bail refused. After release, Steven will likely return to his home town with unconfirmed case management and into boarding house accommodation. The Public Guardian is concerned that Steven will be exposed to gangs in the local area who have a history of exploiting him financially and physically.

Steven is at great risk of continuing in the cycle of custodial sentences – release to community without appropriate supports – deterioration of his mental health – resulting in re-offending behaviour and reengagement with the criminal justice system.

The Public Guardian and Probation and Parole agree that Steven needs secure, supported accommodation with staff with Indigenous experience, intensive case management and the capacity to address his complex needs.

Hypothetical ISP support: ISP would discuss with Steven whether and how he would like to connect with his local Aboriginal community, and facilitate that connection if he wishes. Steven would receive grief counselling about his mother and behaviour support, and in cooperation with Probation and Parole the ISP would support Steven to adhere to his parole conditions. A joint mental health care plan would be developed with the community mental health team.

Debbie (non-client)

Debbie is a middle-aged woman with psychotic disorder due to chronic substance abuse. She is unable to manage her emotions, for example she often cries uncontrollably in public. When police are called, her distress worsens, and she becomes physically aggressive, throws objects and breaks public property. Debbie used amphetamines and alcohol heavily from her late teens onwards.

Her family life broke down, as did all support services. Although she was eligible for ISP, there were insufficient vacancies.

Debbie's homelessness and misuse of drugs and alcohol continued. Since her failed ISP nominations, she has had several longer admissions to mental health facilities. Back on the streets, she is no longer able to access emergency accommodation due to her reputation. Debbie presents to hospital emergency at least three times per week, often brought in by police who find her naked and assaulted. The hospital has a response plan where they admit her once per month for one week to stabilise her health and her mood.

In 2014, the hospital approached the Minister of Health to seek an intervention, and the Public Guardian has taken on an advocacy role.

After the evaluation period, ISP identified a vacancy for Debbie. She was transitioning into the program and working collaboratively with her case manager and senior clinical consultant.

Hypothetical ISP support: ISP would initially try to minimise harm and stabilise Debbie's health, conduct assessments to understand the reasons for her behaviour, and if she showed motivation to change, ISP would support her to access appropriate services, e.g. counselling.

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