Evaluation of the Integrated Services Project for Clients with Challenging Behaviour: Final Report

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Abbreviations

ABI	Acquired Brain Injury
ABS	Australian Bureau of Statistics
ADHC	Ageing, Disability and Home Care NSW (formerly DADHC)
ARBIAS	Alcohol Related Brain Injury Accommodation Support Service
CALD	Culturally and Linguistically Diverse
CJP	Community Justice Program
DCS	Department of Corrective Services NSW
DSQ	Disability Services Queensland
DJJ	Department of Juvenile Justice NSW
DSRC	Disability Studies and Research Centre
ED	Emergency Department
HASI	Housing and Accommodation Support Initiative
MACNI	Multiple and Complex Needs Initiative
NGO	Non-government organisation
ISP	Integrated Services Project for Clients with Challenging Behaviour
NSW	New South Wales
OBS	Overt Behaviour Scale
PWI	Personal Wellbeing Index
SPRC	Social Policy Research Centre
UNSW	University of New South Wales

Executive Summary

The Integrated Services Project for Clients with Challenging Behaviour (ISP) was established in 2005 and is administered by Ageing, Disability and Home Care (ADHC), Department of Human Services NSW. The Project aims to: foster improved life outcomes for people with complex needs and challenging behaviours; reduce the cost of this group to the service system and the wider community; and contribute to the evidence base in this area. The Social Policy Research Centre (SPRC) was commissioned to conduct an independent evaluation of the Project in 2007. This final evaluation report assesses the outcomes of the Project for clients, the effectiveness of the Project's support processes and governance structures, and examines how the ISP might inform improvements to the broader service system.

Key findings

Nominations to the Project are made quarterly by seven human services agencies in NSW, and the referrals are assessed by the ISP's Project Management Committee. Due to the intensive level of support required by each client, a maximum of eight people were accepted into the Project in each quarterly round, and the total number of clients served over this period was 38. These clients had a median age of 35 years, 89 per cent were under guardianship orders, and all clients lived in insecure housing upon entry. Clients had a complex mix of disabilities and diagnoses, of which the most common was mental illness, followed by intellectual disability and alcohol and drug disorders. Almost all clients had a mix of two or more diagnoses.

The majority of ISP clients experienced improvements in a number of key outcome areas over the course of their involvement with the Project. Clients experienced a decrease in the frequency and impact of their challenging behaviours which contributed to a considerable decrease in the amount of hospital and criminal justice services used by clients. In particular, there was a 90 per cent decrease in the number of days spent as an inpatient in hospital, an 82 per cent decrease in the number of hours spent in emergency, and a 94 per cent decrease in the number of days spent in custody. In addition, clients became more independent in some activities of daily living, particularly budgeting, cleaning, bathing and dressing. They reported improved health and well-being, as well as increased involvement in social and community activities, work, and education.

Staff and stakeholders reported that the ISP successfully supported its target group. Some of the major strengths of the Project's services were: the flexibility, consistency of support, stability of staff, and ability of the Project to learn from experience. They reported that the support could be improved by ensuring that ISP staff have high-level skills required to deal with this challenging client group.

Half of all ISP clients had exited ISP by January 2009. Clients were primarily moved on to group homes, ADHC's Community Justice Program, and NSW Health's Housing and Accommodation Support Initiative, with the median cost of a post-ISP package being $140,000. Although the Project was set up to support each client for 18 months, the average time current clients had spent in the ISP was 21 months, with the 18 former clients spending an average of 25 months in the Project. Due to limited resources and capacity in the broader service system regarding the management of

clients with challenging behaviour and complex needs, stakeholders reported that transitioning clients out of the ISP is the Project's key challenge.

Some interviewees were concerned that the outcomes experienced by some ISP clients could not be sustained after they exited the Project. Analysis of client outcome data showed that exited clients did not differ from current clients in their levels of challenging behaviour, independence in living skills, and economic participation. Personal well-being and involvement in community activities, however, decreased for clients who had exited, which suggests that the transition out of ISP may be problematic for some clients. More data is needed to determine conclusively whether the changes experienced by clients in the ISP are sustainable after exiting the Project.

Overall, the governance arrangements for the Project were reported to have worked well. The key strengths of this structure were strong partnerships between agencies, commitment from stakeholders, and the responsiveness of ISP management to issues raised by stakeholders. The Project also created sound formal working relationships between staff in different agencies, which set a strong foundation for generating broader systemic change in future, and successfully engaged stakeholders at high levels of the NSW Government. However, significant broader service system change around the issue of supporting people with challenging behaviour is yet to be achieved.

Based on expenditure data, the average recurrent net cost per quarter of the ongoing project (expenditure less revenue and set-up costs) is approximately $1,604,404; thus, the cost of providing ISP services over a one year period is approximately $6,417,604. Direct service provision accounted for 80 per cent of total expenditure and the average cost of the Project per client is $207,000. As a result, clients achieved a number of positive outcomes and the cost of providing services post-ISP decreased.

Recommendations

Eight recommendations are made across the three areas the SPRC were asked to consider. These were:

Client outcomes

- Longitudinal measurement and follow-up of ISP client outcomes is necessary to complete further analysis about the characteristics of people who benefited most from ISP support. Future analysis could focus on determining potentially predictive factors as to who would benefit most and least from the ISP.
- The development of a client management system that captures client outcomes could be useful to track people over time.

Service model and governance

- Providing feedback to agencies as to the reasons nominations were not accepted would assist in maintaining and strengthening relationships with partner agencies.
- The continual monitoring of the terms of reference and membership of the Project's committees should be undertaken to ensure that they optimally support the ongoing work of ISP.

- Consideration should be given to implementing more flexible funding arrangements that can be used to support people outside of the Sydney area.
- The Project's transitional model may not be appropriate for all clients. More emphasis on sourcing and supporting people in permanent accommodation from the outset may be beneficial for clients.

Service system

- The Project has the potential to play a key role in advocating for systemic change which focuses on finding sustainable solutions for people with complex needs. Such advocacy could include increasing expertise in the system about how to effectively manage this client group, promoting flexibility and sustainability of funding, and developing more appropriate community based accommodation options for people with complex needs.
- The ISP should review its relationship to the NGO sector especially in relation to the Project's governance structures and referral processes.

For the unabridged recommendations see section 8.1.

Conclusion

The evaluation shows that the ISP has been successful in establishing a service model that has led to positive outcomes for clients. The chief strengths of the ISP are that support can be tailored to the needs of each client and the Project can remain responsive to changing needs. Furthermore, the holistic nature of ISP services assists clients to not only reduce the frequency and impact of their challenging behaviours but to also make improvements in other aspects of their lives, such as social and vocational functioning. Staff and stakeholders expressed a clear commitment to the ISP service model, and the Project has been successful in addressing challenges that have arisen over the course of its implementation. The key ongoing challenge for the Project is to ensure that clients make successful transitions into mainstream services and that the positive outcomes experienced by clients are not jeopardised by this transition. If this is not achieved, the transitional model adopted by the ISP may need to be reassessed.

1 Introduction

The Integrated Services Project for Clients with Challenging Behaviour (ISP) was established in 2005 as a pilot project and is administered by Ageing, Disability and Home Care (ADHC), Department of Human Services NSW.[1] The Project aims to foster improved life outcomes for people with complex needs and challenging behaviours, reduce the associated cost to the service system and community, and contribute to the evidence base for supporting this target group to live effectively in the community. The Social Policy Research Centre (SPRC) was commissioned to conduct an independent evaluation of the Project in 2007. The evaluation aims to understand the outcomes of the Project for clients, the effectiveness of the Project's support processes and governance structures, how the ISP can inform improvements to the broader service system, and the costs and benefits of the Project.

This is the final evaluation report. It provides a profile of the clients served by the Project between September 2005 and January 2009, and analyses the outcomes achieved to date.

1.1 Service context

There is increasing recognition in NSW that people with complex needs are not well served within the existing service system. As a result, new service models are being developed to address these unmet needs. 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 who also have insecure tenancy (NSW Department of Health, 2006). The program is a partnership between NSW Health, Housing NSW and the non-government organisation (NGO) sector, and provides packages of low-to-medium, high, and very high levels of support to people with mental illness. The support provided in packages varies: very high support, for example, provides clients with access to an NGO accommodation-support worker for approximately four to five hours per day, seven days per week.

The Community Justice Program (CJP) is another program that 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, as well as accommodation support and clinical services targeted to individual need (ADHC, 2009). Under the Stronger Together Strategy, the budget for this program is planned to increase from $5.6 million in 2006-2007 to $27.9 million in 2010-2011, at which time there will be 200 people being provided with accommodation and support (Beyond Bars, 2007).

While programs such as HASI and the CJP go some way towards assisting people with complex needs who are not well served by the existing service system, there is still a group of people who, due to the complexity of their diagnoses and behaviours,

[1] The Department of Human Services brings together seven agencies: Aboriginal Affairs NSW; Ageing, Disability and Home Care; Community Services; Housing NSW; Juvenile Justice; the NSW Aboriginal Housing Office; and the provider of shared business services, NSW Businesslink Pty Ltd.

require even higher levels of expert support (McVilly, 2004). This group is less likely to experience the same quality of care as the rest of the disability population, while taking up more time and resources (Victorian Department of Human Services, 2003). It is within this context that the ISP was established in early 2005. The Project is responsible for providing services to approximately 25 people per year who have multiple complex needs that cannot be met under existing service arrangements, are in insecure accommodation, and who pose a threat to themselves or others. The specific aims of the Project are to:

- develop intervention and support plans that reflect the individual needs of clients;
- improve service access, coordination and durability of engagement with services;
- decrease the adverse impact of challenging behaviours on clients, other people and the service system; and
- improve housing, health, social connections and safety for clients through case management, multi-disciplinary assessment and clinical interventions.

Other Australian programs that address complex needs and challenging behaviour

Models to assist people with challenging behaviour and complex needs have also been developed in Queensland and Victoria. These programs fall into two categories: supported accommodation and clinical support, and case management and brokerage used to purchase the necessary supports. One example of the former is *Project 300*, developed by Disability Services Queensland (DSQ) to assist clients with psychiatric illnesses to transition from long-stay institutional care to community-based arrangements (Disability Services Queensland, 2009b). It is similar to the ISP in that it is an integrated service approach combining aspects of specialist disability and clinical support, and supported accommodation, in order to improve clients' social and community participation and independent living skills (Disability Services Queensland, 2009b). The program is targeted at adults living in one extended treatment facility in Queensland, and who have consented to taking part in the Project. A seven-year study of the Project found that, while clients experienced mixed outcomes in relation to clinical functioning and quality of life, most were able to maintain residences in the community and to engage in structured activity outside the home (Meehan et al., 2007).

Another example of the supported accommodation model is the *Alcohol Related Brain Injury Accommodation Support Service (ARBIAS)* which is a partnership between community-based service providers and the Victorian Department of Human Services. *ARBIAS* provides case-management services to people with acquired brain injury (ABI) in Melbourne, and more intensive supports to people with ABI who also have challenging behaviour (McVilly, 2004). These more intensive services involve accommodation (supported accommodation, group homes, and monitored independent living environments) and services to assist clients to develop formal and informal support networks and living skills. The service aims to achieve flexibility in support arrangements depending on needs and circumstance (Arbias Ltd, 2007).

There are two examples of the second model involving case management and brokerage: the *Intensive Behaviour Support Teams* in Queensland, and the *Multiple and Complex Needs Initiative (MACNI)* in Victoria.

Intensive Behaviour Support Teams work with people with complex needs and challenging behaviours, their families and other current formal and informal support networks. The teams aim to develop tailored care plans and coordinate services in order to improve the long-term life outcomes for people with challenging behaviours (Disability Services Queensland, 2009a). To be eligible for support, clients must: be over the age of 18; have a disability attributable to an intellectual, psychiatric, neurological, sensory or cognitive impairment (or multiples of these); have reduced capacity to participate meaningfully in community life as a result of the impairment; have a history of complex and challenging behaviour support needs; and have access to informal and formal support networks able to assist in the implementation of behavioural intervention plans (Disability Services Queensland, 2009a).

MACNI in Victoria employs a care plan coordination model to develop individualised case plans, and deliver case management and behavioural support services to people with challenging behaviour (Victorian Department of Human Services, 2003). The program has a strong emphasis on coordinating government and NGO services; this has been identified as an important aspect of best practice responses to challenging behaviour (McVilly, 2004; Vincents, 2002). Referrals to the program are made by local service providers via relevant regional gateways to a state-wide panel that considers each case based on selection criteria determined by the *Human Service (Complex Needs) Act 2009*. Those referred to the program must have more than one of the following: alcohol and drug related dependency; mental illness; intellectual disability; ABI; physical disability; social isolation; behavioural difficulties; and family dysfunction (KPMG, 2007). Both MACNI and the Intensive Behaviour Support Teams provide services that are accessible to people across the state.

1.2 Defining challenging behaviour

Challenging behaviour is a contested term, and there is disagreement about the environmental, social and neurological factors behind it (Hillery, 1998). The term is mostly used in relation to people who have been diagnosed with intellectual disability (Joyce et al., 2001; Knapp et al., 2005; Lowe et al., 2007) and, to a lesser extent, ABI (Feeney et al., 2001; Kelly and Parry, 2008). One common description is: “culturally abnormal behaviour(s) of such intensity, frequency or duration that the physical safety of the person is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit or delay access to and frequent use of ordinary community facilities” (Henry et al., 1999: 129). This is a useful description, but it ignores the social and environmental factors that may contribute to the behaviour, such as mental illness, and social, criminal, and substance-abuse problems (Mansell, 2007). Challenging behaviour is informed by the co-existence of multiples of these problems and the interrelationship between them (Centre for Developmental Disability Health, 2005).

Within the ISP, the term “challenging behaviour” is used broadly to refer to an array of behaviours that place the person and/or others at significant risk of harm and preclude people from accessing the current service system (Martin and Associates P/L, 2001).

1.3 Framework for service delivery

Like HASI and CJP, the ISP has adopted a partnership approach to service provision. The Project is led by ADHC in conjunction with NSW Health and Housing NSW, and each of these agencies is represented on the ISP's Project Management Committee. In addition to these key agencies, the Departments of Corrective Services, Juvenile Justice, Community Services, the Office of the Public Guardian, NSW Police, and the Council for Intellectual Disability are represented on the Interagency Reference Group, which provides a consultative body that informs ISP activities. The governance structure of ISP is described more fully in Section 4.

Potential clients are nominated quarterly by one of the seven NSW Government human service departments. Following acceptance of a nomination by the interdepartmental Project Management Committee, the ISP's multidisciplinary support team conducts an assessment. To be eligible a client must be 18 years or older, exhibit behaviour that places themselves and/or others at risk of harm, and either have one or more disability or diagnosis, or the client's diagnosis must be in dispute. In addition, the client must require a high level of coordinated multiple agency response, live in insecure accommodation and have significantly impaired access to essential services due to their behaviour. The final requirement is that all other options for support have been exhausted.

The ISP does not intend to replicate existing services in the community, but rather to address people's complex needs and challenging behaviour over an 18 month period to the point where they can be supported within the existing service system. The Project does this by providing clients with a service model based on the level of support each client requires; this can be a 24-hour group home, a self-contained unit with staff on site, or other community housing with on-call assistance from staff (see Appendix D: ISP Units). Next, person-centred case plans are developed in conjunction with the client, nominating agency staff, clinical staff, the client's case manager, accommodation managers and, where appropriate, relatives and guardians. These support plans and guidelines are implemented by residential and clinical staff and are revised as the client's needs change. The ISP aims to keep nominating agencies involved while the client is in the ISP in order to build the capacity of services to better support people with challenging behaviour.

The Project develops a sustainable model of support for a client and identifies an appropriate agency to implement it. When possible this will be the nominating agency but this option is not always available, particularly when no established service provider was previously involved, the nominating agency is not the appropriate one to provide ongoing support (e.g., a criminal justice agency), or if a client is outside of the geographical boundary of the original service provider.

1.4 Methodology

This evaluation aims to evaluate:

- processes for supporting clients;
- outcomes for ISP clients;
- governance arrangements of the ISP and how it informs systemic change; and
- costs and benefits of the ISP.

These aims were met through a mixed-methods approach involving: an analysis of program data collected by ISP staff; administrative data from NSW Health and Corrective Services; interviews with 17 ISP staff and other stakeholders; interviews with four clients conducted three times over the evaluation period; and analysis of expenditure data. More detail about the methodology can be found in Appendix A and in the evaluation plan (Fisher and McDermott, 2008).

This report is structured around the ISP's logic model. It first examines the profile of those accepted and analyses the outcomes experienced by clients. The processes of supporting clients, governance and the Project's impact on the service system are discussed, as is the economic impact of the Project on the service system. The final section includes recommendations and key learning outcomes of the Project.

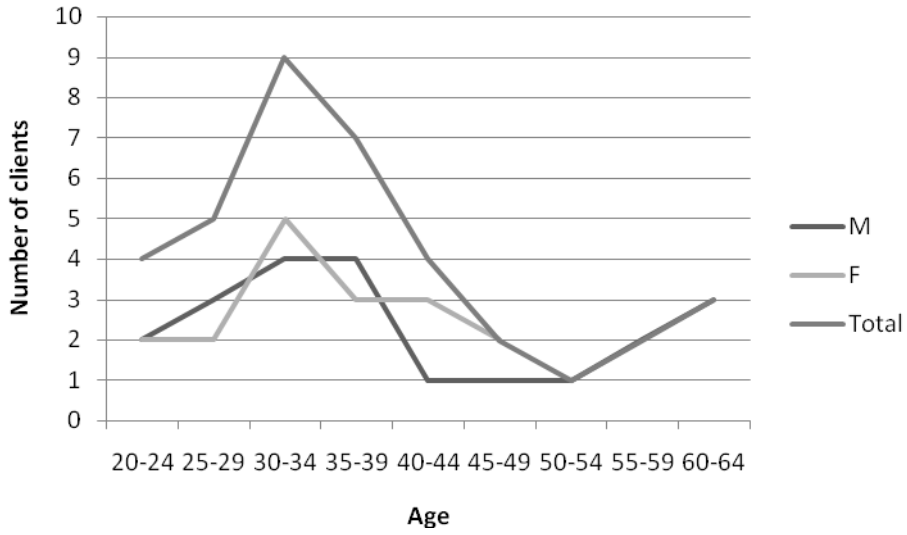
2 Client Profile

Nominations to the ISP are made quarterly by seven human services agencies in NSW, and are assessed by the ISP's Project Management Committee. Due to the intensive level of support required, a maximum of eight people are accepted into the Project in each quarterly round; from 2005-2008, 38 clients were accepted for services.[2,3] This section reviews the profile of clients who were accepted and analyses the extent to which the nomination process was successful in identifying the target group.

2.1 Demographic profile

Of the 38 clients accepted into the Project, 55 per cent were male (n=21) and 45 per cent female (n=17). This is representative of the wider community, but women were over-represented in comparison with the usual client groups of the main nominating agencies, such as mental health services (Muir et al., 2007). The median age of clients was 35 years, although women in the ISP were slightly younger than the men (33 years versus 36 years; Table 2.1).[4] This is consistent with the aim of the ISP to orient interventions to younger people in order to change the lifetime trajectory for people with challenging behaviour and complex needs. Most of the clients (95%; n=36) were single and had never been married.

Figure 2.1: Age Distribution of ISP Clients by Gender, January 2009 (n=38)



2 An additional person was accepted to receive services, but refused to participate in the Project and is therefore excluded from the analysis.

3 Due to Project capacity and funding issues intake rounds could not be held every quarter.

4 Clients are one year older than they were when the profile was first reported in the mid-term evaluation report (see McDermott, S., Fisher, K. R. and Gleeson, R. (2008), *Evaluation of the Integrated Services Project for Clients with Challenging Behaviour: Mid-Term Report*, NSW Ageing, Disability and Home Care, Sydney.)

Regarding the cultural background of ISP clients, eight per cent (three clients) were Indigenous Australians, compared with three per cent in the general population (ABS, 2008), and 29 per cent (11) were from a Culturally or Linguistically Diverse (CALD) background as compared with about 20 per cent of the Australian population (ABS, 2008).[5] Both groups were over-represented compared to other users of community mental health and disability services, although the number of people in the sample is too small to extrapolate to the broader population of people in the community with challenging behaviours (AIHW, 2008, 2009).

Table 2.1: Cultural Background of ISP Clients (n=38)

Ethnicity	Number of clients	Per cent
Indigenous Australian	3	8
CALD	11	29
Other	24	63
Total	38	100

As of January 2009, all but four of the 38 clients had legally appointed guardians. In this respect, ISP clients are different from those in other programs, such as HASI, which only accept clients who can consent to participate in the program.

2.2 Client characteristics

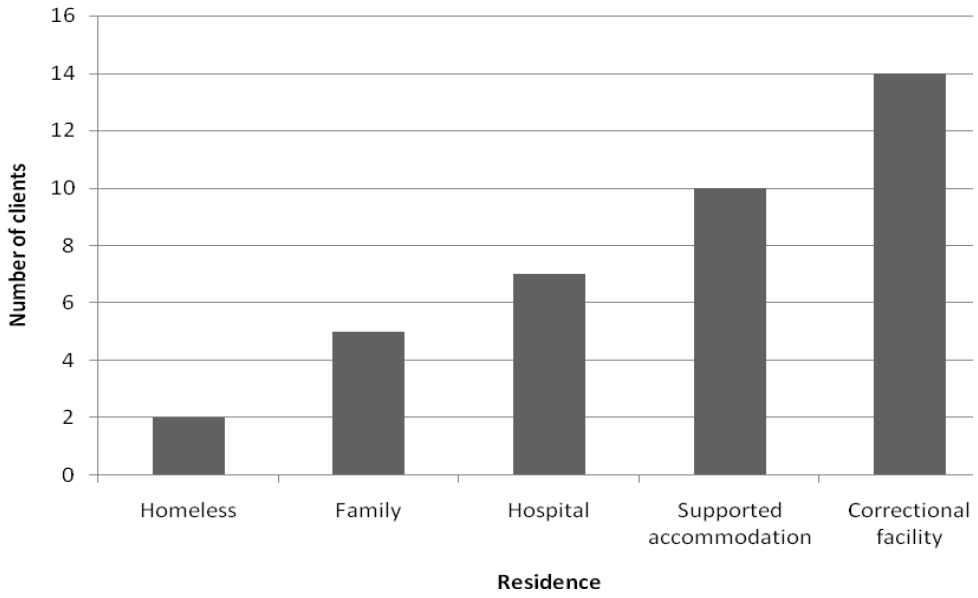
As stated previously, ISP interventions are targeted at people who require a coordinated, multiple-agency response; live in insecure accommodation; and have been denied access to essential services due to high-level challenging behaviour which places themselves and/or others at risk. The majority of staff and stakeholders interviewed for the evaluation believed that the nomination process was successful in identifying clients who meet these criteria. This is reflected in data collected in the evaluation on clients' housing status on entry into ISP and clients' disabilities and disorders.

Housing

Prior to being accepted, about half the clients (55%; n=21) were in gaol or in hospital without stable housing to return to after release or discharge (Figure 2.2). The remaining clients lived in supported accommodation (n=10), with family (n=5) or were homeless (n=2). Analysis of the de-identified case file notes on each client highlighted that, even when clients were living with family or in supported accommodation, these arrangements were insecure and often transitory due to the level and severity of clients' challenging behaviours.

[5] The mid-term evaluation incorrectly reported that 12 clients were of CALD background (one client of European decent had been mistakenly identified as being from a CALD background).

Figure 2.2: Housing Type prior to ISP Entry, March 2008 (n=38)

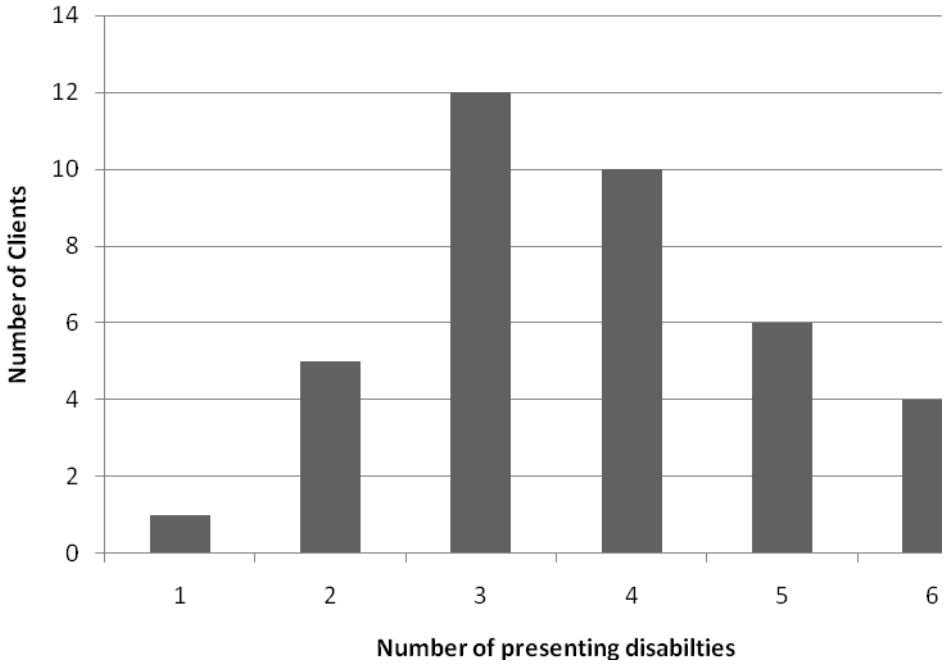


Clients moved into Project housing upon entry (Appendix C and D). While the Project operated nine different units over its tenure, it was operating or funding seven properties as of January 2009. These properties provide the physical infrastructure to support a variety of needs, and the model of support selected for each client is that which best addresses the particular needs of each client. As a result, ISP clients are supported in one of the following options: cluster housing; villas/apartments; co-located housing; group homes; and drop-in support.

Disabilities and disorders on entry to the ISP

Project clients had a complex mix of presenting disabilities and disorders, including mental illness, intellectual disability, substance abuse, acquired brain injury and physical disability. Clients had a median number of four presenting disabilities and disorders; only one person had one diagnosis and the rest (n=37) had two or more diagnosed disabilities or disorders (Figure 2.3).

Figure 2.3: Presenting Disabilities on Entry to the ISP (n=38)



The most common presenting diagnosis was mental illness: 86 per cent (n=33) were diagnosed with at least one mental illness. Over half also had intellectual disability (68%; n=26) and alcohol and drug disorders (58%; n=22). ABI and physical disability were less common, with about one-third experiencing either of these disabilities.

Table 2.2: Presenting Diagnoses of ISP clients (n=38)

	Number of clients	Per cent[2]
Mental illness[1]	33	86
Physical disability	13	34
Intellectual disability	26	68
Alcohol and drug disorder	22	58
Acquired brain injury	13	34
Other[3]	12	32

Notes: 1. 21 of the 33 clients had two diagnosed mental illnesses
2. Clients can have more than one presenting problem so total percentage is greater than 100
3. Examples in the 'other' category include: limited education, foetal alcohol syndrome, deafness, and seizures

The most common diagnosis amongst the people with mental illness was personality disorder (39%; n=15), followed by schizophrenia (37%; n=14). The percentage of people with schizophrenia is similar to that proportion of people who use community mental health services (32%) (AIHW, 2009). In contrast, only three per cent of the users of community mental health services are diagnosed with personality disorders, compared with 39 per cent of ISP clients (AIHW, 2009). This suggests that personality disorder is not consistently managed within the service system, and/or that this particular disorder is a strong contributor to challenging behaviour.

Table 2.3: Mental Health Diagnoses of ISP clients (n=38)

	Primary mental health diagnosis[1]	Secondary mental health diagnosis	Total clients with diagnosis	Per cent of all clients[2]
Schizophrenia	12	2	14	37
Personality disorder	9	6	15	39
Schizo-affective disorder	4	2	6	16
Anxiety	2	3	5	13
Mood disorder	1	2	3	8
Conduct disorder	0	3	3	8
Other	5	3	8	21
No mental health diagnosis	-	-	5	13
Total clients	33	21	-	-

Notes: 1. Primary diagnosis refers to that which causes the most distress and difficulty for the person
2. Demonstrates the frequency of each mental health diagnosis in the ISP population. Total is greater than 100 per cent because 12 people had more than one diagnosis.

ISP staff measured the level of core-activity restriction resulting from each of the clients' disabilities and disorders. The Australian Bureau of Statistics (ABS) identifies four levels of core-activity restriction based on the extent to which someone needs help and has difficulty performing, or uses aids or equipment to perform, core activities such as communication, mobility or self-care tasks (ABS, 2003). 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 and has difficulty understanding or being understood by family or friends;
- Moderate: the person needs no help but has difficulty with a core-activity task; and
- 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 require other support.

Table 2.4 shows that the greatest core-activity restrictions were experienced by clients who had mental illness, ABI, or drug and alcohol disorders, and that most clients with these disorders experienced severe or profound levels of activity restriction. Since most people had several presenting needs on entering the ISP, the combined restriction for each person was far greater than presented in Table 2.4.

Table 2.4: Core Activity Restrictions, March 2008 (n=38)

Impairment	# clients	Mild	Moderate	Severe	Profound	Weighted average
Psychiatric	33	3	5	22	3	2.8
Drug and alcohol	22	2	4	12	4	2.7
Acquired brain injury	13	2	2	6	2	2.7
Other	12	3	2	5	2	2.4
Intellectual	26	6	11	8	1	2.2
Physical	13	4	5	3	1	2.1

Note: The average degree of restriction is a weighted average per person with that reason. Mild=1, Moderate=2, Severe=3, Profound=4.

2.3 Case study clients

Due to the complexity of this small group of clients, in-depth qualitative data was collected from four clients to understand how their lives changed since becoming involved with the ISP. These clients were interviewed three times over a two year period, and their stories demonstrate the complex mix of presenting disabilities and diagnoses, and the insecure nature of housing and support systems experienced by ISP clients. The changes clients experienced since entering the ISP are explored further in Section 4.[6]

Anne

Anne is a 29-year-old Anglo-Australian woman. She was first admitted to a psychiatric hospital at 18 years of age for treatment of hypomania and severe depression, which led to anorexia nervosa, self-harm and suicidal ideation. She lived at the hospital for six years before being released and living independently with community mental health support for two years. She was then hospitalised for treatment of an ectopic pregnancy, and was subsequently admitted as a long stay patient in psychiatric hospitals on five separate occasions. More recently, she was imprisoned for assault and was serving a four-year sentence with a non-parole period of 15 months.

John

John is a 34-year-old man with schizophrenia, mild intellectual disability and ABI. John has had 113 criminal convictions, mainly for theft, property damage and drug possession, as well as a history of poly-substance abuse. When not in prison, John experienced periods of homelessness, and had little coordinated support from services. John's extreme drug-seeking and self-harming behaviours are the primary reason for previous breakdowns in his accommodation and support.

Rebecca

Rebecca is a 33-year-old woman who has eight children, all of whom are now living with the same foster family following intervention via the Department of Community Services. She has a history of psychotic illness (this diagnosis is disputed by some) as

[6] All names have been changed to protect anonymity.

well as Huntington's disease, a genetic condition which causes degeneration of brain cells, resulting in emotional disturbance, reduced intellectual capacity, and uncontrolled movement (National Institute of Neurological Disorders and Stroke, 2008). She has a significant history of poly-substance abuse, and has been using heroin sporadically for the last 14 years. She also has a history of aggression, which has resulted in numerous incarcerations and has spent most of her life homeless. Welfare services have attempted to procure housing for Rebecca, but she has been excluded from most private accommodation in city areas due to her behaviour and drug use.

Alan

Alan is a 61-year old man of Yugoslavian descent. He has been diagnosed with chronic paranoid schizophrenia and alcoholism, but the diagnosis of schizophrenia was disputed by a psychologist who instead diagnosed Alan with a personality disorder and ABI due to his alcohol abuse. He also has severe liver damage due to alcohol abuse. Alan has a long history of homelessness with intermittent periods of incarceration. Since 2005, he has been under guardianship and financial management orders, and has spent 43 days in a psychiatric institution and 12 months in prison. He also has a history of physically aggressive behaviour.

2.4 Conclusion

The ISP was successful in targeting people with complex needs and challenging behaviour who are living in insecure housing and who have difficulty accessing required services. All were living in insecure housing before entry, and the majority (97%) had multiple disabilities and diagnoses which contributed to extremely high levels of challenging behaviour. The next section explores the changes experienced by clients in relation to their challenging behaviour, service use, ability to live safely in the community, as well as their health and well being, since becoming clients of the ISP.

2.5 Summary

- Of the 38 ISP clients, 55 per cent were male (n=21) and 45 per cent female (n=17). This is closely representative of the wider community, but females are over-represented in comparison with the client groups that access services from the main nominating agencies.
- The median age of clients was 35 years; the predominance of younger clients is consistent with the aim of ISP to orient interventions at younger people, so that it changes the lifetime trajectory for people with challenging behaviour and complex needs.
- Both Indigenous Australians and people of CALD background were over-represented, but the sample was too small to generalise to the whole population of people with challenging behaviour.
- In January 2009, 34 of 38 clients (89%) were under guardianship orders, indicating that the client group is different to other programs, such as HASI, which only accepts voluntary clients.
- One of the criteria for entry to the ISP is insecure accommodation. Prior to being accepted, about half of the clients (n=21; 55%) had been in prison, hospital, or other large residential facilities without stable housing to return to after discharge. The remaining clients lived in supported accommodation (n=10), with family (n=5) or were homeless (n=2).
- Clients had a complex mix of presenting problems, including mental illness, intellectual disability, substance abuse, acquired brain injury and physical disability. Clients had a median number of four presenting problems; 97 per cent (n=37) had two or more diagnosed disabilities or disorder.
- The most common presenting problem across ISP clients was mental illness: 86 per cent (n=33) had a mental health diagnosis. Over half were diagnosed with intellectual disability (n=26; 68%) and alcohol and drug disorders (n=22; 58%).
- The highest levels of core-activity restriction were experienced by clients who had mental health problems, ABI, and drug and alcohol disorders.

3 Client Outcomes

This section reports on the impact of the Project on outcomes experienced by 36 clients in five key areas: challenging behaviour; appropriate service use; ability to live safely in the community; health and well-being; and social connections and community participation.[7] The analysis presented in this section is drawn primarily from data collected by Project staff at two points in time during the evaluation period: March 2008 (Phase 1) and January 2009 (Phase 2).[8] In addition to the data collected at Phase 1 and 2, additional data was available on the Overt Behaviour Scale (OBS), which was used to measure changes in challenging behaviour, as well as administrative data collected from NSW Health and Corrective Services on clients' hospital and criminal justice service use before and during the ISP. Findings in each of the sections are discussed in relation to the longitudinal interviews conducted with the four case study clients. It is important to note that ISP clients are a small, diverse group of people, so generalisations from the quantitative data are drawn with caution.

3.1 Challenging behaviours

Clients of the ISP are complex not only because they have multiple disabilities and disorders, but because they exhibit challenging behaviours which negatively impact on accessing services in the community. The OBS, developed by the ABI Behaviour Consultancy in Victoria, was used to measure changes in this domain (Kelly et al, 2006). This validated instrument quantifies the frequency and severity of nine categories of challenging behaviours, including: verbal aggression; physical aggression against objects; physical aggression against self; physical aggression against other people; inappropriate sexual behaviour; perseveration or repetitive behaviour; absconding, inappropriate social behaviour; and lack of initiation.

These nine categories are used to calculate scores on three scales. The first of these scales, the 'Cluster' score (0-9), indicates the number of behavioural categories exhibited by a client (e.g. a score of two indicates that a client demonstrates verbal aggression and inappropriate social behaviour). The second scale, the 'Total Levels' score (0-34), is the total sum of each of the levels of behaviour exhibited within the nine categories. For example within the category of 'Verbal Aggression' a client may both make personal insults and threats of violence, constituting two levels of sub-behaviour. Corresponding with each level of challenging behaviour is a score between one and four that assigns a severity value to individual sub-behaviours; these values compose the 'Clinical Weighted Severity' score (0-77), which is the final scale in the OBS. This scale provides an absolute number that defines the overall severity of behaviour exhibited by a client across all categories. As well as the cluster, total

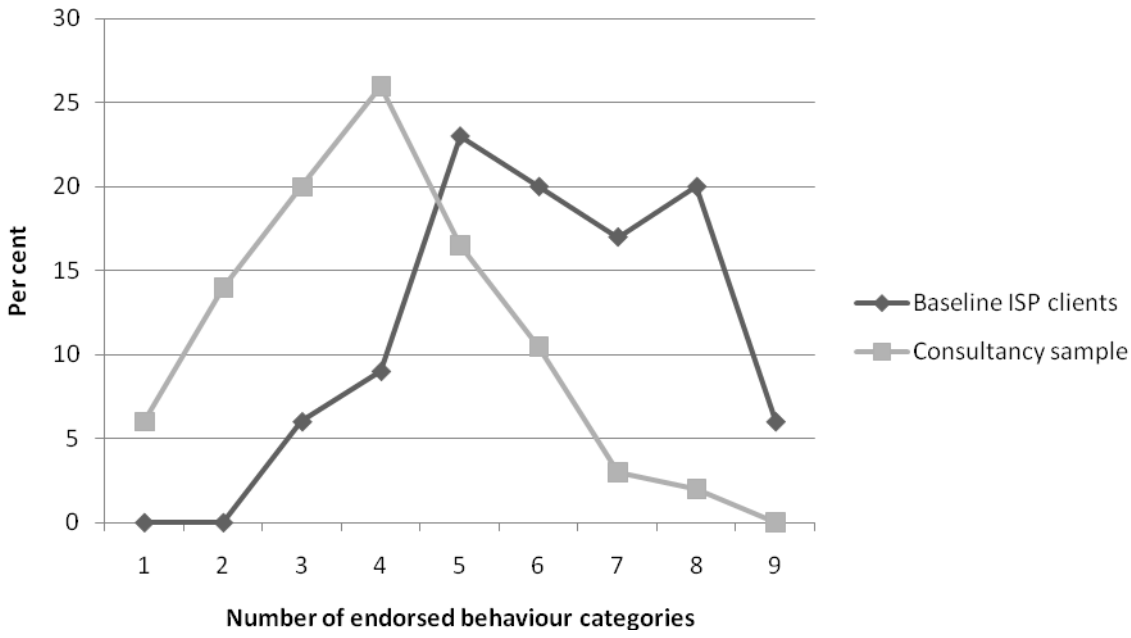
[7] Two of the 38 clients died before entering ISP accommodation and are therefore excluded from the longitudinal analysis.

[8] The Project began providing services to clients in September 2005 and the evaluation commenced in November 2007. As a result, the evaluation was not able to record baseline data for clients on most measures. Thus, at Phase 1 (March 2008) current clients were involved in the Project for an average of 17 months and nine out of 36 people had exited. At Phase 2 (January 2009), clients spent an average of 21 months in the Project and 18 out of 36 clients had exited. Differences between exited and current clients are discussed in Section 5 of this report.

levels, and Clinical Weighted Severity scores, clinicians are also able to rate the frequency and impact of each of the behaviours on a five point likert scale, which provides a deeper understanding of how the behaviours may change over time.

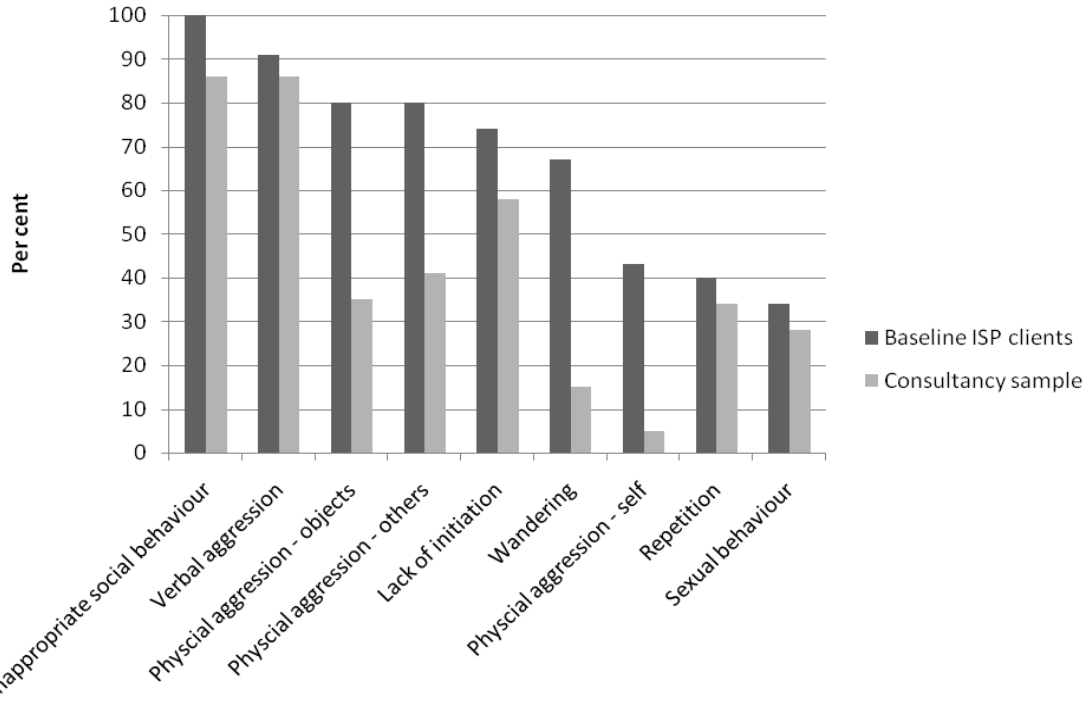
Complete OBS data were available for 35 clients upon entry into the Project and at Phase 1 (March 2008). Twenty nine clients had data available at Phase 2 (January 2009); data were unable to be obtained for six people who had exited from ISP before this time. Upon entry into the Project, the median cluster score was six, indicating that most clients exhibited behaviours in six of the nine broad categories measured by the OBS (Figure 3.1). The most common challenging behaviours exhibited were inappropriate social behaviour (100%), verbal aggression (91%), physical aggression against objects (80%) and physical aggression against others (80%). As compared with a sample of clients with acquired brain injury referred to the ABI Behaviour Consultancy for treatment of challenging behaviours (Kelly et al., 2008), ISP clients exhibited much higher rates of challenging behaviours: an average of four types of behaviours were exhibited by Consultancy clients as compared with six types of behaviours displayed by ISP clients (Figure 4.1).

Figure 3.1: Number of Challenging Behaviour Categories, ISP clients (n=35) and ABI Consultancy Sample (n=190)



Compared with Consultancy clients, ISP clients experienced higher frequencies of challenging behaviour across all categories; there was a statistically significant difference between the two groups in the categories of: physical aggression against objects, physical aggression against others, physical aggression against self, and wandering ($p<0.05$, Chi-square test for goodness of fit). Figure 3.2 compares the frequency of behaviours in each of the categories for the two samples; this reinforces the point that ISP clients are an extremely complex sample.

Figure 3.2: Proportion Exhibiting each of the Challenging Behaviours, ISP clients (n=35) and ABI Consultancy Sample (n=190), per cent



The ISP aims to reduce client's challenging behaviours over the course of their involvement in the Project. Table 3.1 provides an overview of the three key indices measured by the OBS (the cluster score, number of levels of behaviour, and Clinical Weighted Severity score). From entry into the Project until Phase 1 (at which time most clients were still in the Project), the levels and severity of challenging behaviours decreased. The reduction in severity between entry and Phase 1 was statistically significant ($p<0.05$) according to the Wilcoxon Signed Ranks test. Between Phase 1 and Phase 2, however, the scores in all three categories increased back to baseline levels.

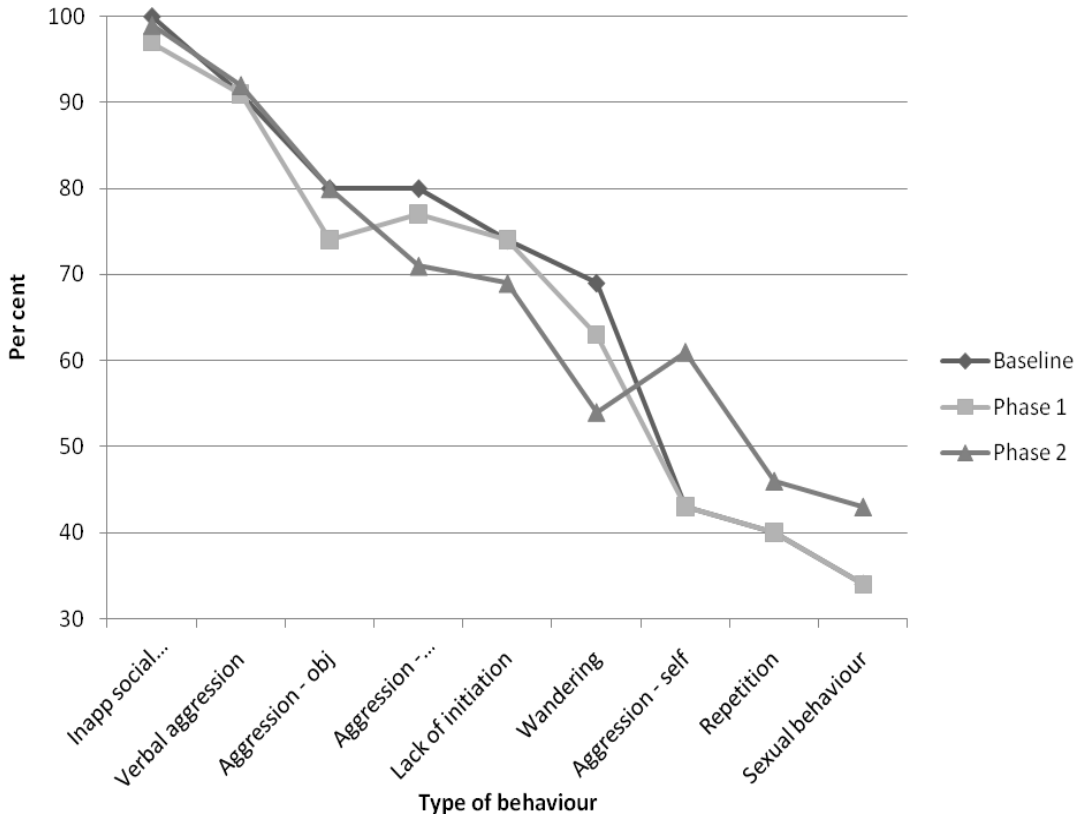
Table 3.1: Measures of the Level and Severity of Challenging Behaviours, Baseline, March 2008 and January 2009

	Entry to ISP (n=35)	Phase 1 (n=35)	Phase 2 (n=29)
Median cluster score	6	6	7
Median number of levels	14	12	17**
Median severity score	30	22**	29**

**p<0.05, (Wilcoxon Signed Ranks test)

There were also no statistically significant changes in proportion of clients exhibiting behaviours in each of the nine categories measured by the OBS between baseline, Phase 1 and Phase 2 (Figure 3.3). The frequency of some behaviour, such as aggression against objects, aggression against others, and wandering decreased between baseline and Phase 2, while aggression against self, repetition and sexual behaviour increased from baseline.

Figure 3.3: Proportion of ISP clients Exhibiting each of the Challenging Behaviours, Baseline, Phase 1 and Phase 2, per cent (n=35)



Therefore, results of the OBS do not indicate a consistent overall decrease in the number and severity of challenging behaviours. However, analysis of the data suggests that the frequency and impact of challenging behaviours did improve over time. For instance, the *frequency* of incidents such as throwing objects, inflicting cuts and bruises on self, attacking others ($p<0.05$) and of major incidents of self harm, prolonged behaviour involving no harm, and the lack of initiation ($p<0.1$) decreased significantly. The *impact* of moderate threats and clear threats of violence, nuisance and annoyance ($p<0.05$) and the impact of non-genital touching and lack of initiation ($p<0.1$) also decreased significantly.

There are a number of possible explanations for this. First, the severity of challenging behaviours may be only fully exposed after clients have been in the ISP for a substantial period of time and following a "honeymoon period". Secondly, many of the clients had never lived successfully in the community before ISP with many coming to the Program directly from gaol and other secure environments, and so it may be unrealistic to expect that large changes in behaviour could be achieved. Indeed, studies have found long term challenging behaviours to be extremely treatment resistant (Mansell et al., 2001). Thirdly, by Phase 2 a number of clients were waiting to exit from ISP but these exits were delayed because arrangements for ongoing care had not yet been finalised. It is possible that these delays contributed to the increase in challenging behaviour observed between Phase 1 and Phase 2. Finally, the sensitivity of the OBS to detecting targeted change in the ISP client group may also be a contributing factor.

Staff reported that the behavioural and therapeutic approaches implemented by the Project successfully assist clients to achieve reductions in their challenging behaviours. This was also reflected in the comments of three out of the four case study clients. Before ISP, for example, Anne had a great deal of difficulties with self harm and overdosing. Since her involvement with ISP,

> My mental health is so much better, I used to self harm every one to two days. ISP has helped me come up with different strategies that work.

John also reported that the strategies implemented by the ISP had helped him to avoid contact with the criminal justice system. He stated.

> I don't mind [living here]. I get all the support I need. I get more trust on my own in the community than 10 months ago because I've proved I can hold a job down four days a week. I've stayed out of trouble now for more than a year.

In conclusion, while as a group clients did not experience consistent changes in the global levels of challenging behaviour as measured by the OBS, reductions in the frequency and impact of the challenging behaviours did occur across the client group. This finding was supported by interviews with staff and in the responses of three of the four case study clients and is borne out by data presented in the following section on use of hospital and criminal justice services.

3.2 Use of Hospital and Criminal Justice Services

The ISP aims to reduce inappropriate or unplanned service use, including the overuse of hospital services and contact with the criminal justice system. To measure this, the Project was able to access administrative data from NSW Health and Corrective Services, making it possible to compare changes in service use before people entered the ISP and while clients were in the Project.

Hospital services

Data on hospital use was collected via the NSW Health Inpatient and Emergency Database on 36 ISP clients from July 2003 until June 2008. Over this period, clients spent a total of 9,407 days in the hospital and visited the emergency department 1,868 times. The total cost of hospital services provided to clients over the five-year period was $4,854,530 (Table 3.2).

Table 3.2: Total Inpatient and Emergency Department Services Used, July 2003-June 2008 (n=36)

	Unit	Total (03-08)	Median	Median pp/year
Total inpatient stays	Stays	952	190	3
Total inpatient days	Days	9407	1881	25
Total involuntary days	Days	5656	1131	5
Total days in psychiatric units	Days	8014	1602	9
Total inpatient cost	**Cost**	**4,203,632**	**840,726**	**12,836**
Total emergency visits	Visits	1868	373	5
Total hours spent in emergency	Hours	12096	2419	37
Total ED charge	**Cost**	**650,897**	**130,179**	**1,723**
Total hospital cost	**Cost**	**4,854,529**	**970,906**	**13,584**

The data on hospital use was annualised in order to provide consistent points of comparison to services used by clients before and during ISP; comparison data was available for 34 of the 36 clients because two people were not linked to their start dates before the data was collected by NSW Health.

Analysis of the annualised hospital and emergency department data shows a considerable decrease in the amount of hospital services used per year across all categories (Table 3.3). In particular, there was a 90 per cent decrease in the number of inpatient days per year, an 83 per cent decrease in the number of days spent in psychiatric units, and an 82 per cent decrease in the number of hours spent in emergency. The changes in all categories were statistically significant according to the Wilcoxon Signed Ranks Test. Similar reductions were experienced by clients of MACNI in Victoria, in which emergency department admissions fell by about 75% and hospital admissions fell by 35% (KPMG, 2007). In comparison, ISP clients experienced a 58% decrease in the number of visits to the emergency department and a 90% decrease in the number of days spent in hospital.

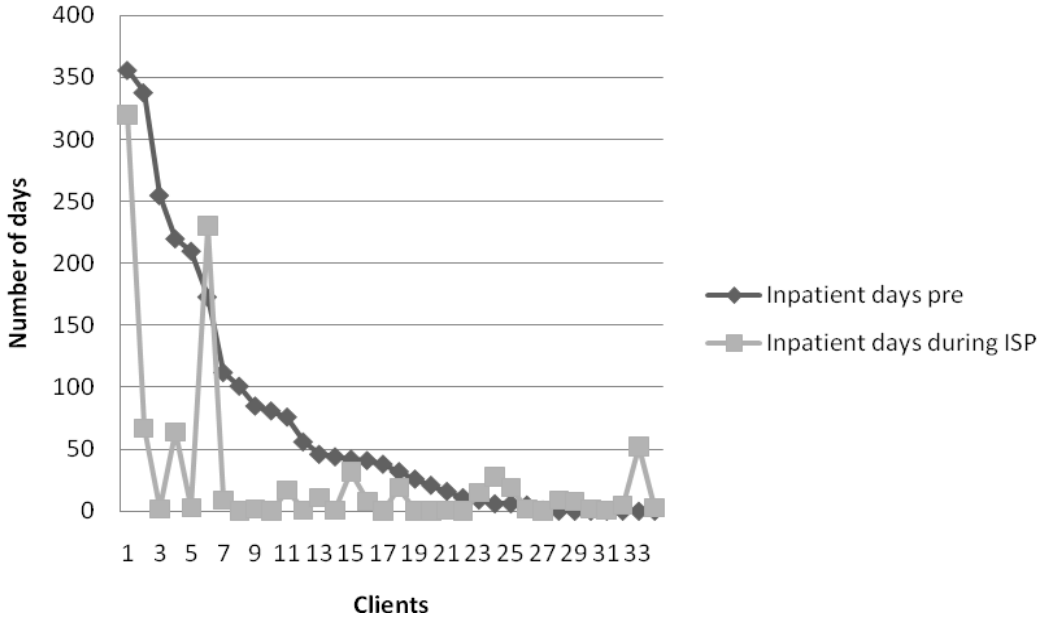
Table 3.3: Median Inpatient and Emergency Department Services Used Per Person per Year, Before and During ISP (n=34)

	Before	During	Change	Per cent change
Inpatient stays/year**	4	2	-2	-59
Inpatient days/year **	35	3	-32	-90
Involuntary days/year **	4	0	-4	-100
Days in psychiatric units**	9	1	-8	-83
Emergency visits**	6	2	-4	-58
Hours spent in emergency**	60	11	-49	-82

Source: Inpatient and Emergency Database, NSW Health
Notes: Median is used to mitigate the outlying cases within the sample
Data were only available on 34 clients who could be linked with their ISP start dates
**p<0.05 (Wilcoxon Signed Ranks Test)

Figure 3.4 demonstrates the change in the number of days clients spent in hospital before ISP and while clients were in ISP. The graph shows that most clients experienced decreases in the number of days spent in hospital; small increases in hospital use were observed for only six people.

Figure 3.4: Change in Days Spent as an Inpatient in Hospital, annualised (n=34)



The decrease in hospital use is reflected in the significant decreases in the cost of providing hospital services to each client per year; Table 4.4 shows that there was a 70 per cent reduction in the cost of providing emergency services to this group and a 60 per cent reduction the total cost of hospital services used by clients once they entered ISP. Thus, the provision of hospital services across the group cost about $1,261,392 one year prior to ISP compared with $517,673 per year during ISP (Table 3.4).

Table 3.4: Median Hospital Use per Person, Per Year Before and During ISP (n=34)

	Unit	Before	During	Change	Per cent change
Cost of inpatient stays**	$	15,203	6,332	-8,871	-58
ED cost **	$	2,315	679	-1,636	-71
Total cost **	$	18,419	7,507	-10,912	-59

Source: Inpatient and Emergency Database, NSW Health
Notes: Median is used to mitigate the outlying cases within the sample
**p<0.05 (Wilcoxon Signed Ranks Test)

Criminal justice services

In addition to the high use of hospital services, many ISP clients were in contact with corrective services immediately prior to ISP: 14 people had transferred from a correctional facility directly into ISP and 21 clients had been in custody in NSW at some point as an adult. The Project was able to obtain data from Corrective Services on each of these 21 clients so the evaluation could examine the change in service use one year prior to ISP and at one and two years in ISP.

The data show that these 21 clients spent a total of 4128 days in custody in the year prior to joining ISP. After one year of involvement in the Project, contact with

Corrective Services decreased substantially to a total of 803 days and continued to decrease so that, by the end of clients' second year in ISP, only 259 days were spent in custody. This represents a 94 per cent decrease in contact with Corrective Services between the year prior to ISP and clients' second year in ISP (Table 3.5). This significant decrease is partly due to the fact that nine clients had been incarcerated for most of the year prior to becoming ISP clients.

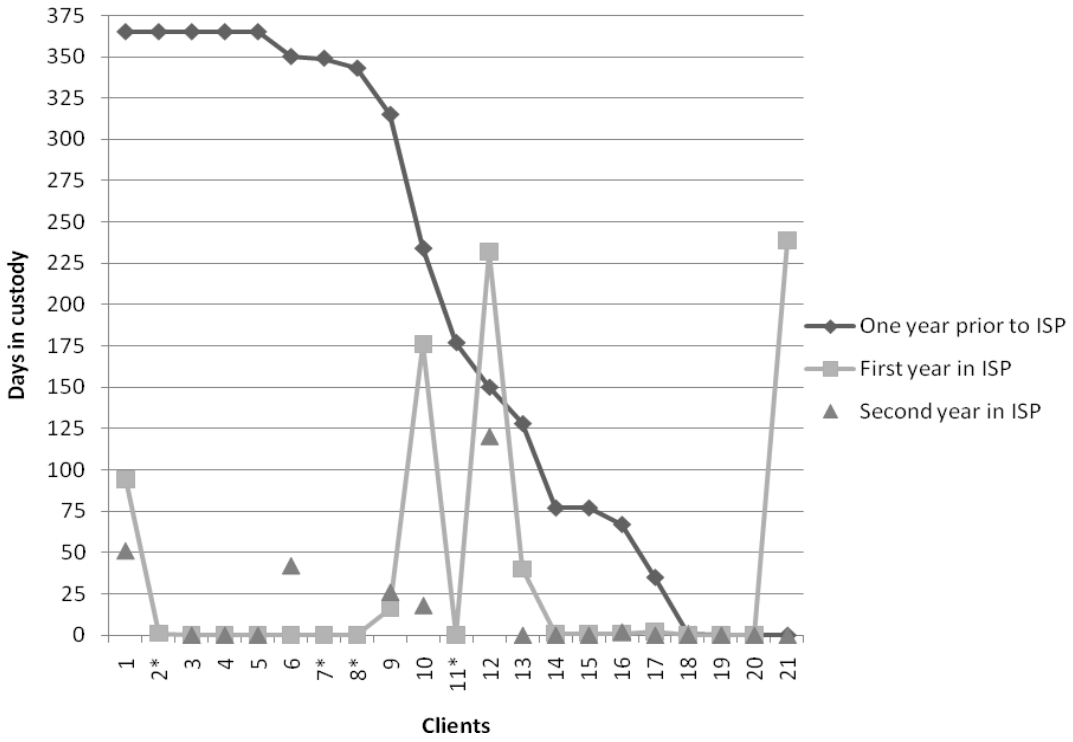
Table 3.5: Change in Corrective Service Use 12 months prior to ISP, 12 and 24 Months in ISP (n=21)

	12 months prior	First year in ISP	Second year in ISP	Per cent change
Number of days**	4128	803	259	-94

Notes: Only 21 of the 36 client have been in custody in NSW
Per cent change calculated between 12 months before ISP and clients' second year in ISP
**p<0.05 (Wilcoxon Signed Ranks Test)

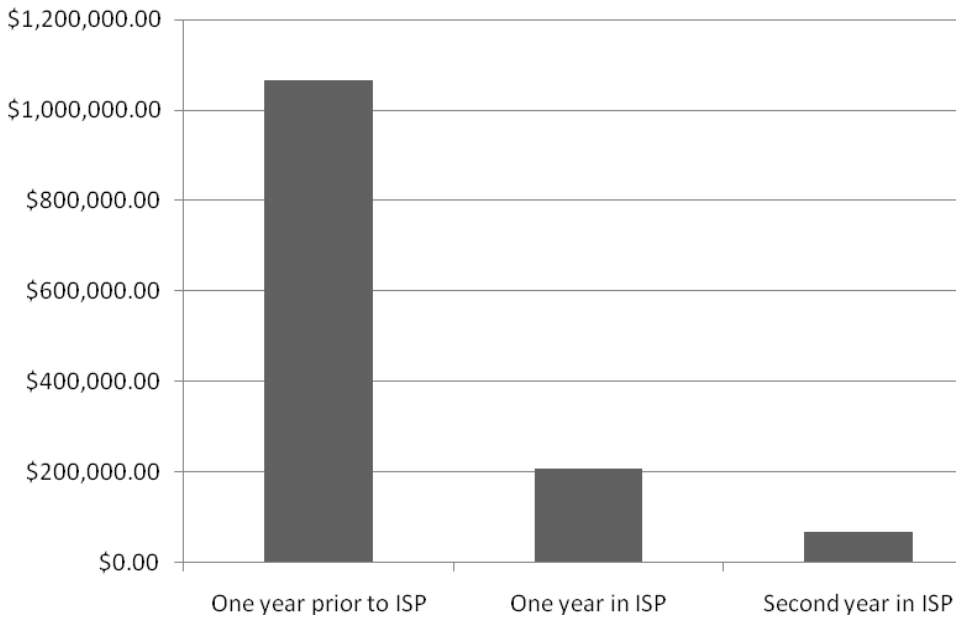
Figure 3.5 maps the trends in service use experienced by the 21 clients who had been in custody at some point as an adult in NSW. It demonstrates that most clients experienced a substantial decrease in contact with the criminal justice system during their first year in ISP, and that service contact educed for all clients by the end of their second year in the Project.

Figure 3.5: Contact with Criminal Justice Services 12 months prior to ISP, 12 and 24 Months in ISP (n=21)



The reduction in service use translates to a corresponding decrease in costs for Corrective Services. One year prior to joining ISP, these 21 clients collectively cost Corrective Services $1,065,024; this decreased to $66,822 in clients' second year in ISP (Figure 3.6).[9]

Figure 3.6: Change in Total Cost to Corrective Services per year (n=21)



To further examine changes in hospital and criminal justice service use, the data received from both services was linked to the case study clients and compared.[10] Table 3.6 shows that all four of the case study clients had a reduced amount of contact with the criminal justice and hospital systems in NSW, resulting in substantial cost reductions to NSW Health and to Corrective Services. Not all clients experienced reductions in service use: two clients used more criminal justice services than they did in the year prior to ISP, and two additional clients utilised hospital services more frequently than before entering ISP.

9 The cost of detaining a person in custody is approximately $258 per day (see Corrective Services (2006), *Key Performance Indicators*, Corrective Services NSW, Sydney.) It is likely that this figure underestimates the true cost to Corrective Services because it does not take into account the higher cost of providing extra support to complex clients (e.g. isolation or mental health units).

10 It is important to note that the service use data only captures hospital services and contact with the criminal justice system in NSW, and does not factor in contacts clients had with other services in such as police, homelessness services, ADHC, Department of Housing, and services in other states.

Table 3.6: Changes in Service Use and Cost for Case Study Clients, annualised

Case study client	Before ISP				During ISP				Change in cost ($)
	Inpatient days	ER visits	Days in custody	Total cost ($)	Inpatient days	ER visits	Days in custody	Total cost ($)	
Alan	81	14	343	162,146	0	0	0	0	-162,146
John	11	2	349	104,814	0	1	0	116	-104,698
Anne	42	13	365	130,459	32	25	1	37,889	-92,570
Rebecca	38	7	177	63,446	0	0	0	0	-63,446

The ISP has facilitated the reduction in hospital and service use for most clients. This indicates that, although global changes in challenging behaviour were not observed on the OBS, the supports provided to clients have been successful in reducing inappropriate service use for this group.

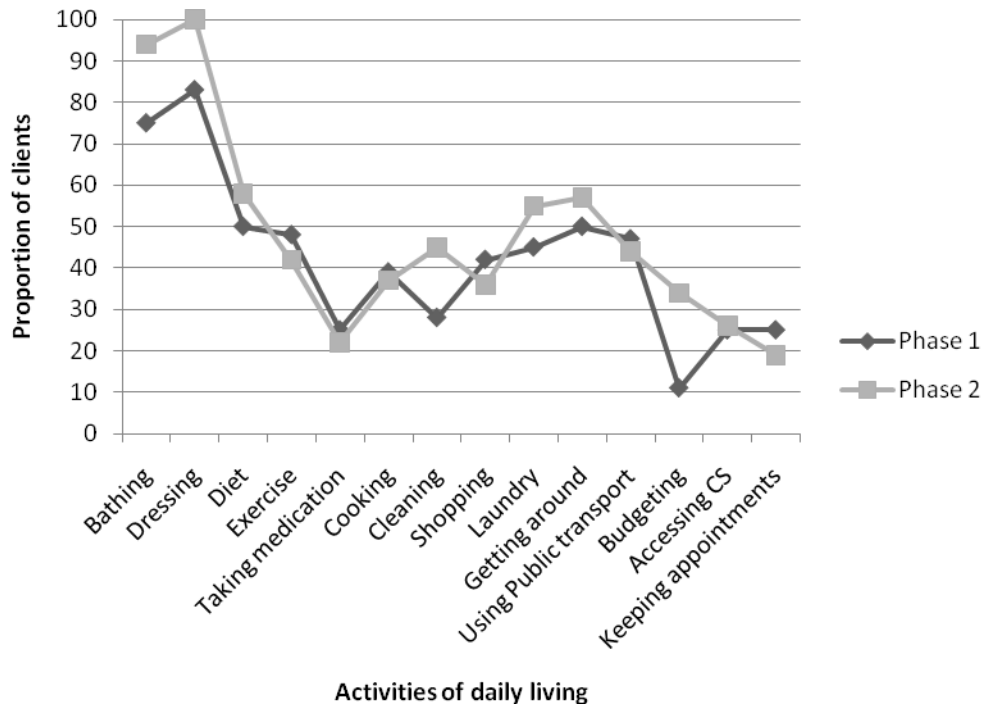
3.3 Ability to live safely in the community

The ISP aims to teach clients how to live safely in the community. Living skills are an important element of people's ability to participate and function in the community (Drake et al., 2003), and so clients' ability to live safely in the community was measured by analysing changes in living skills of clients between Phase 1 and 2 of the evaluation. ISP staff rated the level of independence displayed by clients in the areas of self care (including bathing, dressing, diet, exercise, taking medication) and other daily living activities (such as cooking, cleaning, accessing public transport and keeping appointments).

Figure 3.7 shows that the 36 clients had varying degrees of independence in self care and daily living activities in Phase 1, at which time most clients were independent or supported less than half of the time on only four activities: bathing, dressing, diet and getting around. Between Phase 1 and 2, clients experienced increases in independence in relation to budgeting (23% increase); bathing (19% increase); dressing (17% increase); and cleaning (17% increase). In most other domains, clients' levels of independence remained roughly the same. This indicates that clients did experience an increased ability to live safely and effectively in the community between Phase 1 and 2 of the research, but that the changes were relatively small.[11] As with the OBS, it also may suggest that client's behaviours are somewhat entrenched and difficult to change over a short period of time.

[11] A true baseline was not captured for these clients, so these changes may have been greater than the figures indicate.

Figure 3.7: Proportion of Clients who are Independent or Supported Less Than Half of the Time in Activities of Daily Living, March 2008 and January 2009 (n=36)



These relatively small increases in independence were discussed proudly by three of the four clients interviewed for the evaluation. John reported that he likes that the ISP,

> Gives me new skills, so I can look after myself and be independent…I'm cleaning my own room every day now. I'm well presented – I'm going to a wedding in Victoria and tried on a suit and tie. I looked really outstanding.

Both Rebecca and Anne reported that they were taught new skills in relation to cooking, cleaning and budgeting. Anne stated,

> Before I didn't know how to cook, but now I cook fluently. The staff have taught me and I can make chicken schnitzel and steak.

One of the case study clients, Alan, did not report a change in living skills and seemed to become more dependent on ISP during his time as a client. In the first interview, he stated that he did some of cooking on his own, but by the third interview he stated, "I'm too lazy to cook or clean. People are cooking for me."

ISP clients had high levels of dependence in relation to daily living tasks upon entry into ISP. They did experience some increases in independence, particularly in relation to budgeting, cleaning, bathing and dressing, but in many areas, little change was registered. This again shows that most ISP clients have well-established behaviours that are resistant to major changes over a short time period.

3.4 Health and well-being

The ISP aims to improve client health and well-being. This section reports on self assessed measures of changes in health and well-being as experienced by clients in ISP and those who have left the Project.

Self assessed health

ISP clients have a diverse range of diagnoses and conditions, so it was not possible to implement a clinical measure that could compare changes in health conditions across the sample. For this reason, changes in client's health status were rated qualitatively through the use of a self-assessed health question that was adapted from the Australia Bureau of Statistics (ABS). This facilitated comparisons between ISP clients, the general Australian population (ABS, 2006) and HASI clients (Muir et al., 2007). As with other client outcomes, information on self-assessed health was gathered from clients who were still involved in the Project and those who had transitioned to mainstream services at March 2008 (Phase 1) and January 2009 (Phase 2).

At Phase 2, most ISP clients (75%, n=18) rated their health as excellent, very good or good (Table 3.7). These scores did not change between Phase 1 and 2 of the research, which indicates that clients experienced stable health conditions between the two phases of the evaluation. While ISP clients still rated their health as poorer than the Australian population, their scores at Phase 2 were higher than the scores of HASI clients. This finding must be interpreted with caution, however, given that data was unable to be obtained on 12 clients.[12]

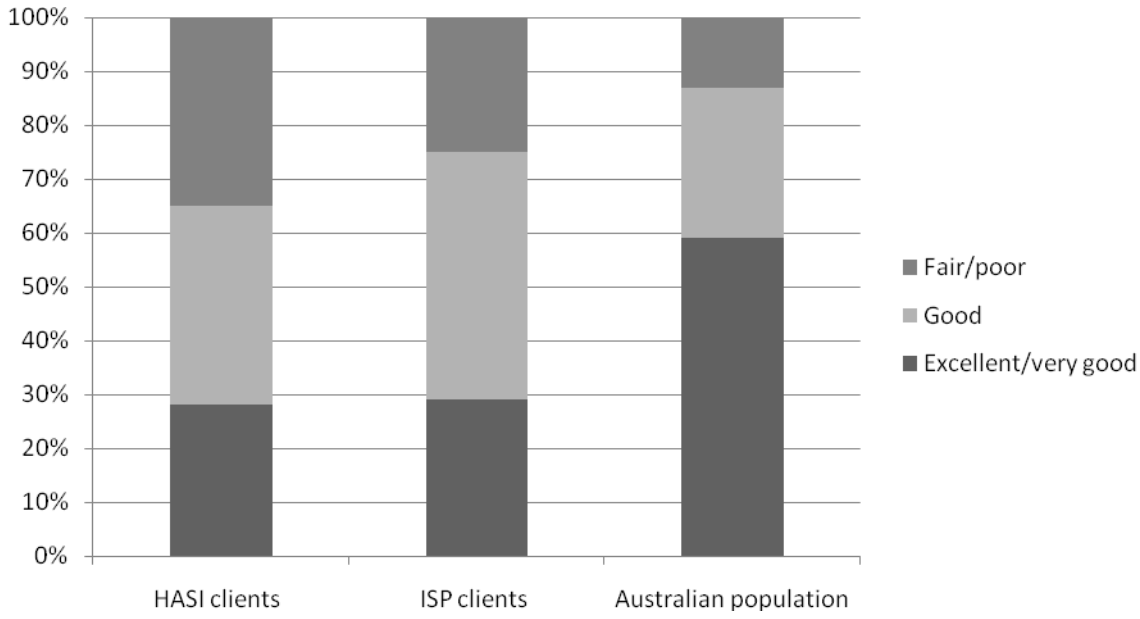
Table 3.7: Self Assessed Health during ISP Compared to HASI clients and the Australian Population, January 2009, per cent

	ISP clients (Phase 2, n=24)	HASI clients (Phase 3, n=51)	Australian population**
Excellent/very good	29	28	59
Good	46	37	28
Fair/poor	25	35	13

**p<0.05 (Chi-square goodness of fit test between ISP and Australian population scores)

[12] Staff reported that they could not elicit adequate responses to this question from these clients.

Figure 3.8: Self Assessed Health, HASI (n=51), ISP (n=24) and Australian Population, per cent



ISP clients also rated their health compared to one year ago and, at Phase 2, almost all ISP clients (92%; n=22) reported that their health was better or the same as one year prior; this is a slight increase from Phase 1, when 88 per cent of ISP clients (n=21) assessed their health as better or about the same as one year ago. Compared to the Australian population, former and current ISP clients reported far greater positive change in their health during both rounds of data collection. Positive changes in physical and mental health were experienced by three of the case study clients. For example, in her second interview Anne stated that,

> My physical and mental health are good at the moment. I went five weeks without self harm, which is the longest since I was 14. I was in hospital about three of four weeks ago but I haven't self harmed since.

Alan, who earlier was reported not to have experienced any changes in his living conditions, was 62 years old and, over the course of the three interviews did not register any improvement in his health. He stated,

> I got a lot of trouble in my brains, my body and my legs. I need to walk around but I can't. It's too late now [to change]…my legs aren't good and I smoke too much.

Personal well-being

The Personal Wellbeing Index (PWI), an internationally validated instrument, was used to measure subjective well-being in relation to clients' life as a whole, standard of living, health, achievements in life, personal relationships, safety, feeling part of the community and future security (Cummins, 2005). The results were standardised on a scale of 1-100 and, for the purposes of this evaluation, were analysed

longitudinally between Phase 1 and Phase 2 to detect change in client well-being during their involvement with the ISP.[13,14] For comparative purposes, clients' personal well-being results were also measured against the Australian population norm (Cummins, 2005) and scores from clients in the HASI program (Muir et al., 2007). The HASI sample was chosen as a comparison group because, like ISP clients, all clients have complex needs and insecure tenancy upon entry into HASI.

Between March 2008 and January 2009, clients experienced an overall increase in personal well-being; statistically significant increases ($p<0.05$) were recorded in the areas of standard of living, achievements in life, future security and life as a whole (Table 3.8). These increases moved ISP clients closer to the Australian population norm and, in some domains such as achievements in life, safety, feeling part of the community and future security, the scores of ISP clients surpassed those of the Australian population.

Table 3.8: Personal Wellbeing Index Mean of ISP Clients (n=26), HASI Clients (n=55) and Australian Population, per cent

	Sample	Phase 1	Phase 2	p[1]
Standard of living	ISP clients	56.8	83.6	.000**
	HASI clients	70.0	65.0	-
	Australian population	-	78.3	-
Health	ISP clients	59.2	71.2	.079*
	HASI clients	56.0	53.7	-
	Australian population	-	75.1	-
Achievements in life	ISP clients	58.0	73.6	.021**
	HASI clients	64.0	56.6	-
	Australian population	-	73.5	-
Personal relationships	ISP clients	54.7	64.4	.241
	HASI clients	63.2	60.4	-
	Australian population	-	79.2	-
Safety	ISP clients	66.6	77.2	.338
	HASI clients	70.4	68.2	-
	Australian population	-	80.2	-
Feeling part of the community	ISP clients	60.0	74.0	.078*
	HASI clients	57.7	64.3	-
	Australian population	-	71.1	-
Future security	ISP clients	57.9	74.4	.010**
	HASI clients	68.0	61.2	-
	Australian population	-	73.0	-
Life as a whole	ISP clients	55.2	70.8	.048**
	HASI clients	59.4	58.0	-
	Australian population	-	78.3	-

Notes: Based on the Wilcoxon Signed Rank Test (*p<0.1, **p<0.05)
10 clients were missing data due to refusal or inability to participate

13 The data collected in Phase 1 (March 2008) does not represent a baseline measurement, except for the four clients in the last round of intake.

14 Two rounds of scores were only available for 26 clients; three clients refused and seven clients were not capable of participating.

Data shows that ISP clients experienced improvements in their health, well being, and general quality of life since becoming involved with the Project. Clients experienced particularly substantial improvements in relation to their achievements in life, future security, standard of living and life as a whole.

3.5 Social connections and economic participation

The ISP aims to assist clients to develop positive social connections and increased economic participation. At Phase 1, staff reported that the relationships with friends and family had improved since clients had entered the Project. Because Phase 1 was not a true baseline, however, it is not surprising that few changes in the frequency of social contact were experienced by clients between Phase 1 and 2 of the research: at Phase 2, 58 per cent had regular contact with parents, 70 per cent had regular contact with siblings, and 72 per cent had regular contact with friends.[15] The only substantial difference between the two time periods was that frequency of contact with friends had increased; 72 per cent had contact with their friends on a monthly basis or more frequently as opposed to 61 per cent during Phase 1 (Table 3.9).

Table 3.9: Frequency of Social Contact (n=36), per cent

Contact with...	Phase	n	Daily	Weekly	Monthly	Yearly	Never/NA
Parents	Phase 1	36	25	19	14	56	36
	Phase 2	36	22	25	11	56	36
Partner	Phase 1	36	0	3	3	0	94
	Phase 2	36	8	0	3	0	89
Siblings	Phase 1	36	14	31	22	28	31
	Phase 2	36	14	25	31	28	28
Children	Phase 1	36	0	6	3	0	92
	Phase 2	36	0	0	6	0	94
Friends	Phase 1	36	25	19	17	3	36
	Phase 2	36	33	25	14	6	22

Not only did the frequency of contact with friends and family increase, but ISP staff helped clients to develop more positive relationships in their lives. For example, Rebecca reported

> Sometimes I want to be back with the father of my baby, but he's just going to want me to take drugs. My baby boy is 2 ½ months old and I have other children and sisters and a brother to think about, so I've gotta support my family. I miss being rowdy and doing what I want with my boyfriend but my children are more important.

In Rebecca's case, ISP has helped her to understand that taking drugs prohibits her from accessing her children, and so she has chosen to develop relationships that do not tempt her to resume taking drugs.

The ISP encouraged clients to become involved in social and other community participation activities as appropriate. Table 3.10 shows that the majority of the 36

[15] Regular contact is defined here as occurring on a monthly, weekly or daily basis.

clients (81%, n=29) had become involved in social and community activities since joining the Project. Some clients had also become involved in volunteering (14%, n=5), paid employment (28%, n=10) and education (31%, n=11). One of the case study clients spoke appreciatively about this aspect of the support provided by ISP because it helped him to feel like part of the community,

> Most of the time I like being a part of the Project because it helps me go forward. It makes me feel like I'm part of the community, and shows me and others that I'm doing something worthwhile. I'm pleased with myself [because of this].

Table 3.10: Number of Clients who Participated in Social and Economic Activities since entry to ISP (n=36)

	n	Per cent	Median # hours per week
Volunteering	5	14	4
Work	10	28	12
Education	11	31	3
Social activities	29	81	-

Notes: Number of clients who had participated in this activity over the past year

According to qualitative data collected on each of the clients, most were not involved in any community or economic activity prior to becoming ISP clients, and so the levels of involvement shown in Table 4.10 suggest improvements in this area. It also demonstrates that participation in economic activities amongst this group remains low, which is likely due to the continuing challenges posed by high levels of challenging behaviour and multiple diagnoses and disorders.

3.6 Post-ISP client outcomes

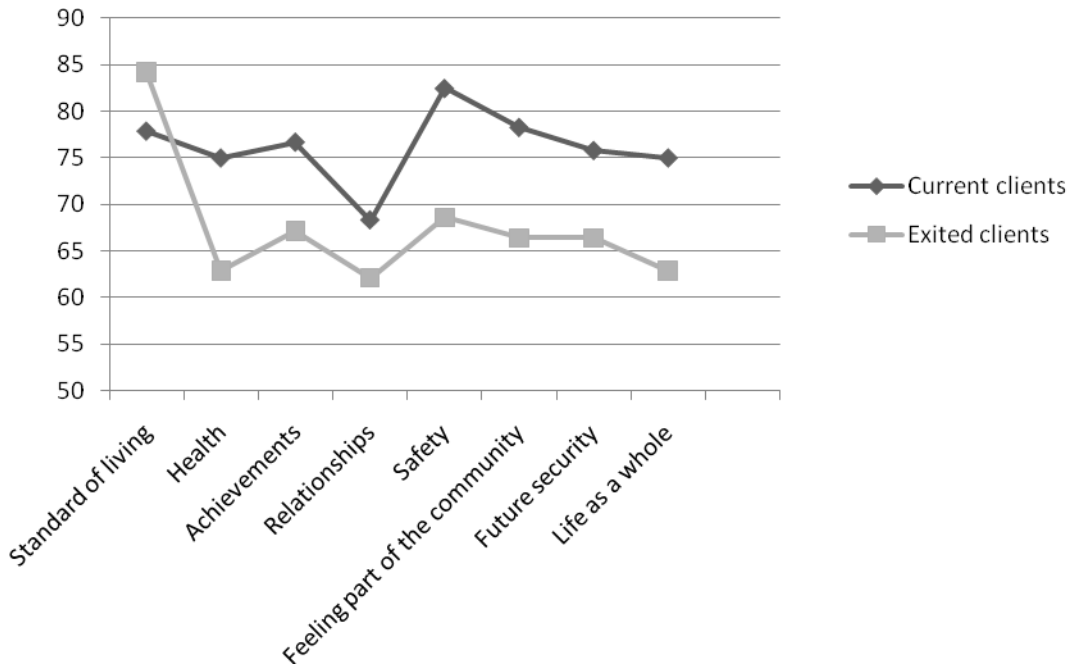
As of January 2009, the average time current clients had spent in the ISP was 21 months. The 18 former clients, however, had spent an average of 25 months before exiting the Project (Table G.1). This suggests that the 18-month timeframe before clients are exited from the Project may be unrealistic, particularly given the complex and longstanding nature of problems faced by clients. Stakeholders commented that client transitions out of ISP were further hindered by the lack of services available that have the capacity to support complex clients appropriately in the community. Even when appropriate agencies were found, ISP staff often had difficulty securing collaborative agreements with the agency about ISP's recommended model of support. As a result, some staff expressed concern that the positive gains made in ISP may not be sustainable after clients exit from the Project.

Data on exited clients was collected over the course of the evaluation and compared against current ISP clients. This data, however, is limited because of the small number of clients who had exited from the Project, and the difficulties project staff had accessing data about clients after they had exited. For this reason, the evaluation was only able to obtain comparable data between current and exited clients on the OBS, PWI, ABS health question, living skills, as well as clients' social and economic participation.

Results from the comparisons between current and former clients were mixed. On the one hand, there were no significant differences in the independence of clients who were still in ISP compared with those who had exited, nor were significant changes in clients' behaviour reported after leaving ISP. In addition, people who had left ISP had the same rates of participation in volunteering, work and education as those who remained in the Project. This indicates that many of the changes made by clients in ISP were sustained after transitioning out of the Project.

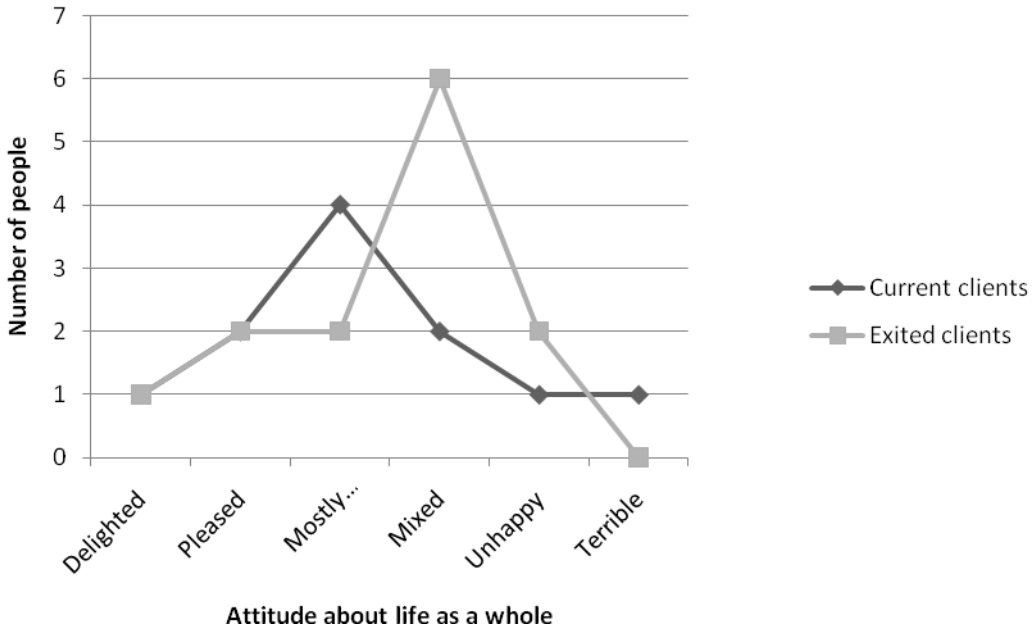
On the other hand, there is some evidence that client well-being decreased after people left ISP. Clients who were less involved in social activities once they had left the Project (68% of current clients, n=13 compared with 47% of exited clients, n=9) and, in addition, the PWI scores of clients who had exited were lower than people who were still in ISP (Figure 3.9).

Figure 3.9: PWI Scores of Clients still in ISP (n=13) and People who had Exited From ISP (n=13) by Phase 2, per cent



Differences between current and exited clients in Phase 2 of the evaluation were also reflected in the subjective ratings clients gave about their lives. Figure 3.10 shows that more people who had exited had either mixed or negative attitudes about their lives compared with those who were still in ISP.

Figure 3.10 Attitude about Life as a Whole, Current Clients (n=11) and Exited Clients (n=13), January 2009



This data, though limited, demonstrates that many of the changes experienced by clients while in ISP were sustained directly after exiting from ISP. However, client well being and involvement in social activities declined after transitioning out of the Project. This suggests that that the transition out of ISP can be problematic for clients and may impact on the sustainability of client outcomes; this is further discussed in Section 5.

3.7 Conclusion

This section has shown that clients have experienced generally positive changes in their lives since entering the ISP. For example, clients experienced a reduction in the frequency and impact of some challenging behaviours, which may have contributed to the considerable reductions in inappropriate hospital use and contact with the criminal justice system experienced across the group. Almost all interviewees agreed that the Project provides an essential service for a client group whose needs are too complex to fit into the existing service system and the flexible and individual nature of the support provided worked particularly well for this client group. Other factors that contributed to positive client outcomes included the commitment of staff and the ability of the Project to adapt as the project matured.

The next section analyses the effectiveness of ISP processes in relation to client outcomes and discusses some of the challenges associated with transitions out of the Project.

3.8 Summary

- Changes in challenging behaviours were measured by using the Overt Behaviour Scale (OBS) which showed that, upon Project entry, the most common challenging behaviours exhibited by clients were inappropriate social behaviour (100%), verbal aggression (91%), physical aggression against objects (80%) and physical aggression against others (80%).

- There were mixed results in relation to the global measures of challenging behaviour: the levels and severity of challenging behaviours decreased between baseline and Phase 1 of the evaluation but, between Phases 1 and 2, the levels and severity of challenging behaviour increased. However, the data shows that the frequency and impact of some behaviour decreased significantly over the course of the Project.

- There was a remarkable decrease in the number of hospital services used per year; in particular, there was a 90 per cent decrease in the number of days spent as an inpatient, an 83 per cent decrease in the number of days spent in psychiatric units, and an 82 per cent decrease in the number of hours spent in emergency.

- This translated into a 60 per cent decrease in cost burden for NSW Health; the provision of hospital services for clients one year prior to ISP cost about $1,261,392 per year compared with $517,673 per year during ISP.

- Clients also demonstrated a considerable decrease in contact with Corrective Services: there was a 94 per cent decrease in the number of days spent in custody one year prior to ISP and clients' second year in the Project.

- Clients became more independent in some activities of daily living, particularly budgeting, cleaning, bathing and dressing. In most other areas, minimal change was registered. This shows that ISP clients will likely require continuing support with daily living skills even after they have exited from the Project.

- At January 2009, three quarters of ISP clients rated their health as excellent, very good or good. These scores did not change between Phase 1 and 2 of the research, which indicates that clients experienced stable health conditions between the two phases of the research.

- ISP clients experienced an improved quality of life since becoming involved with the Project. Clients were particularly positive about their achievements in life, future security, standard of living and life as a whole.

- At January 2009, 58 per cent had regular contact with parents, 70 per cent had regular contact with siblings, and 72 per cent had regular contact with friends. This was reported by stakeholders to be an increase on baseline measures.

- ISP encouraged clients to become involved in social and other community participation activities as appropriate. The majority of clients (81%) had become involved in social and community activities since becoming a client of ISP. Some clients had also become involved in volunteering (14%), work (28%) and education (31%).

- Although the Project is set up to provide support for 18 months, as of January 2009, the average time current clients had spent in the ISP was 21 months, while the 18 former clients had spent an average of 25 months before exiting the Project.

- Exited clients did not differ from clients in ISP in regards to OBS results, independence in living skills, and economic participation, indicating that many of the changes made by clients in ISP were sustained after transitioning out of the Project.

- However, personal well-being and involvement in community activities decreased for clients who had exited, which suggests that the transition out of ISP may be problematic for clients.

- More data is needed to determine conclusively whether the changes experienced by clients in ISP are sustainable after exiting from the Project.

4 Processes for Supporting Clients

Once clients are accepted into the ISP, clients are assessed by the Project's multidisciplinary clinical team, which develops case plans that inform the identification of appropriate accommodation and other supports for clients based on their individual needs. The clinical team provides support to residential staff who are responsible for the day-to-day implementation of these case plans. Besides the clinical and residential support, person-centred case management is provided by the Project in order to maintain relationships with the multiple agencies involved and ensure that the client's needs are comprehensively addressed. This section analyses ISP staff and stakeholder perceptions of the processes used to support clients.

4.1 Nomination process

The majority of staff and stakeholders reported that the nomination process was successful in identifying clients for whom the Project was intended and that most agencies had positive experiences of the nomination and referral process.

A number of areas for improvement were also identified. Referring agencies sometimes had limited information on client backgrounds, and respondents reported that this impacted negatively on people's chances of being accepted into the Project. Moreover, it was reported that the application process created significant additional work for the referring agencies, which were required to gather a substantial amount of supporting information to make a referral. Respondents reported that it was therefore frustrating not to receive feedback when applicants were not accepted into the Project. As well, there were a few interviewees who believed that it would be useful to accept nominations from the broader community of service providers, including NGOs, rather than only from the seven human service agencies. This was seen as particularly important if ISP intends to transition clients to NGO support upon exit from ISP.

An additional issue raised by some interviewees was that other programs to support people who required specialised services had been implemented since ISP was established in 2005, which may change how the nomination process should be targeted in future. For example, the Community Justice Program (CJP), led by ADHC, was established in 2006 in order to assist people with intellectual disability to transition out of the criminal justice system. Some people who were originally accepted into ISP would now be more appropriately served by the CJP.

4.2 Supporting clients in ISP

Evaluation data shows that ISP clients experienced reductions in the frequency and impact of their challenging behaviour, a significant decrease in inappropriate service use, small improvements in the ability to live safely in the community and social contact, and, finally, substantial improvements in health and well-being. Interviewees attributed these changes to the ISP service model, which emphasises the *individualised* and *flexible* support provided to ISP clients. These elements are particularly important in the successful provision of services to a diverse and complex group of clients with challenging behaviours. The *clinical support,* which is provided through interdisciplinary teams, was identified as another key component of ISP services; case plans devised by the clinical team included therapeutic and behavioural management strategies, including communication and risk reduction measures, which are based on clinical knowledge of appropriate and effective ways to manage challenging behaviour. Working in multidisciplinary teams also ensured that clients

are provided with *holistic services* that address their needs at multiple levels, including health and mental health, vocational, social and life skills. The skills of staff were praised by one of the case study clients, Rebecca, who stated:

> If it wasn't for them, I wouldn't be anywhere. They are so well trained in helping people who have been on the streets, violent, have mental problems, on drugs.

Rebecca later commented that she feels the support provided by ISP is holistic, "How could I ask for more? We get looked after so well". John also felt as though he was getting the support he needs, "They're making changes for the best and they ask how I feel about it. I know I'm benefiting from it." Anne stated: I reckon I'm getting heaps, I can't think of more support, but if I think of something they'd help me find it."

Participants reported that the successful implementation of the clinical plans required *consistency* from all staff, including the accommodation support workers and case managers, which were achieved through strong *communication* channels. Some of the mechanisms by which communication was facilitated included a fortnightly meeting involving all staff associated with each client and through the accessibility of staff at all levels of the project.

Other factors that interviewees thought contributed to the successful provision of services were the *low turnover of staff* which reflected a strong commitment to working with people with challenging behaviour and support for the ISP service model. The stability of the workforce contributed to the consistency of support provided to clients. In addition, the ISP has demonstrated the *capacity to learn from experience* and alter support mechanisms that are not working as well as could be. For example, an assessment unit at metro residences was established in the project's early stages, but a number of problems with this unit emerged over time. In particular, this environment proved not to be the most appropriate setting in which community living skills could be assessed. Consequently, the assessment unit was closed and the Project focused on assessing and managing clients in community based settings, where they could potentially reside for the 15-18 months stay with the project.

Effectiveness of ISP support for certain groups

Analysis of the outcome data for the 36 clients showed that the project had varying levels of success in achieving outcomes and roughly three groups were identified. The first group, which accounted for about 70 per cent (n=25) of clients, engaged with ISP services to varying degrees and showed gradual but consistent improvements in their behaviour, well being and living skills, as well as notable reductions in use of hospital and criminal justice services. Stakeholders reported that the process of connecting with clients was assisted when there were established pathways of engagement, such as Guardianship or Community Treatment Orders, because it allowed for gradual connections to be built between clients and staff. This group of clients responded to the holistic, flexible and consistent nature of ISP services, as well as to the positive reinforcement provided by staff.

The data suggests that, while ISP assisted most clients to achieve positive outcomes, some clients did not benefit as much as others. A second group (19%; n=7) responded well to the provision of stable housing through the Project and to the high level of

accommodation support and, as a result, experienced a decrease in inappropriate service use. However, the behavioural issues of these clients remained and, in some cases, clients did not develop the skills to live more independently in the community. Two of the case study clients fell into this category.

ISP was effective in reducing the impact of these clients on the broader service system, but this group of clients will continue to require high levels of support for the remainder of their lives.

Clients in the final group (11%; n=4) did not engage effectively with ISP staff and services. Clients either did not have the capacity to engage with ISP services or showed a preference for continuing the lifestyles they had before entering Project and, as a result, their challenging behaviour and inappropriate service use did not decrease over the course of the Project. All four of these clients had been institutionalised at an early age and had a history of physical violence, aggression and criminal activity. Further analysis of the characteristics of this group of clients is required as it is likely that these clients will remain problematic for the service system regardless of the intensive services received from ISP or similar programs.

Aspects of ISP support that could be improved

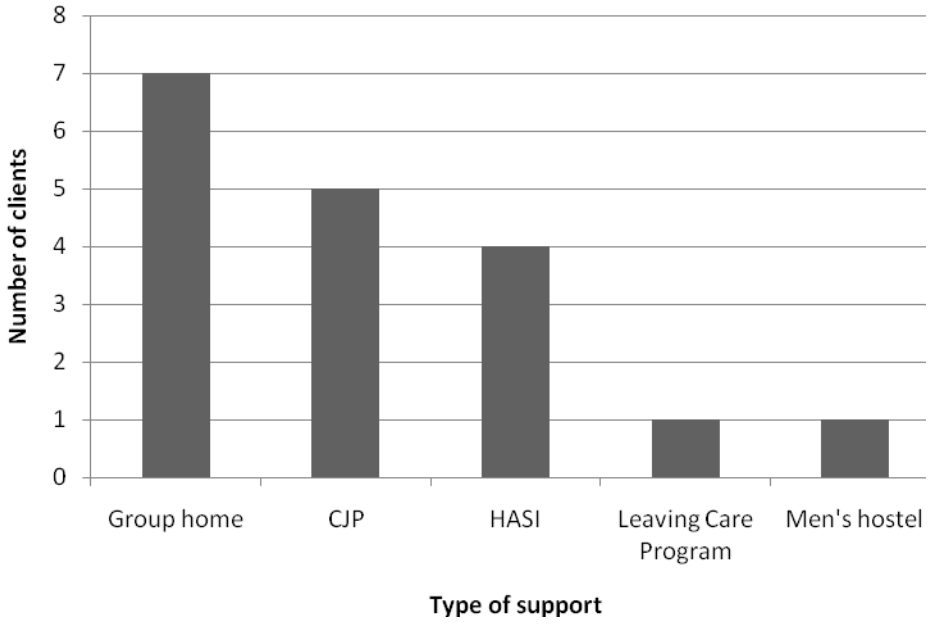
Opinions regarding the effectiveness of ISP support were generally positive but participants did comment on a few aspects of ISP services that could be further strengthened. Firstly, a number of interviewees stated that the clinical team require ongoing training and support to develop and maintain the *appropriate skills and techniques* to successfully deal with clients with challenging behaviour. For example, it was reported that in the early stages of the Project the focus of staff and services was skewed towards crisis management and, as such, was not balanced with a preventative approach to clients' challenging behaviours. This issue was recognised by ISP management, who appointed an experienced clinician to provide clinical leadership and to put processes in place that better supported the work of the clinical team.

Secondly, ISP did not accept any new clients after early 2008 and there were also some delays in discharging clients. For these reasons, a number of interviewees reported that some clients were provided a *higher level of support* than was intended in the original model. This was an issue because some clients reportedly became dependent on the higher levels of support which made their transition out of the Project difficult to manage. Finally, some staff expressed the concern that as the Project expanded and more clients were accepted, staff *workloads* could become too onerous. Ensuring sustainable workloads will require constant monitoring and adjustment.

4.3 Transitioning out of ISP

By January 2009, half of all clients (n=18) had exited the Project onto packages of support that were judged to best suit their individual needs. Seven clients had moved into a group homes: six placements were funded by ADHC in a group home specifically designed to accommodate people with complex needs, and one person moved into an established group home. Another five people were supported in the CJP and four people were transferred onto a HASI package.

Figure 4.1: Clients' Post-ISP Accommodation Support, January 2009 (n=18)



Preliminary data collected on people who exited from ISP indicates that their housing outcomes since exiting from the Project have been wholly positive: 89 per cent were reported to still be living in stable housing. The majority were also successfully managing to maintain their physical environments (81%) and to pay their rent on time (72%). Only 53 per cent of former clients, however, were reported to have maintained good relationships with their neighbours.

Table 4.1: Former ISP Client Housing Situation, January 2009 (n=18)

	Number of clients	Per cent
Stable housing	16	89
Good relationships with neighbours	9	53
Well maintained physical environment	13	81
Rent regularly paid on time	13	72

The cost of each post-ISP package of support varied depending on client needs: the smallest package cost $16,000 to place a client in a men's retirement hostel and the largest package cost $327,780 to accommodate a client in a secured large residential facility in which support is provided by the CJP. The median cost of a package of care for these 18 clients was $140,000. The supports for thirteen of the eighteen clients (72%) are funded by ADHC; the remaining five clients are funded by NSW Health (HASI).

The ISP aims to provide intensive and comprehensive support over a fifteen to eighteen month period in order to reduce clients' challenging behaviours and identify ongoing support models that can be delivered by mainstream services. Analysis from the first evaluation report showed that the majority of clients who had exited the ISP had been in the project for longer than eighteen months, which indicates that transitioning out of ISP may take longer than expected (McDermott et al., 2008). Staff

and stakeholders confirmed that successful transitions out of the project are hindered by obstacles such as identifying services in the community with the capacity to appropriately support clients. Additionally, when an appropriate agency is identified, ISP staff can have difficulty securing collaborative agreement with such agencies regarding ISP's recommended model of support.

A number of strategies were put in place to address these transition issues including introducing clients to the new service over a longer period of time and spending time with the new organisation in order to demonstrate how to implement the clinical care plans devised by the ISP. Even so, many staff reported that the positive changes experienced by clients while in the Project were often put at risk after clients left due to difficulties associated with service transition. Participants reported that some agencies were unable to consistently implement case plans developed by the ISP due to: a lack of appropriate and flexible resourcing; limited knowledge and understanding in other organisations around how to manage clients with complex needs and challenging behaviour; and the lack of consistency around the implementation of clinical case plans.

It is important to note that many ISP clients had never lived independently in the community prior to entering the Project, and so some difficulty adjusting to another service provider after exiting the Project was understandable. It was, however, discouraging for staff to see some of the gains clients had made were eroded after their transition.

4.4 Conclusion

Some interviewees pointed to elements of ISP support that could work better but most agreed that the project provided an essential service for a client group whose needs are too complex to fit into the existing service system. The flexible and individual nature of the support provided worked particularly well for this client group. Other factors that contributed to positive client outcomes included the commitment of staff and the ability of the project to adapt as the project matured. The ability to manage client transitions in and out of the project is an essential aspect of the project, as the ISP intends to provide support for a limited period of time. It is this area that presents the key challenge to the capacity of the ISP meet its long term aims.

4.5 Summary

- The nomination process was reported to be successful in accessing the target group.
- To improve the process, interview participants asked for recognition that some agencies lacked specific information on clients' backgrounds which potentially impacted on the client's eligibility for the project; more feedback on why some clients were not accepted; and to accept referrals from non-government organisations.
- Staff and stakeholders considered the ISP to have been highly successful in supporting its target client group. Some of the major strengths of the ISP's services were: flexibility, holistic support, consistency of support, stability of staff, and ability to learn from experience.

- Support could be improved by ensuring that staff have training and support to ensure they have high-level skills required to deal with this challenging client group

- There was some concern that clients may be receiving a higher level of services than required or sustainable under the current model.

- Half of all ISP clients (n=18) had exited ISP by January 2009. Clients were moved on to: group homes (n=7), CJP (n=5), HASI (n=4), men's hostel (n=1) and Leaving Care (n=1). The median cost of a post-ISP package was $140,000.

- Exit data indicates that former clients have experienced stable housing after exiting from ISP. They have also been successful in maintaining the physical environment and paying rent consistently.

- Transitioning clients out of the ISP is the Project's key challenge, because of limitations in the broader service system's support models, limited knowledge of how to manage clients with challenging behaviour, and limited resources to support this group of clients effectively.

5 Governance and Service System Impact

Like HASI and CJP, the ISP has adopted a partnership approach to service provision. The Project is led by ADHC in conjunction with NSW Health and Housing NSW, and each of these agencies is represented on the ISP's Project Management Committee, which provides the primary policy guidance and sets the direction for the Project. The ISP manager reports on the activities of ISP via the Director of the Office of the Senior Practitioner (ADHC), to the Deputy Director General of ADHC and to the Mental Health Senior Officers Group. There is also an Interagency Reference Group, which provides a consultative body that informs ISP activities and which is made up of representatives of the three key agencies, as well as the Departments of Corrective Services, Juvenile Justice and Community Services, and the NSW Trustee and Public Guardian, NSW Police, and the Council for Intellectual Disability. ISP service activities are also informed by a Clinical Reference Group, which consists of independent consultants and senior clinical staff from NSW Health and ADHC. This group provides expert advice to ISP staff about the management of current clients and the capacity of the wider service system to support people with specific illnesses and disorders in the community. Finally, an Evaluation Reference Group was formed to guide the current evaluation process and includes representatives from a number of the above-named organisations and NSW Treasury. (See Appendix A for a diagram of the Project's governance structure).

5.1 Governance arrangements

Engaging stakeholders

All of the nine interviewees who were involved with the governance of the ISP believed that the relevant agencies were represented at appropriate levels within the current structure. Participants also identified a number of key opportunities for successfully engaging relevant stakeholders in the Project's governance, as well as a number of barriers.

Factors that were reported to have promoted the successful engagement of stakeholders included the high level and long term commitment within the NSW Government to the Project. Another factor was the strengthening of partnerships between NSW Health and ADHC as a result of working together to establish and operate the ISP, with staff in both departments reporting that they could contact one another to discuss collaborative approaches to address complex cases (see Case Example 1).

Case Example 1

A young man with borderline intellectual disability and severe behavioural problems had been living in a mental health ward for two years. Staff at the ISP worked to find an alternative accommodation option for him by facilitating negotiations with ADHC and NSW Health. These discussions resulted in the provision of one-off funding to transition the young man into a community-based accommodation option offered by an NGO that could appropriately address his complex needs.

The strong relationship between the two agencies was also fostered via the Project Officer position shared between ADHC and NSW Health. The existence of this

position assisted the ISP to understand the unique contexts and cultures of both agencies.

A key barrier to engaging stakeholders early in the Project was staff turnover in the service system, which resulted in lack of continuity and affected the commitment of agencies over time. Some of the interviewees involved in the governance of the Project said that they would like communication channels to be more open and to receive regular correspondence about actions taken by the Project. One way of addressing this issue would be to clarify with members on the Interagency Reference Group their expectations about their ongoing roles and responsibilities as the Project matures.

Governance

Participants reported that the Project's governance arrangements worked well in providing advice on crucial issues. The Interagency Reference Group was reported to be a valuable advisory body, whose effectiveness was facilitated by regular meetings and the responsiveness of ISP management to issues raised by the Group. For example, early in the Project's implementation some members of the Group were concerned about the high-levels of physical restraint used with some clients. As described in Section 4 support processes were modified to ensure that clinical leadership was strengthened, and processes were implemented to ensure that these practices were appropriately authorised and accountable.

The Project Management Committee, which was responsible for making decisions guiding the Project's activities, was also crucial to its effective operation. Interviewees reported that the Committee had been effective in informing the Project and supporting it to achieve its aims. The Committee's work has been facilitated by the fact that it is composed of a small group of people who have been consistently involved in the Project over a long period of time, with the result that the members have an in-depth knowledge of the history of the ISP, its support processes, and the client group.

The governance arrangements worked well in the pilot project but participants identified potential areas for improvement. The continuation of an effective Interagency Reference Group is critical to the future of the ISP because the Project relies on the representatives of this group to inform their agencies and to act as a conduit between the agencies and the Project. Some participants felt that the membership could be reviewed as the Project matured, and that the group could focus on encouraging broader changes within the service system, e.g. exploring the possibility of promoting earlier identification and intervention with high-risk clients across the service system. Whatever priorities are selected, participants reported that the group was central to providing relevant advice on the Project's activities, and that it could assist in building ongoing commitment from key agencies and from key individuals within those agencies.

Finally, as the need to engage more closely with a range of government and NGO services increases, it may be useful to invite NGO community-based organisations to be part of the Interagency Reference Group. The need to further engage with the community sector to promote wider system change is discussed in the next section.

5.2 Service System

The ISP is a unique service model that provides clients with clinical support, case management, accommodation support, and housing. The aim of providing intensive, holistic services is to reduce challenging behaviour so that clients can ultimately be supported to live safely in the community. In addition, the Project aims to contribute to changes in the local service system around supporting people with challenging behaviour in the broader community. This section considers benefits and drawbacks of the model according to staff and other stakeholders, and the extent to which the ISP has informed practice in the broader service system.

Service model and funding

The majority of services in the ISP, from housing to clinical support, are funded and managed by ADHC. Along with the other benefits of the service model that were discussed in Section 4, the direct provision of a comprehensive range of services ensures that clients receive consistent and well-coordinated support from workers at all levels of the organisation.

One of the primary risks associated with the model that was identified by participants was that the provision of holistic, comprehensive services might lead to an insular model of service provision. In some cases, service providers had not been closely involved while clients were in the ISP, and the consequent lack of information- and caseload-sharing with other agencies and organisations contributed to more difficult transitions for clients.

The high amount of support provided by the ISP was reported to produce positive outcomes for clients while they were supported by the Project, but the independence of the model sometimes made it difficult for clients to transition to other community-based providers. For this reason, some interviewees suggested that there could be other ways of supporting clients' transitions out of the Project, e.g. by providing NGOs with targeted additional resources and clinical support. This could assist NGOs to develop their capacities to support people with challenging behaviour effectively in the community.

Informing systemic change

An important aim of the ISP is to identify lessons learned and to promote better system responses to the needs of clients with challenging behaviour. Participants reported that the advocacy efforts of the ISP focused primarily on the upper levels of government and on services to support the 38 clients in the Project.

The Project has promoted broader systemic change in some areas. Staff reported that engaging high-level government staff was crucial for generating service-wide changes to programs disadvantaging or excluding people with complex needs and challenging behaviour. For example, in supporting the needs of the 38 ISP clients, it has contributed to promoting greater interagency coordination and greater flexibility of eligibility criteria for both ADHC and NSW Health programs. This has been achieved via advocacy with key stakeholders, including decision-makers at senior levels.

There are two primary limitations to the Project's advocacy efforts. First, it cannot be assumed that advocacy with senior decision-makers will target all levels of the agency or the broader service system. People in the lower levels of government may not be

informed and consequently they will have limited knowledge of ISP's advocacy efforts and role in the service system. Second, NGOs and agencies providing direct services were not a priority target of these advocacy efforts. The lack of engagement with services in the broader community limits the extent to which wider change around the issues of challenging behaviour can be achieved within the local service system.

5.3 Conclusion

The existing governance structure has worked well for the ISP during its establishment and implementation phase, but it is important that the roles of each of the committees are reviewed as the Project matures. The ISP service model has produced positive outcomes for its clients. In future it will be important to engage other programs and services in the community and expand the Project's influence over the broader service system to promote improved service responses to the needs of people with complex needs and challenging behaviour.

5.4 Summary

- Overall, the governance arrangements for the Project were reported to have worked well. The key strengths of the governance structure were the strong partnerships and commitment from stakeholders; and the responsiveness of ISP management to issues raised by stakeholders.

- Governance arrangements could be improved by reviewing the role of the Project's Interagency Reference Group if the Project is expanded, and by engaging NGOs in these arrangements to build capacity in the community.

- The Project created formal working relationships between staff in different agencies, which set a good foundation for generating broader systemic change in future, and successfully engaged stakeholders at high levels of the NSW Government.

- However, significant broader service system change around the issue of supporting people with challenging behaviour is yet to be achieved. Advocacy for systemic change remains a clear priority for the ISP as it matures from a pilot project to a recurrently funded program within the human service sector.

6 Economic Analysis

This economic evaluation of the ISP compares the costs of the Project with client outcomes. The analysis uses expenditure data collected by staff from the beginning of the Project up until March 2008. Cost data from April 2008 to January 2009 were not included because the Project was winding down during that period and did not take on any new clients, and so the data would have provided an unrealistic picture of the actual recurrent costs of the Project.

6.1 Costs

Based on expenditure data, the average recurrent net cost per quarter of the ongoing project (expenditure less revenue and set-up costs) was approximately $1,604,404, and thus, the cost of providing ISP services over a one-year period was approximately $6,417,604. Direct services to clients accounted for 80 per cent of total expenditure (Table 6.1)

Table 6.1: ISP Expenditure and Revenue per Quarter July 2007 to March 2008 ($)

	July-September 2007	October-December 2007	January-March 2008	Average per quarter July 07-March 08
General services				
Project management[1]				
Management team	66,193	127,429	72,630	88,751
Operating	24,069	18,158	14,329	18,852
Support services				
Clinical team	177,327	129,998	179,312	162,212
Specialists	23,421	29,654	24,902	25,992
Operating	3,002	24,895	7,797	11,898
Supported living	30,600	31,833	39,559	33,997
Direct services to clients				
Southwest network				
Staff	616,526	671,037	582,183	623,249
Operating	80,138	70,121	66,710	72,323
Set up	-	-	-	-
Northwest network				
Staff	358,944	537,751	746,202	547,632
Operating	50,346	40,744	56,414	49,198
Set up[2]	-	120,107	-	40,036
Total expenditure (1)	1,430,656	1,801,727	1,790,038	1,674,140
Less				
Revenue offset client fees[3]	9,625	35,950	23,535	29,703
Set up costs (2)	-	120,107	-	40,036
Recurrent net cost requirement (1) - (2)[4]	1,420,941	1,645,670	1,766,503	1,604,401

Notes:
1. Excludes evaluation costs. Does not include other costs covered by ADHC e.g. rent
2. Establishment of three new interim housing properties
3. Supported living fees at 55 per cent Disability Support Pension
4. Some one-off expenses not identified such as the evaluation and wind-down costs

This figure includes only those recurrent costs that would not exist without ISP, particularly project management costs (e.g. the management team, clinical team, specialists, supported living management), and direct service costs (e.g. housing, accommodation support, client advocacy). Establishment, wind-down and one-off costs (e.g. this evaluation) are excluded from this figure, as are costs incurred by other

agencies and non-financial costs (e.g. time and stress). Full expenditure data is provided in Appendix E.

The annualised recurrent cost per current client is $207,000 (Table 6.2). The cost was determined by determining the average expenditure and average number of clients in the Project over the last two quarters in 2007 and the first quarter of 2008 because, by this time, the Project had matured and costs had stabilised, and hence they closely reflected the actual recurrent costs. It is also indicates the average number of clients that will be served at any one time by the Project.

Table 6.2: Annualised Recurrent Cost of ISP per Client

					Assessment unit closed			Ongoing project			Project ave. July 07-March 08
	Oct-Dec 05	Jan-Mar 06	Apr-Jun 06	Jul-Sep 06	Oct-Dec 06	Jan-Mar 07	Apr-Jun 07	Jul-Sep 07	Oct-Dec 07	Jan-Mar 08	
1. Clients in ISP	8	16	21	24	24	24	27	32	30	30	**31**
2. Clients accepted	8	8	3	3	3	3	7	2	4	4	**4**
3. Clients exited	-	-	-	-	-	-	-	2	4	4	**4**
Total clients	16	24	24	27	27	27	34	36	38	38	**38**
Cost per client ISP contact ($000)	77	89	148	125	151	213	185	178	219	235	**$207**[16]
Cost per client (all, $000)	77	89	148	125	151	213	185	150	173	186	**$169**

The cost of $207,000 may appear expensive compared to other programs that support people with complex needs in the community, such as HASI. However, the cost of HASI packages (in which the highest level of support costs $70,000) covers only accommodation support, and does not include housing and clinical program costs that are provided through ISP.

The mid-term evaluation report stated that the average cost of providing services to 18 clients prior to ISP was approximately $376,000. This figure was provided by referring agencies upon entry, but the method for determining this cost across the group is not clear and this figure should be treated with caution. However, the median cost of the post-ISP packages of support – $140,000 – is less than the cost of their support while in ISP, which suggests that the cost of providing supports to clients after ISP is decreased because clients are able to be supported by mainstream services.

[16] This number differs slightly from the mid-term report due a change in how an accepted client is defined.

6.2 Outcomes

The cost of ISP was approximately $6,417,604 per year for approximately 31 places; this covers the management and clinical teams, case management, housing, accommodation support and client advocacy. The cost of approximately $207,000 per client contributed to the following outcomes:

- reductions in the frequency and impact of some challenging behaviours;
- increased independence in some activities of daily living;
- increased access to stable housing;
- increased well-being;
- increased involvement in social and community activities, and
- decreased hospital use and reduced contact with corrective services.

Table 6.3 summarises the primary outcomes experienced by clients during their involvement in ISP.

Table 6.3: Outcome Data for ISP clients

Outcome	Description	Comparison	Entry[1] or Phase 1 data[2]	Phase 2 data	Implication
Challenging behaviour	Severity of challenging behaviour (CWS-OBS)	-	32[1]	30	A 2-point decrease in the severity of challenging behaviour was observed
Living skills[3]	Budgeting	-	11%[2]	34%	23% increase in independence
	Bathing	-	75%[2]	94%	19% increase in independence
	Dressing	-	83%[2]	100%	17% increase in independence
	Cleaning	-	28%[2]	45%	17% increase in independence
Physical health	% responding excellent, very good, good on general health question	65%[4]	-	75%	ISP clients were more likely to report good health than HASI clients
Personal well-being	Life as a whole	78%[5]	55%	71%	Statistically significant increases were recorded in all areas of personal well being
Participation	Social activities	-	-	81%	Most clients had become involved in social activities
	Education	20%[4]	-	31%	Higher rates of participation in education than HASI clients
	Work	26%[4]	-	28%	Similar rates of participation in work as HASI clients
Hospital use (annualised)	Median # hospital days/yr	-	35[6]	3	90% reduction
	Median # days psych units/yr	-	9[6]	1	83% reduction
	Median # hours in emergency/yr	-	60[6]	11	82% reduction
	Cost of hospital svcs ($,000)/yr	-	$1,261	$517	60% reduction in cost
Corrective services	# days spent in custody/yr	-	4128[7]	259[8]	94% reduction
	Cost of corrective services use ($,000)/yr	-	$1,065	$66	94% reduction in cost

Notes:
1. Entry data
2. Phase 1 data
3. Per cent who require support less than half of the time
4. Average of HASI clients, Phase 3 (Muir et al., 2007)
5. Australian population (Cummins, 2005)
6. Median service use/year prior to ISP
7. Number of days spent in custody one year prior to entering ISP
8. Number of days spend in custody two years after entering ISP

6.3 Conclusion

In summary, the recurrent cost per client of approximately $207,000 has resulted in a number of positive client outcomes, as well as a substantial reduction in inappropriate service use across the group, leading to cost savings for NSW Health and Corrective Services. While the costs of ISP may be higher than other initiatives that support people with complex needs in the community, such as HASI, the ISP provides services to one of the most difficult groups in the community. Moreover, the cost of providing services to clients who had exited was further reduced, but follow-up is needed in future to determine whether the outcomes achieved by clients were sustained after exit.

6.4 Summary

Based on expenditure data, the cost of providing ISP services over a one year period was approximately $6,417,604.

Direct service provision accounted for 80 per cent of total expenditure.

The average annual cost per client was $207,000, and it cost approximately $140,000 to support clients after they have exited from the ISP. The average cost per client prior to entry to the ISP was $376,000 as reported by nominating agencies but this figure should be viewed with caution as it was based on 18 clients and the method for determining costs across the group was unclear.

Outcomes for clients included:

- some reduction in the frequency and impact of challenging behaviours;
- decreased hospital use and reduced contact with corrective services;
- increased independence in activities of daily living;
- access to stable housing;
- increased well-being; and
- increased involvement in social and community activities.

7 Conclusion and Recommendations

The ISP accepted a group of 38 clients with multiple and complex needs and high-level challenging behaviour. All were living in insecure housing and had great difficulty accessing and utilising required services. This report analysed program and administrative data, and qualitative interviews with ISP stakeholders and clients in order to understand outcomes for these clients, the effectiveness of the Project's support and governance structures, and the implications of the ISP for the broader service system. This section provides some concluding comments and recommendations in the areas of client outcomes, the ISP service model and governance, and the service system.

7.1 Client outcomes

The ISP has been successful in helping clients achieve a reduction in the frequency and impact of challenging behaviours, improved health and well-being, and decreased levels of hospital and criminal justice service use. The data suggests that some clients benefited more than others from ISP support; a small number did not engage effectively with ISP services and will continue to be problematic for the service system. These findings are similar to those from the evaluation of the MACNI program in Victoria (KPMG, 2007). Some comments and recommendations on the clients served by ISP are:

1. Further analysis is required to help determine the characteristics of those groups of clients who did well with the ISP compared to those who did not do as well. Developing a capacity to determine potentially predictive factors as to who would benefit most and least from ISP interventions would assist in working with the target population.

2. The longitudinal measurement and follow-up of ISP client outcomes is clearly indicated. The ISP should consider developing a monitoring system with the capability to track all people nominated to the Project including those who are accepted and those who are not and systematically collect and compile comparative data at baseline, exit, and follow-up intervals.

7.2 Service model and governance

Staff and stakeholders expressed a clear commitment to the ISP service model, and spoke particularly favourably about the flexibility and consistency of supports provided to clients. In addition, the Project has garnered high levels of government support and has successfully promoted partnerships between ADHC, Housing NSW and NSW Health. Appropriate governance arrangements have been established to support the aims of the pilot stage of the program. Some recommendations for the future of the Project are:

1. Participants requested that the Project provide feedback when applicants are not accepted; such feedback processes would also assist ISP to maintain and strengthen its relationships with referral agencies.

2. The terms of reference and membership of the Project's peak committees including the Interagency Reference Group must be continually monitored to ensure that they optimally support the work of the ISP.

3. Unlike MACNI in Victoria and the Intensive Behaviour Support Teams in Queensland, the ISP is only available to people in the Sydney metropolitan area. The ISP should consider implementing more flexible funding arrangements that can support people outside of the Sydney area to provide more equitable supports across the state.
4. The ISP has accepted some of the most complex clients in the service system and operates in the context of a transitional model. In other sectors, such as the homelessness sector, questions are being raised about the effectiveness and appropriateness of transitional housing models and, in the current NSW Homelessness Action Plan, emphasis has been placed on long-term accommodation and support (NSW Government, 2009). The primary question for the ISP is whether a transitional model is appropriate for all clients, or whether more emphasis should be placed on housing first models that support people in permanent accommodation from the outset (e.g. HASI). This determination will need to be made in future, when more data on exited clients is available.

7.3 Service system

All participants reported that it is important to have a Project such as the ISP in the service system to support people whose needs cannot be met by mainstream services. A key challenge for the ISP is to facilitate successful transitions out of the Project and this is dependent on building broader service system capacity. This includes the development of greater knowledge, skills, resources and a range of organisational supports in the mainstream service system to assist people with complex needs. Some recommendations around this aspect of the Project are:

1. While the ISP assists clients to achieve positive individual outcomes, the Project should consider the role it could play in advocating for more sustainable and systemic change for people with complex needs and challenging behaviour within the broader service system. To this end, the ISP could inform improvements in the service system, including: increasing expertise in how to effectively manage clients with challenging behaviour; promoting flexibility and sustainability of funding; and developing more appropriate community based accommodation options.

2. The NGO sector is also striving to assist people with complex needs, and it may be argued that the ISP's governance structures and referral processes do not adequately take this into account. With confirmation of ongoing funding, it will be important for the ISP to review its relationship to the NGO sector.

Appendix A: Evaluation Methodology

This is the final report of the evaluation of the ISP. It analysis three key elements of the Project and how these elements interact with one another:

- Governance: whether the implementation of the project has been consistent with the project aims. Involves exploring overarching arrangements and responsibilities within the ISP;
- Service model: cost, linkages between services, impact, processes, and staff of the project and local agencies;
- Individual clients: Outcomes experienced by clients receiving service, as well as the wider support network, including families and the wider community.

The evaluation used a longitudinal, mixed methods approach to comment on the effectiveness of the service model, governance, and outcomes for individual clients. A logic model theoretical framework was used to guide the research so the relationships between these three key elements could be explored.

This section provides a brief overview of the four methods used to meet the research aims, including: administrative data; secondary data; interviews with stakeholders and clients; and financial data. More detail about the theoretical framework, evaluation questions, and the methods used to address these questions can be found in the evaluation plan (Fisher and McDermott, 2008). The research received ethics approval from the UNSW Human Research Ethics Committee in 2007.

Administrative data

During the planning phase of the evaluation, researchers develop an information sheet to collect a set of standard qualitative and quantitative questions to be collected on all current and former. The client information sheet includes questions on: demographics; reasons for entry to ISP; mental health and disability; and number of health care and criminal justice services used before, during and, if applicable, after ISP. Other questions addressed living skills, social and community participation, relationships and economic participation. Questions on well-being and community participation were drawn from validated instruments so that comparison can be made to other research, such as the PWI (Cummins, 2005), and other studies about supporting people with challenging behaviour (Kelly et al., 2006; Robertson et al., 2004; Stancliffe et al., 2007). In addition, qualitative questions were included in the client information sheet to allow ISP staff to provide descriptive accounts of clients' progression through the Project.

Project staff were also asked to include de-identified supporting documentation along with the data on the information sheet. The type and amount of data received varied for each client, but included ISP, client behaviour and intervention plans, hospital data, criminal record data, guardianship reports, incident reports, and risk assessments. This information was used to develop a more holistic understanding of each client's situation and change in service use.

ISP staff were asked to collect information on their clients at two points in time – March 2008 (Phase 1) and January 2009 (Phase 2) – that corresponded with the

timeframe of the evaluation. Information from current clients and former clients were collected during both time periods, although accessing information on former clients proved to be difficult in some cases. As stated earlier in this document one of the limitations of the evaluation is that it was unable to capture baseline information for most ISP clients because the evaluation period began two years after the Project was established.

In addition to the information sheet developed by the evaluation team, staff were asked to complete the standardised Overt Behaviour Scale (OBS) which was used to track changes in challenging behaviour over time in the following categories:

1. Verbal aggression;
2. Physical aggression against objects;
3. Physical aggression against self;
4. Physical aggression against other people;
5. Inappropriate sexual behaviour;
6. Perseveration or repetitive behaviour;
7. Absconding;
8. Inappropriate social behaviour; and
9. Lack of initiation.

These nine categories are used to calculate scores on three scales. The first of these scales, the 'Cluster' score (0-9), indicates the number of behavioural categories exhibited by a client. The second scale, the 'Total Levels' score (0-34), is the total sum of each of the levels of behaviour exhibited within the nine categories. These sub-behaviours are ranked in order of severity and are identified by a clinician ticking the appropriate box that matches with client behaviour. For example within the category of 'Verbal Aggression' a client may both make personal insults and threats of violence, constituting two levels of sub-behaviour. Corresponding with each level of challenging behaviour is a score between one and four that assigns a severity value to individual sub-behaviours. The final scale, the 'Clinical Weighted Severity' score (0-77), is the total sum of these values. This scale provides an absolute number that defines the overall severity of behaviour exhibited by a client across all categories. These scales and individual behavioural results inform the primary modes of analysis when using OBS. For the purposes of this evaluation the OBS was used to measure behaviour at entry into the Project, at Phase 1 and at Phase 2.

Secondary data

The collection of secondary data on ISP clients from NSW Health and Corrective Services was negotiated by the ISP over the course of the evaluation. Data from NSW Health was collected on 36 clients from 2003-2008 and includes information on the number of times clients went to hospital and to the emergency department, the total length of time in hospital and the total cost of the hospital use over the period. The

data was linked to client start dates, which were provided by the Project to NSW Health; data on hospital service use could be linked for 34 of the 36 clients. Because the total number of contacts was recorded rather than each individual contact, the data before and during ISP was annualised so that there were consistent points of comparison for each client.

Data was also collected by Project staff on the number of days each client spent in custody in NSW as an adult. Twenty one clients were identified as having a forensic history in NSW and data was collected on these clients one year before entering ISP, and while they were in the Project. The date and length of each contact was provided to the evaluation team, which made it possible to determine service use patterns at one and two years in ISP. The cost of custody was estimated based on the most recent Corrective Services annual report.

Interviews with stakeholders and clients

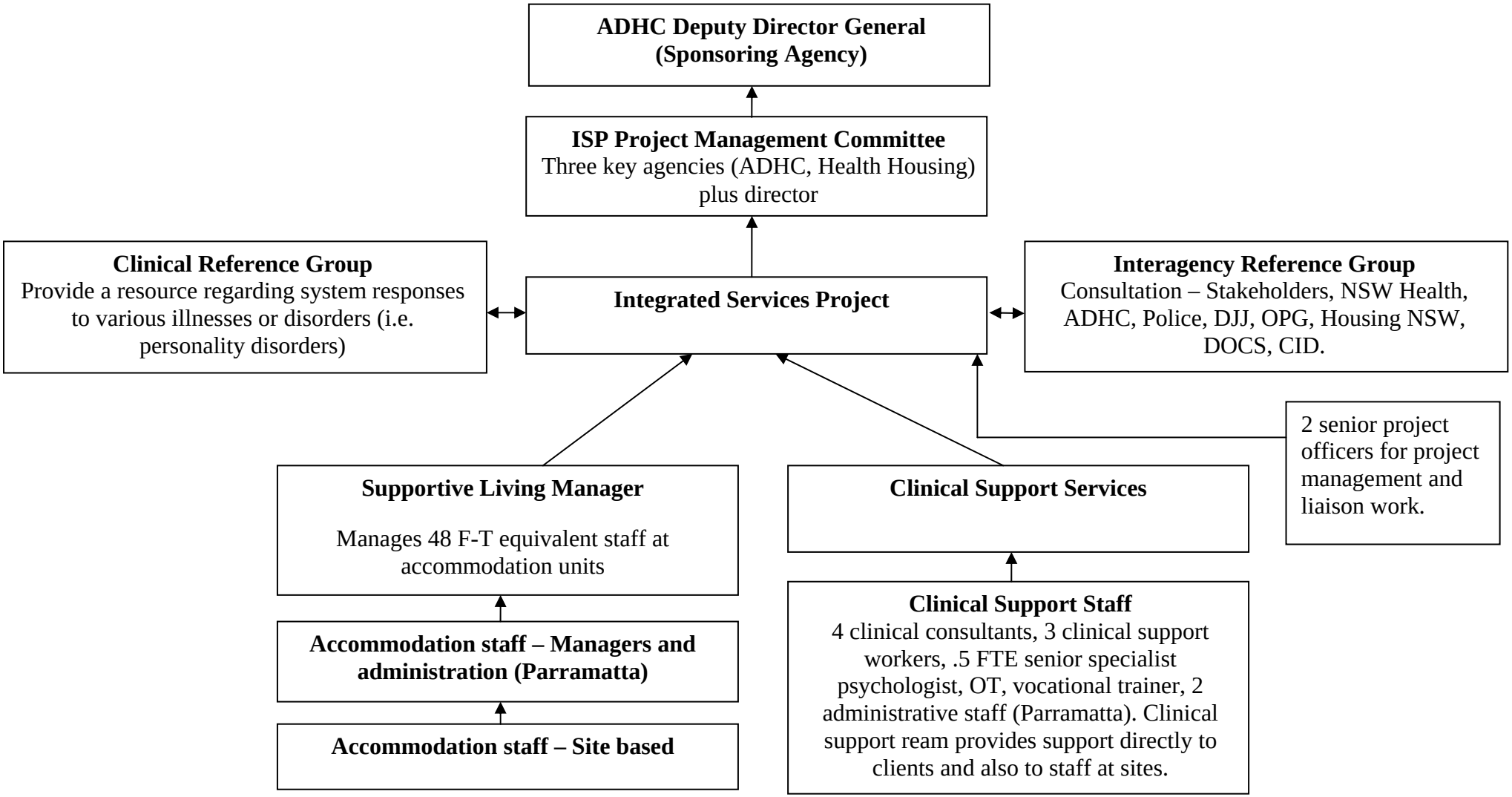
Seventeen ISP staff and other stakeholders were interviewed in May 2009 as part of the evaluation. The sample included representatives from government agencies responsible for the project implementation and policy; staff responsible for service delivery; service providers in other government and non-government organisations; and a client advocate. Staff and stakeholders were asked to describe their role in the Project, and their experience of project implementation, governance, and service model.

The research also included interviews with four clients at three points in time (March/April 2008, February/March 2009 and September 2009). Four clients from the final intake of the Project were invited to participate in March/April 2008, but one client refused so one of the four interviews was delayed while a replacement interviewee was sought. As a result, one interview was conducted after the ISP client left prison in June 2008. Clients answered questions about the quality of care, social connections, confidence, community participation, personal well-being, and service use. Repeat contact with these clients allowed the evaluation to uncover changes in participants' experience of ISP and changes in their lives over this time period.

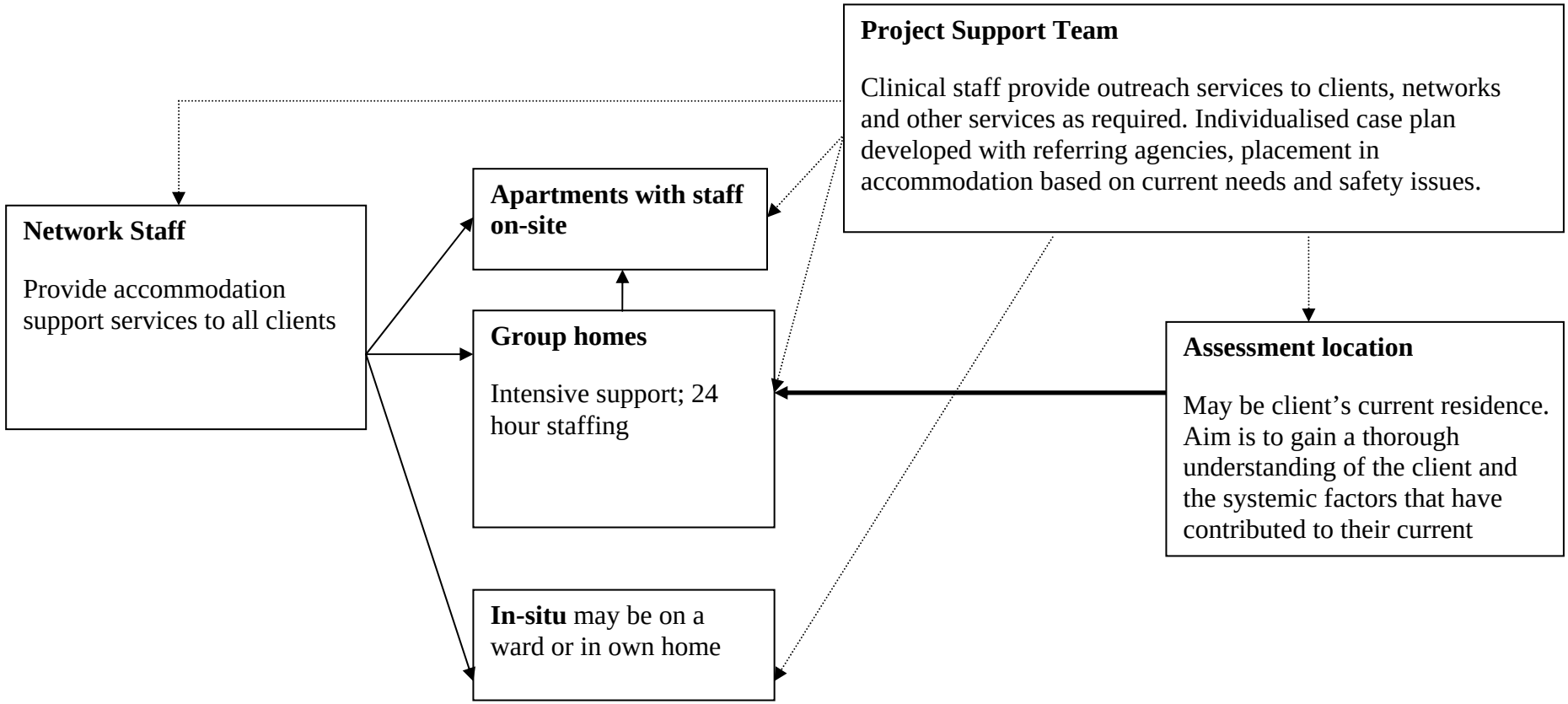
Financial Records

ISP managers transferred financial records for the cost effectiveness analysis. The records include financial costs to the Project from its establishment through to the stable operation of ISP from mid 2007 to March 2008. The financial records will be updated for the remainder of the evaluation. It is possible that later costs will include wind-down costs, which are not typical of an ongoing project.

Appendix B: ISP Responsibility Matrix



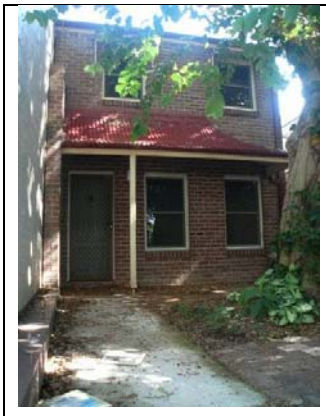
Appendix C: Model of ISP Accommodation and Support Services



Appendix D: ISP Units

Figure D.1: Description of ISP Units

ISP Unit	Physical description	Potential capacity
	2 bedroom + office in main house, with annexed to 2 bedroom self contained (Rental)	4
	3 bedroom + office house co-located with another 4 bedroom house (owned)	7
	Block of 3 units with dual egress 2 bedroom + office: upper floor 2 bedroom unit and 1 bedroom unit : ground floor (owned)	5
	Acreage site : Subdivided into 3 units • 4 bedroom + shared office • 3 bedroom + shared office • 3 bedroom (owned)	10

	Terrace 2 storey 3 bedroom + 1 office (Housing)	3
	2 bedroom + office in main house with annexed to 2 bedroom self contained unit (rental)	4
	3 bedroom + office Semi rural setting	3
	3 bedroom + office in main with self contained unit in rear of house	4

Appendix E: Cost Data

Figure E.1: ISP Expenditure and Revenue per Quarter April 2005 to March 2008 to Calculate Recurrent Net Cost Requirement

Significant Events	Funding allocated						Assessment unit closed	Readjustment post-assessment unit		Ongoing project			Ongoing ISP average per quarter (Jul 07-Mar 08
	Apr-Jun 05	Jul-Sept 05	Oct-Dec 05	Jan-Mar 06	Apr-Jun 06	Jul-Sept 06	Oct-Dec 06	Jan-Mar 07	Apr-Jun 07	Jul-Sept 07	Oct-Dec 07	Jan-Mar 08	
General services													
Project management [a]													
Management team	126002	92065	85611	86715	82134	90193	112781	86451	82849	66193	127429	72630	88,751
Operating	720	12771	21111	18899	24707	18543	16556	28385	18731	24069	18158	14329	18,852
Support services													
Clinical team	-	14112	109797	103445	114577	107835	96650	111938	84504	177327	129998	179312	162,212
Specialists	5800	-	7750	50	11943	14103	17129	23046	25879	23421	29654	24902	25,992
Operating	-	-	6581	7807	4791	2347	9903	1168	16334	3002	24895	7797	11,898
Supported living	-	9413	27068	27051	27015	27978	26180	31334	27138	30600	31833	39559	33,997
Direct services to clients													
Assessment unit[b] -													
Staff	-	63955	531638	502959	714162	415381	444914	-	-	-	-	-	-
Operating	-	9813	31083	39563	665	70504	28761	-	-	-	-	-	-
Set up	-	9132	1809	1720	50148	58654	-	-	-	-	-	-	-
Southwest network													
Staff	-	-	17351	98286	221897	185142	256315	613224	731953	616526	671037	582183	623249
Operating	-	-	12145	18501	34057	72435	84372	68014	102045	80138	70121	66710	72323
Set up	-	-		30992	164346	225435	-	-	-	-	-	-	-
Northwest network													
Staff	-	-	22118	155815	385508	340970	344790	410131	402221	358944	537751	746202	547632
Operating	-	-	-	15806	28981	25519	30845	30074	51138	50346	40744	56414	49198
Set up	-	9132	1809	32712	266144	284089	-	-	-	-	120107	-	40036
Total expenditure (1)	132522	211261	874062	1107609	1916581	1655039	1469196	1403765	1542792	1430656	1801727	1790038	1674140

Less													
Revenue offset client fees[c]	-	-	-	-1130	-3332	-20441	-25595	-31637	-30717	-29625	-35950	-23535	-29,703
Assessment unit (2)	-	82900	564530	544242	764975	544539	473675	-	-	-	-	-	-
Set up costs (2)	-	9132	1809	32712	266144	284089	-	-	-	-	120107	-	40036
Recurrent net cost requirement (1) - (2)[d]	**132522**	**119229**	**307723**	**531785**	**888794**	**846852**	**1021116**	**1435402**	**1573509**	**1460281**	**1717570**	**1813573**	**1663808**

Notes: a. Excludes evaluation costs. Does not include other costs covered by ADHC e.g. rent
b. After December 2006, absorbed into Southwest and Northwest networks
c. Supported living fees at 55 per cent Disability Support Pension
d. Some one-off expenses not identified e.g. Temporary project costs e.g. evaluation, wind down costs

Appendix F: Case Study Summaries

This section of the report provides a short summary of the four clients who participated in the longitudinal element of the ISP evaluation. The names used in this report are pseudonyms.

Anne

Anne is a 29 year old Anglo-Australian woman. She is the third of nine children who were brought up in an emotionally dysfunctional home – she describes being physically, sexually and emotionally abused by her father. Anne was taken into foster care at the age of nine and maintains regular phone contact with this family.

When she was 18, Anne was admitted to psychiatric hospital for treatment of hypomania and severe depression, which led to anorexia nervosa, self-harm and suicidal ideation. She lived at the hospital for six years. In 2003, Anne was released from the hospital and lived independently in the community for two years with community mental health support. In October 2004 at age 25, Anne was admitted to hospital for treatment of an ectopic pregnancy. Following that incident, she was admitted to five psychiatric hospitals interspersed by short stays in the community.

More recently, Anne was accommodated at a prison where she was serving a four-year prison sentence, with a non-parole period of 15 months, for Assault with Intent to Rob. She was located to ISP group home accommodation in July 2007. She reports that living in ISP "has its ups and downs". She finds it difficult to deal with her roommate who sometimes yells and does not respect her. She feels that she gets enough staff support and services, but she does have some difficulty dealing with the staff turnover.

Anne meets with her case manager once a week to discuss how she is going. She likes that her case manager is encouraging because "most of my life I had no one to praise me". She also reports being on a behaviour management plan with a psychologist, whom she likes, and a psychiatrist, who she does not like as much. Aside from this, however, she feels that if she needs more help she can talk to the staff and they will provide it to her. She feels she is doing better now than she was before ISP and because of this, she is no longer self-harming every day. In the future, she would like more freedom to go out into the community unsupervised. She would eventually like to have her own unit, a pet, and to live by her own rules.

Anne does not have any friends and finds it hard to make friends because she has a difficult time trusting people. She also feels that the lack of independent access makes it hard for her to make new friends. She does keep in contact with her foster family in South Australia, whom she speaks to via email every two to three weeks. She is currently completing a Certificate 3 in accounting at TAFE. So far, her studying is going well: she achieved 84 per cent on a recent assignment. Anne does not work at the moment but has worked in casual jobs in the past. She likes to go for coffee, to the movies, and out for doughnuts.

John

John is a 34 year-old male with schizophrenia, mild intellectual disability and an acquired brain injury (ABI). He is described by ISP staff as a likable and easy going character who has had it rough. John has an extensive forensic history as indicated by his 113 convictions, mainly for theft, property damage and drug possession, up until July 2005. He has a history of polysubstance abuse and has been a regular user of heroin, marijuana, and amphetamines. When not in prison, John experienced periods of homelessness, and had little coordinated support from services. John's extreme drug seeking and self-harming behaviours are the primary reasons for previous breakdowns in his accommodation and support.

It is reported that John's biological parents both had psychiatric disorders; it is believed that John was neglected and became a ward of the state at 14 months of age. At the age of 13, John was forced to leave his foster home due to allegations that he had made inappropriate sexual advances to a younger child in the home. He has since had limited involvement with his foster family except to contact them from time to time to request money. John's brother, who was a significant source of social support, died of a drug overdose in 2006.

John transitioned into the ISP in December 2007 from gaol. Since John entered ISP he has been working toward independent community access as well as various skill building activities. He continues to attend a TAFE course although he said that he sometimes lacks the motivation to complete tasks. He did secure employment briefly however his employer was not able to provide the support he needed and as a result the placement broke down.

John likes that ISP has given him new skills and is helping him to become more independent. He said that he does not know where he would be without ISP support, "I do like the ISP…they are there to help me…I'm slowly getting together with my life. I am a bit better than I was". He reports getting on well with most of the staff except that he sometimes gets angry with the rules in ISP but realises that they are in place to help him to improve his behaviour.

John reports making a few friends through the fitness classes that he attends twice a week. At the classes, he is involved in soccer, jogging, baseball and other sports. He also likes to go for walks, to watch videos, read books, to play the guitar and to sing. He is going to TAFE to do reading, writing, and math and he would eventually like to study ancient history. He speaks to his mum once a week on the phone and also stays in contact with his sister in law. He would like to eventually have and live with a partner. In the future, he would like to have his own "housing commission flat" and to look after himself using the skills he has learnt in the ISP.

Rebecca

Rebecca is a 33 year-old woman. Her home environment was reported to be chaotic, with marked domestic violence and sexual trauma. Rebecca spent much of her youth in foster care and was living on the streets from 11 years of age. Rebecca has had eight children, although two died at birth. She is also the grandmother of a two and a half month old child, who is the same age as her youngest baby. All of her children are with DOCS and living with the same foster family.

Rebecca has a history of psychotic illness, however there is a lack of clarity surrounding her mental health diagnosis. Diagnoses include borderline personality disorder, paranoid schizophrenia and bipolar disorder. Rebecca is often aggressive, has poor coping skills, and has reported hearing voices. Rebecca also has a diagnosis of Huntington's disease, a genetic disease which causes a degeneration of brain cells, resulting in emotional disturbance, reduced intellectual capacity, and uncontrolled movement (National Institute of Neurological Disorders and Stroke, 2008). Rebecca has a significant history of poly-substance abuse, and has been using heroin sporadically for the last 14 years. She reported spending approximately $50 per day on heroin and engaged in prostitution to fund the habit.

Rebecca has spent the majority of her youth and adult life living as a homeless person. This was not a happy time for her and she reported that,

> My insides were full of pain, pain from the cold [and] really bad food. I went to the Wayside Chapel to get food vouchers and had to wait hours to have a shower. It was embarrassing looking like crap, especially being a woman.

Welfare and community services have attempted to procure housing for Rebecca, but she has been blacklisted from most private accommodation in city areas due to her behaviour and drug use. Public housing placements have also broken down as she has voluntarily left these placements to return to the streets. Drug and Alcohol services and in-house hospital services are unable to accommodate her due to the lack of insight she has into the nature of her deficits, and the fact that there are no orders in place stipulating that she must comply with treatment programs.

Rebecca has a history of aggression and has been incarcerated on numerous occasions, mostly for assault related charges. She was first incarcerated in 2001 and was incarcerated again in 2007 for assault and malicious damage. She served a six month sentence, after which she was transferred to a psychiatric hospital in preparation for the birth of her child. DoCS removed the child from care after the birth.

Rebecca very much enjoys her accommodation and living with her roommate. Although she sometimes misses doing what she wants to do, she knows that the Project is helping her to be stable and to support her children. She would eventually like to have her own "Housing Commission flat". Rebecca feels like she is doing much better now that she is off the street. Her key worker drives her to her volunteer job at the Salvation Army and she feels that her case manager "really cares about me". She appreciates the support that staff provide to her and stated that "I love it here…I want the staff to know I really appreciate it".

Rebecca has made contact with her brother and sister since being involved in ISP. She had not talked to them since she was ten years old but now they speak on the phone frequently. Rebecca also sees her children every week. She participates in the community through gardening, window shopping, and shopping at second hand shops. She tries to save her money for her children. She would like to study but she is scared people would think her to be dumb because she does not know how to read and write.

Alan

Alan is a 61-year old man of Yugoslavian descent. He is a divorcee who has four children of whom two are still alive. He is an alcoholic and has been admitted to various psychiatric hospitals. He is Yugoslavian and his father fought in the Second World War against the Germans.

Alan has been diagnosed as suffering from chronic paranoid schizophrenia and alcoholism, but this diagnosis was disputed by a psychologist who analysed the client for the court system. He was instead diagnosed with a personality disorder and an acquired brain injury associated with alcohol abuse and repeated head injuries while intoxicated. He sustained significant liver damage due to alcohol abuse. Alan has a long history of homelessness with intermittent periods of incarceration. Since 2005, he was placed under financial and coercive guardianship, spent 43 days in a psychiatric institution and spent over 12 months in prison over that period. He also had a history of physically aggressive behaviour.

Upon entry into the Project Alan was not in touch with any family, nor did he have any close friends, however over the course of his interviews he did not report developing any new friendships or learning new skills.

Appendix G: Additional Data Tables

Table G.1: Summary of Client Characteristics – Age, Gender, ISP Status and Months in ISP, January 2009 (n=38)

ISP status	Age (years)	Sex	Time in ISP (months)[a]	Reason for exit
Current clients	31	M	34	
	22	M	33	
	31	F	30	
	39	M	30	
	36	M	28	
	40	M	24	
	29	F	20	
	30	F	19	
	30	M	18	
	62	M	18	
	35	M	17	
	40	F	17	
	40	F	16	
	32	F	16	
	37	M	16	
	47	F	16	
	35	F	11	
	62	M	10	
	24	M	7	
Total = 19		**8 11**		
Exited clients	55	M	36	Completed ISP
	27	F	35	Completed ISP
	31	F	31	Completed ISP
	34	M	30	Completed ISP
	57	M	30	Completed ISP
	38	F	29	Completed ISP
	36	F	28	Completed ISP
	43	F	28	Completed ISP
	33	M	26	Completed ISP
	33	F	25	Completed ISP
	54	M	25	Completed ISP
	46	M	25	Completed ISP
	22	F	25	Completed ISP
	22	M	21	Completed ISP
	37	F	17	Completed ISP
	23	F	13	
	37	M	3	
	62	M	1	Died
	25	M	1	Died
Total = 19		**9 10**		

Notes: a. Time is from point of nomination acceptance until the beginning of January 2009
b. Nomination accepted and processed but client refused services. Client excluded from all analyses

Table G.2: Challenging Behaviour at Baseline, Phase 1 and Phase 2, per cent

Behaviour	Baseline (n=35)	Phase 1 (n=35)	Phase 2 (n=29)
Verbal aggression	**91**	**91**	**92**
Loud noises	66	66	70
Mild insults	74	71	65
Moderate threats	86	74	81
Clear threats of violence	63	57	50
Physical aggression against objects	**80**	**74**	**77**
Slams doors	63	54	72
Throws objects	57	51	64
Breaks objects	51	43	38
Sets fires	26	31	24
Physical aggression against self	**43**	**43**	**60**
Self harm(no injury)	20	29	32
Self harm (minor injury)	23	14	32
Self harm (moderate injury)	29	20	36
Self harm (major injury)	26	20	28
Physical aggression against others	**80**	**77**	**68**
Threatening gesture	71	66	60
Strike others (no injury)	69	51	48
Attacks others (moderate injury)	34	29	36
Attacks others (severe injury)	6	0	4
Inappropriate sexual behaviour	**34**	**34**	**40**
Sexual talk	23	23	24
Touching (non genital)	17	9	20
Exhibitionism	14	14	20
Masturbation	9	6	0
Touching (genital)	0	3	4
Coercive sexual behaviour	3	0	0
Repetition/Preservation	**40**	**40**	**48**
Prolonged behaviour (no harm)	40	26	44
Prolonged behaviour (minor harm)	3	12	12
Prolonged behaviour (serious harm)	0	0	0
Wandering/absconding	**69**	**63**	**59**
Enter prohibited area	43	40	36
Leave safe environment	54	34	36
Escape secure premises	40	29	32
Inappropriate social behaviour	**100**	**97**	**100**
Socially awkward	71	63	88
Nuisance	60	57	67
Non compliant	77	74	67
Petty crime	29	37	42
Danger to self/others	66	46	46
Lack of initiation	**74**	**74**	**56**

Table G.3: ISP Current Client Self Care Skills, March 2008 and January 2009, per cent

	Phase	n	Independent	Supported less than half	Supported more than half	Fully dependent	Don't know
Bathing	Phase 1	36	56	19	17	3	6
	Phase 2	19	68	26	5	0	0
Dressing	Phase 1	36	58	25	11	3	3
	Phase 2	19	89	11	0	0	0
Diet	Phase 1	36	17	33	28	19	3
	Phase 2	19	26	32	26	16	0
Exercise	Phase 1	36	17	31	31	11	11
	Phase 2	19	26	16	42	11	5
Taking medication	Phase 1	36	3	22	17	50	8
	Phase 2	19	11	11	16	63	0
Cooking	Phase 1	36	14	25	22	25	14
	Phase 2	36	20	17	28	25	10
Cleaning*	Phase 1	36	6	22	36	19	17
	Phase 2	36	28	17	28	19	8
Shopping**	Phase 1	36	6	36	22	22	14
	Phase 2	36	25	11	30	27	6
Laundry	Phase 1	36	14	31	19	19	17
	Phase 2	36	33	22	25	11	9
Getting around	Phase 1	36	33	17	22	25	3
	Phase 2	36	34	23	6	34	3
Using public transport	Phase 1	36	28	19	22	22	8
	Phase 2	36	33	11	8	36	6
Budgeting**	Phase 1	36	3	8	44	36	8
	Phase 2	36	14	20	6	54	6
Accessing comm svs	Phase 1	36	8	17	33	25	17
	Phase 2	36	17	9	23	42	9
Keeping appts	Phase 1	36	11	14	22	31	22
	Phase 2	36	8	11	14	56	8

Notes: *p<0.1 ,**p<0.05 (Chi-square)

1. Data item was left off a revised version of the data collection instrument, so Phase 2 data is only available for people still in ISP on the items of bathing, dressing, diet, exercise and taking medication

Table G.4: Personal Wellbeing Index, Clients in ISP and Clients Exited from ISP, per cent

Satisfaction with *		March 2008	January 2009	% Change
Standard of living	Clients in ISP	57.1	77.9	+20.8
	Clients Exited from ISP	48.0	84.2	+36.2
	Australian Norm[1]	-	78.3	-
Health	Clients in ISP	54.3	75.0	+20.7
	Clients Exited from ISP	88.0	62.9	-25.1
	Australian Norm	-	75.1	-
Achievements in life	Clients in ISP	54.8	76.7	+21.9
	Clients Exited from ISP	68.0	67.1	-0.9
	Australian Norm	-	73.5	-
Personal relationships	Clients in ISP	49.9	68.3	+18.4
	Clients Exited from ISP	74.8	62.1	-12.7
	Australian Norm	-	79.2	-
Safety	Clients in ISP	62.7	82.5	+19.8
	Clients Exited from ISP	90.0	68.6	-21.4
	Australian Norm	-	80.2	-
Feeling part of the community	Clients in ISP	55.2	78.3	+23.1
	Clients Exited from ISP	74.0	66.4	-7.6
	Australian Norm	-	71.1	-
Future security	Clients in ISP	52.8	75.8	+23.0
	Clients Exited from ISP	78.0	66.4	-11.6
	Australian Norm	-	73.0	-
Life as a whole	Clients in ISP	53.8	75.0	+21.2
	Clients Exited from ISP	52.0	62.9	+10.9
	Australian Norm	-	78.3	-

Source: ISP Project Data.

Notes: March 2008: Still in ISP: n=21 Exited: n=5

January 2009: Still in ISP: n=13, Exited: n=13

10 clients were missing data in January 2009 due to refusals or could not be contacted

Personal Wellbeing Index (PWI). Scale 0-100 where 0=completely unsatisfied, 100=completely satisfied (Cummins 2007).

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