Evaluation of the Time Out House Initiative in Queensland

Final Report

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Abbreviations and glossary

Aftercare	TOHI Cairns
APQ6	Activity and Participation Questionnaire
CALD	Culturally and linguistically diverse
CAT	Common Assessment Tool
CANSAS	Camberwell Assessment of Need Short Appraisal Schedule
CRM	Collaborative Recovery Model
FNQRDGP	Far North Queensland Rural Division of General Practice
Heads Up	TOHI Logan
HREC	Human Research Ethics Committee
NSW	New South Wales
NHMRC	National Health and Medical Research Council
MOU	Memorandum of understanding
PWI	Personal Wellbeing Index
QLD	Queensland
Reference Group	Staff of Queensland Alliance for Mental Health, TOHI providers and representatives of young people and carers
RAS	Recovery Assessment Scale
Social network	Family and significant friends and carers of the young person
Steering Committee	Staff of Queensland Government and Reference Group
TOHI	Time Out House Initiative
SPRC	Social Policy Research Centre
YFS	Youth and Family Service (Logan)
YP	Young people, young person

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Executive summary

Time Out House Initiative

From 2010 to 2013 Queensland Department of Communities (Community Mental Health) funded the Queensland Alliance for Mental Health to run the Time Out House Initiative (TOHI) in two communities. Approximately 180 young people used the program. A total of $6.477 million was allocated to implement and evaluate the pilot over three years.

The objective of TOHI was to improve young people's emotional wellbeing, social participation and community inclusion, and mental health self-efficacy. The pilot targeted young people whose circumstances either have had an impact on their mental health now or, if unaddressed, were likely to have an impact.

TOHI was designed to provide early intervention in a short term, recovery focused, safe and youth friendly residential program along with outreach and case management support. Young people 15–25 years could use approximately three months outreach support; and older young people (18–25 years) could opt to stay in the Time Out house for approximately three weeks.

Queensland Alliance contracted two nongovernment organisations to deliver the pilot—a consortium led by Aftercare in Cairns and Youth and Family Service (YFS) in Logan. The Logan program ended in 2012 and in May 2013 the pilot continued to deliver services to young people in Cairns.

The unusual aspect of the TOHI model was in-house residential support for young people. In the program design, the house was intended to be the core of the model, supplemented with case management as the young people left the house. In practice, the outreach and case management became the focus of the support for most young people, before and after using the house, or instead of using the house.

The existing mental health partnerships and the consortium approach were a benefit in the Cairns program. External stakeholders spoke highly of the initiative in terms of the strength of the partnership and the referrals between the pilot and relevant service providers. Several partners regarded TOHI as filling a missing piece with the existing youth and health services.

Summary of evaluation findings

Target group: Young people whose circumstances have had an impact on their mental health now or in the future if unaddressed

Around 180 young people used the program, with similar numbers of young men and women. Most participants were aged 18–25 years in Cairns. In Logan, a larger group of younger participants (15–17 years) took part. Some Indigenous and culturally and linguistically diverse young people used the pilot services. Numbers of these groups however remained low and were not representative of the populations in the two pilot locations.

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The pilot reached out to young people who had needs related to supporting their mental health. Young people using TOHI services were dealing with a range of needs that could negatively impact or had impacted on their mental health. Common needs faced by participants included social isolation or limited social networks and community support; disengagement from education and work; insecure or unsafe housing; and an unstable home environment that, for some, was characterised by family conflict, domestic violence, suicide and substance use in the family. Many young people in Cairns had a mental health diagnosis or ongoing mental health problems. The majority of those young people felt that they required help to deal with their symptoms, better look after themselves and maintain their wellbeing.

Support model: Outreach case management and referrals (~3 months) and residential intervention (~3 weeks) to address circumstances that impact on mental health

Throughout the implementation of the pilot the eligibility criteria for young people and support timeframes changed. TOHI lowered the age criteria to 15 years for outreach and case management support in both locations. In Cairns the staff reported that young people aged 18 to 25 years was an appropriate age range for the house and that they had few referrals which did not fit this criteria. In Logan few young people identified that they wanted to stay in the Time Out house. Those who did want to stay were younger than 18 years old and therefore not eligible.

The case management and outreach support appeared to be successful in both locations. Both participants and stakeholders involved in TOHI reported that it was a useful strategy to support young people facing marginalisation that could or had affected their emotional wellbeing and mental health. The evidence on the usefulness of the residential component of the pilot was mixed. While the Time Out house worked well for the young people using TOHI services in Cairns, in Logan the house remained underutilised throughout the pilot implementation. Also, some young people who stayed in the Logan house reported that they were unsatisfied with aspects of the support. Furthermore, staff and other stakeholders in Logan questioned the usefulness of the residential support model for the target group.

The timeframe for support in practice also varied from the design. Most young people relied on the outreach support and case management before and after or instead of the house, sometimes over many months. Support in the house also ranged from days to months in Cairns.

Impact on path and links to service access, informal support networks and goal setting as needed – youth and adult services, health, mental health and other clinical and non-clinical services

All stakeholders reported a number of helpful factors in the implementation of the TOHI pilot. The key ones included flexibility of the model and the planning and coordination to meet young people's needs; linking participants to relevant clinical and non-clinical services and community supports; and use of person centred service delivery and empowerment approaches.

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Most TOHI participants had plans in place or were working to identify their goals. According to all stakeholders the planning and goal setting process was useful for breaking down and working towards a young persons' bigger goals step-by-step. Young people using TOHI services also reported that they benefited from being connected and supported to access a range of clinical and non-clinical services, including social and recreational outlets. Many young people identified participation in education and work as a priority. In both locations young people reported that they were receiving support to access the services they needed and that TOHI had helped them to build confidence to work towards achieving their goals.

Staff in Cairns identified the transition period for young people leaving the TOHI house as a critical stage, as the support mechanism changed from daily to weekly. In particular for some participants with little support in the community, this meant that they were more at risk of disengaging from the support and services they had established during their time in the Time Out house. Cairns built on their consortium contacts to strengthen referrals to and from mental health services. Logan relied on their local youth service contacts.

Improved outcomes – social connections (family, friends); community participation (education, work); self-efficacy (greater independence, recovery); wellbeing and quality of life

Most findings in this report rely on qualitative data, interviews and case narratives with young people using TOHI services and other relevant stakeholders. Participants reported a range of benefits as a result of their involvement, including improved social relationships, a better sense of self, emotional wellbeing and increased confidence, and some also greater independence. Greater independence meant different things to young people, some re-engaged in education, work or volunteering, others learned independent living skills, in particular if they were more strongly involved in the pilot (for example, some young people who had stayed in the Cairns Time Out house). In Cairns, a small proportion of young people (n=18) who completed a second CANSAS survey reported on average improved mental health self-efficacy.

Little reliable quantitative evaluation data were available to measure changes in TOHI participants' wellbeing, socio-economic or community participation as a result of their involvement with the pilot. Some of the quantitative data showed improvements, for example, in young people's personal wellbeing outcomes, however, these findings have to be interpreted with caution. They may or may not be connected to participants' involvement in the pilot and cannot be assumed to be representative of the full TOHI cohort (in most cases quantitative data were only available for a small proportion of TOHI participants).

Implications of the TOHI pilot for similar programs

Coordinated support

The TOHI outreach, case coordination and management provide lifestyle support and referral to clinical and non-clinical services for young people. Person-centred case

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management was a useful tool to access services for marginalised young people, who may experience early signs of mental health issues.

Other parts of the program that some young people used were residing in the house and additional clinical case management from a mental health provider. The consortium model of service providers and community partners with mental health expertise assisted with engagement, capacity and referrals.

Managing the needs of young people at risk of more severe mental health problems required staffing capacity and structured processes to link to clinical expertise and to respond to emergencies, which were developed during the TOHI pilot

Future opportunities for connections with inpatient and headspace services would require greater mental health capacity within the TOHI staff and stronger relationships with the mental health providers.

Housing

Homelessness and precarious housing in the context of housing shortages affected many young people in the program. As an early intervention program, with the agreement of the Steering Committee, TOHI interpreted the eligibility criterion to include homelessness, since housing support can address other underlying factors affecting their wellbeing.

Support timeframes

Many young people at both sites needed longer intervention than the original plans for 3 weeks for residential support and 3 months for outreach and case management. They required sufficient time to develop trust to engage with a service. They also experienced complex needs that took a longer time to address, such as referrals for housing and mental health professionals. Some people needed 6–8 months of case-management support, depending on the complexity of their needs and goal, and the time to build trust and relationships.

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1 Introduction

From 2010 to 2013 Community Mental Health, Department of Communities Queensland funded the Queensland Alliance for Mental Health to run the Time Out House Initiative (TOHI) in two communities. The pilot was funded with the Queensland Government's Plan for Mental Health 2007–17 which identified prevention and early intervention as a priority. A total of $6.477 million was allocated to implement and evaluate the pilot over three years.

The TOHI pilot aimed to provide early intervention in a short term (three weeks) safe and youth friendly residential program and approximately three month outreach and case management support for young people whose circumstances either have had an impact on their mental health now or, if unaddressed, were likely to have an impact. Queensland Alliance contracted two nongovernment organisations to deliver the pilot – a consortium led by Aftercare in Cairns and Youth and Family Service (YFS) in Logan. The Logan program ended in 2012 and in May 2013 the pilot continued to deliver services to young people in Cairns.

The Social Policy Research Centre (SPRC) at UNSW Australia (UNSW) with Griffith University were contracted by the Queensland Alliance to evaluate the pilot over the three year timeframe. The evaluation examined the outcomes, process and costs of the pilot program to inform future service development. This is the final evaluation report (earlier reports are available on the web, Gendera, Fisher, Clements, & Rose, 2012; Gendera, Fisher, Robinson, & Clements, 2012).

1.1 Evaluation method

The longitudinal, mixed method evaluation design measured outcomes for young people who could benefit from early intervention case management support, their families and informal supports; the program process; and costs. The methodological approach was developed to fit the aims of the TOHI pilot, the evaluation objectives and the conceptual framework. For more details refer to the full evaluation plan (Gendera, Fisher, Robinson, & Clements, 2011). The following datasets were available.

Program and outcome evaluation data

The two service providers transferred administrative, outcome and cost data for the evaluation. For this final report participant and outcome data were available about young people in the program from July 2010 to May 2012 for Logan, and June 2010 to September 2012 for Cairns. Data were available for 103 young people in Cairns, and 77 in Logan. The total number of young people using TOHI services in both

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locations was higher but could not be included in the analysis for various data quality reasons.[1]

Quantitative data were available on the following measures: Personal Wellbeing Index (PWI); Activity and Participation Questionnaire (APQ6); Recovery Assessment Scale (RAS), short and long version; and the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS). Some program data were also available from internal assessments, such as the Needs Assessment in Logan, and the satisfaction survey in Cairns (the latter is not included in this report). Cairns cost data were available for the 2011–12 financial year.

Table 1.1shows the number of respondents to each of the survey measures in Cairns and Logan. The longitudinal evaluation method was for young people to complete one survey at the beginning of their engagement with TOHI, either at entry into the TOHI house, or when they started receiving outreach case management support, and one at exit from the pilot. This was not always possible and many participants had no data for one or both of the data collection waves. Only a small proportion of TOHI participants completed a second survey of any of the measures.

Table 1.1 Total numbers of TOHI participants with data available

	Number of young people who completed surveys			
	Cairns*		**Logan****	
	One survey	**Two surveys**	**One survey**	**Two surveys**
PWI	70	19	49	13
APQ6	56	10	69	n/a
RAS	71	18	n/a	n/a
CANSAS	100	33	n/a	n/a
Needs Assessment	n/a	n/a	61	n/a
Total YP with any data	103		77	
Total YP supported 2010–12	115		n/a	

Source: Program management and outcome data collections 2010-12; Logan provided PDF scans of surveys.

Notes: *Cairns: If more than two surveys were received, the most recent survey was counted as Survey 2 and the middle survey/s were omitted from the analysis. If no dates were indicated, then either the indication of entry/exit survey was used, or the lower score was used as the first survey.

**Logan: No survey completion dates were provided. If more than one survey was completed, the lower score was assumed to be the first score. No dates for APQ6 were provided for Logan, and it is unclear whether clients repeated surveys as client ID's were not consistent. All APQ6 surveys for Logan were assumed to be baseline.

[1] Not included in the analysis are young people who did not engage or where no data were provided for analysis for the final report. In Cairns and Logan internal program reporting suggested that number of service users was higher. The implication of this data limitation is that some of the results presented in the report and tables are skewed towards young people who did remain engaged or reported outcomes, leaving out those who did disengage for some reason.

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Fieldwork data

Qualitative data were available from written case studies from the young people and researcher interviews for the baseline report in 2011 and progress report in 2012. In both locations service providers invited young people to write down the story of their involvement with TOHI and assisted them as required. Instructions to the staff were to prioritise the words and input from the young person.

Twenty young people from Cairns wrote their story for the baseline report (10) and progress report (10), accompanied by some case information from their workers. In Logan, young people provided their story as stand-alone narratives for the baseline report (5) and progress report (10). Their stories were in their own words, without contextualising material from case workers.

In addition, the researchers interviewed stakeholders, young people, family members, service provider staff, and external partners in both sites. The people interviewed in 2011 and 2012 were not all repeat interviews. All young people were new respondents and so were their supporters. Some staff and stakeholder interviews overlapped in the round 1 and 2 data collection. **Error! Reference source not found.**summarises the qualitative data sources and respondent numbers by site and time of data collection.

Table 1.2 Sample sizes for qualitative data sources

	Cairns		Logan	
	2011	2012	2011	2012
Young people case studies	10	10	5	10
Young people interviews	5	5	2	4
Supporter interviews	2	1	–	2
Staff, management interviews	2	3	2	2
External stakeholder interviews	2	2	1	2

Note: Target sample sizes were not reached in Logan due to difficulties engaging young participants.

The main factors impacting on qualitative data collection were challenges engaging young people to take part in an interview or provide a case study. Young people, and in particular marginalised young people, are often highly mobile and sometimes difficult to engage in research. The researchers also experienced some difficulties reaching the supporters of the young person – their family or friends. This was because many young people did not want their family to be actively involved or informed about their participation in the TOHI pilot. Many had strained relationships with their family and other young people explained that they had few trusted supporters in the community who could be approached for an interview. Overall the TOHI program focused mainly on the young person and their needs.

All findings in the report use pseudonyms to protect confidentiality.

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1.2 Limitations and data quality

The evaluation has a number of limitations, especially with the quantitative data. At the design stage of the evaluation framework both provider agencies were already using or had agreed to use a range of validated instruments to collect longitudinal outcome data for TOHI participants. However, due to inconsistent implementation of the pilot and the survey measures, such as PWI and APQ6, significant gaps remain in data. Only a small proportion of young people completed more than one survey. This restricted the longitudinal outcomes analysis, which should be interpreted with caution.

Logan data were missing for about a third of the young people who used TOHI services, including no quantitative data in the baseline analysis.

In addition to the missing data and small sample sizes, the second limitation to data quality was inconsistent timing of administering and recording the follow up measures. Service providers expected to collect the second survey when young people left the program. However, the timing of data collection of the first and second survey was not clearly recorded and varied from case to case. For example, not all surveys had dates recorded, which meant that analysis was undertaken assuming higher scores to be longitudinal data if a person had completed more than one survey. This is probably a biased assumption and would not be accurate for all cases.

Limitations for the qualitative data mainly included missing or incomplete data. In particular for Logan the qualitative samples were smaller than the target numbers. Sometimes the data were incomplete, where for example case workers did not provide contextualising information.

As noted above, some of these challenges are common for this target group. It is often difficult to engage young people in standardised research. Some of the challenges could also be linked to insufficient management support.

The evaluation framework (Gendera et al., 2011) was designed to address such possible limitations by including mixed methods. The limitations are acknowledged in the report and were taken into account in the analysis.

1.3 Report structure

The report is structured in the following order: Section 2 describes the program as delivered by the two providers and profile of the participants. The outcomes for TOHI participants are presented in Section 3. Section 4 examines the service use and effectiveness of the service delivery processes. Section 5 summarises lessons and future program development, as well as lessons arising for similar programs. Appendix A presents the tables of detailed data analysis, which should be used with caution due to the limitations listed above. Appendix B provides a cost-benefit analysis for TOHI Cairns only.

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2 Program and support model description

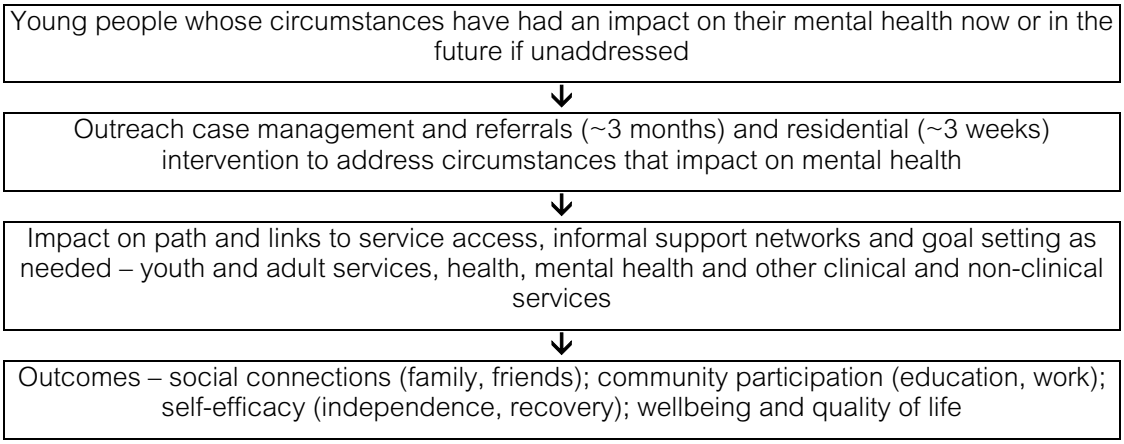
2.1 Aims of TOHI

The objective of TOHI was to improve young people's emotional wellbeing, social participation and community inclusion, and mental health self-efficacy. The pilot targeted young people whose circumstances either have had an impact on their mental health now or, if unaddressed, were likely to have an impact.

TOHI was designed to provide early intervention in a short term, recovery focused, safe and youth friendly residential program along with outreach and case management support. Young people 15 to 25 years could benefit from approximately three months outreach support; and older young people (18 –25 years) could opt to stay in the Time Out house for approximately three weeks.

The program logic (Figure 2.1) illustrates the pilots' objectives.

Figure 2.1 Time Out House Initiative (TOHI) Program Logic



The TOHI recovery focused intervention approach built on evidence that effective, timely and coordinated non-clinical and clinical care and support can improve the outcomes of young people, and reduce long term societal costs of mental ill health (Muir et al., 2009).

2.2 Roles and responsibilities of the TOHI partners

The pilot program was funded by Community Mental Health, Department of Communities. The Queensland Government allocated $6.477 million for three years. The program was jointly managed by the Department and the Queensland Alliance for Mental Health. Two nongovernment organisations, one in Cairns (Aftercare) and one in Logan (Youth and Family Service), were funded to implement the TOHI pilot.

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2.3 Service delivery and service model

The two NGOs provided support to young people aged 15 to 25 years whose circumstances either have had an impact on their mental health now or, if unaddressed, were likely to have an impact. The core features of the service delivery model included:

- A strengths based practice approach, targeted and person-centred support in an outreach and case management capacity (for 15 –25 year olds) and residential (for 18 –25 year olds), to enable young people's emotional wellbeing and recovery from a variety or combination of psychosocial stress
- Intensive non-clinical, and where needed clinical care coordination, and lifestyle support in a recovery focused environment
- Collaboration and articulation with a range of community services to provide young people with support pathways, to address young people's emotional and mental health needs; and to develop opportunities for socio-economic participation and community inclusion
- Supporting young people to restore and maintain connection with family, friends, other supports and their community (community inclusion) and
- Enhancing the capacity of social networks to remain supportive of the young person.

Eligibility

During the implementation of the TOHI pilot the eligibility criteria were adjusted to be able to respond to young people's needs and the local communities. The adjustments occurred in consultation with the funding body and TOHI Reference Group. The main changes included:

- provide outreach and case management support for longer than 3 months, and if needed up to 9 months, depending on the young person's goals and level of engagement
- allow for longer periods staying in the house, or repeat stays for some participants, if they were assessed as engaging well in the program
- extend services to young people who may be at risk of homelessness or homeless in some cases, if they also met the other criteria and
- provide outreach and case management support to young people aged from 15 years, rather than the original 18 years.

2.4 Governance and service delivery model

TOHI had different governance and service delivery in each location.

Cairns TOHI

Aftercare, a community mental health agency, was the lead agency contracted to implement the TOHI pilot in Cairns. Aftercare formed a consortium with local service

providers, including mental health and youth services, and the Far North Queensland Rural Division of General Practice (FNQRDGP). The consortium partners provided expertise and advice, in-kind support and resources, and joint case management for young people. Some TOHI outreach staff were employed through the partner agencies and their salaries were partly paid through Aftercare. Consortium partners had a Memorandum of Understanding (MOUs) with TOHI and sat on the pilot program Reference Group.

TOHI Cairns refurbished a previous hostel to house up to four young people at a time. The house also had spaces for socialising, a TV room, a garden, bedrooms for two staff, a kitchen and dining area. It was located close to the Cairns promenade and had a recreational feel to it. TOHI also ran social group activities from the premises, such as art groups and yoga. It established a social recreational group that organised outings, such BBQs, bushwalking, movies, going to the beach and fishing, for the young people using TOHI.

The main focus of outreach support was referral to health, mental health and other relevant services and linking to activities to enhance social inclusion and participation. Young people with higher support needs sometimes received co-case management from their mental health service provider. Outreach participants were encouraged to take part in group house activities and to stay in the house if needed. Several outreach participants used the residential support once they familiarised themselves with the program or needed that level of support.

Young people stayed in the house for various reasons. Some young people sought ‘time out’ from a stressful family environment; some wanted to focus on their wellbeing or achieve their goals in a supportive environment; and others wanted to enhance their independent living skills. Service providers reported that many participants in the house focused on resolving some form of personal crisis, including finding stable and safe housing, which was often one of their needs. Many young people staying in the house received outreach support before and after their stay.

Logan TOHI

The TOHI Logan was implemented by Youth and Family Services (YFS) until June 2012. YFS has a history of working with young people. They are a not-for-profit organisation that provides support for young people and their families, including family relationships, domestic violence, and disability services. In Logan the TOHI pilot was known as the Heads Up program.

In the beginning YFS engaged the Local Division of General Practitioners (DGP) and worked closely with Qld Health. The relationships between the DGP and TOHI were defined through a MOU and TOHI Logan had a dedicated reference group linking them with other partner agencies. Throughout the implementation of the pilot they established further links to local youth mental health providers. However, according to a range of stakeholders, these efforts were not sufficient to ensure participation and referral by all partner agencies to TOHI. YFS reported that they might have had

more support from the local services and referrals from the DGP if they had been partners on the program funding submission.

The TOHI house was located in the centre of Logan, near the industrial area. Young people who stayed at the house could use community based recreational activities provided by YFS at other premises. No dedicated groups or programs operated from the house. As part of the outreach component YFS provided regular weekend outings and activities for TOHI participants.

The main focus of outreach and case management support in Logan was to provide targeted case management and connect young people to relevant services and supports in the community. Staff focused on recovery and de-stigmatisation from mental health, and linked young people to social activities to enhance their social inclusion.

A small number of young people stayed in the Logan TOHI house. They were mainly referrals from partner organisations such as Qld Health and youth agencies. Most eligible young people only wanted the case management support and did not express interest in the residential component. Some younger people under 18 years were interested in the residential part of the pilot, but this age group did not fit the age criterion.

In April 2012, YFS sought a variation to the service delivery contract for an expansion of the outreach support and closure of the TOHI house. By the end of June 2012 the Department of Communities ceased funding the TOHI Logan as a result of a number of factors, including the low use of the residential support.

2.5 Participant characteristics and target groups

Approximately 180 young people used the program. The information about characteristics of the young people who used TOHI services to May 2012 in Logan, and September 2012 in Cairns showed that participants were reasonably representative of a young population in these locations and the pilot target group (Table 2.2).

In both locations similar numbers of young men and women used the program, with women slightly overrepresented in Logan. Most participants were aged 18 –25 years in Cairns, with one participant 27 years and outside of the original target group. In Logan, participants were more evenly split between the younger and older ages, with 40% of the participants aged 15 –17 years. The difference in age groups in the two locations reflected the greater use of the house in Cairns, where participants had to be aged 18 years or older, and the TOHI Logan where the program was established within a youth service (Section 4).

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Table 2.2 Characteristics of Cairns and Logan TOHI participants

	Cairns		Logan	
	Young people	%	Young people	%
Gender				
Men	58	56	30	39
Women	45	44	47	61
Total	103	100	77	100
Age				
15 –17 years	18	17	31	40
18 –27 years	84	82	46	60
Unknown	1	1	0	0
Total	103	100	77	100
Country of birth				
Australia	90	87	61	79
Other	11	11	15	19
Unknown	2	2	1	1
Total	103	100	77	100
First language				
English	95	92	–	–
Other	5	5	–	–
Unknown	3	3	77	100
Total	103	100		
Indigenous status				
Indigenous	18	17	6	8
Non-Indigenous	80	78	70	91
Unknown	5	5	1	1
Total	103	100	77	100
Marital status				
Single	14	14	–	–
De facto/partnered	43	42	–	–
Unknown	46	45	77	100
Total	103	100		

Sources: Program management data collections July 2010–May 2012 Logan, Cairns June 2010–Sept 2012.
Note: Cairns n=103, excludes 16 clients that did not engage with program;
Logan n=77, no information about non-engaged clients

Both TOHI sites engaged with Indigenous young people. In Cairns, 18 young people identified as Indigenous (about 15% of the total of young people who did engage with the program). In Logan, 6 young people out of the 77 participants who had information provided identified as Indigenous. In Cairns some service providers and external stakeholders felt that Indigenous young people were underrepresented in the pilot considering the high Indigenous population in this area. There was no evidence from the program management data that young Indigenous people were more likely than non-Indigenous people to get in touch with TOHI but not remain engaged in the pilot.

In the interviews staff in Cairns reported that they tried different strategies to reach out to these groups but without great success. Some providers commented that they program cannot be ‘everything to everyone’ and that Aboriginal and Torres Strait

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Islander young people may feel more comfortable using designated Indigenous youth and health services.

The pilot engaged with culturally and linguistically diverse (CALD) young people, with 11 participants born overseas in Cairns, and 15 in Logan (of the 77 young people of which this information was available). However the majority of these young people spoke English at home and only five young people in Cairns spoke a language other than English at home. In Logan, some service providers reported that they felt that CALD young people were underrepresented among the TOHI participants compared to the overall population in their service area.

Wellbeing and mental health at the time of entry to TOHI

Wellbeing

TOHI aimed to improve the wellbeing of young people. The pilot focused on early intervention, which is to support young people early and provide links to non-clinical and clinical care, where needed, and avoid more severe mental health problems or hospitalisation in the future.

A validated instrument to measure people's subjective wellbeing is the Personal Wellbeing Index (PWI). The questionnaire asks respondents to rate their satisfaction with their life as a whole, and eight separate life domains on an 11 point likert scale (0–10). There exist a number of forms for different population groups, depending on age or specific life circumstances. Young people using TOHI services were asked to complete the PWI-A adult survey at the time when they started receiving services through the pilot.[2]

TOHI participants' satisfaction with their life as a whole was on average 23 percentage points lower than that of the comparison group of Australian young people aged 18–25 years (Table 2.3). In both locations, young people using TOHI were much less satisfied with individual life domains compared to young people in the wider community. TOHI participants were least satisfied with their personal relationships and their achievements in life when compared to the outcomes of other young people in these domains. TOHI participants also rated their health 24 percentage points lower than young people in the community.

[2] The two PWI forms that were applicable to the TOHI young people are the PWI-A which is designed for use with the general adult population, aged at least 18 years, and the PWI-SC which is designed for use with school-age children and adolescents (IWG 2006, Cummins and Lau, 2005). This decision had been made on the basis of the original age criterion for TOHI clients which was 18 years and over. Although comparisons have been made between the scores of the TOHI groups and each age group in aggregate, it can be assumed that the scores of young people aged under 18 years may vary due to the differences in questions between the PWI-SC and the PWI-A. It is unclear how much variation would have been present.

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Table 2.3 Personal Wellbeing Index scores at entry to TOHI

	Cairns (n=70) Mean	Logan (n=49) Mean	Normative score PWI-A 18–25 years Mean
Life as a whole	50	52	74
Standard of living	53	55	77
Health	53	50	75
Achieving in life	48	44	72
Personal relationships	53	52	78
Safety	64	54	79
Part of community	54	48	70
Future security	57	52	70
Spirituality	68	38	80
Overall score (Q2-Q8 above)	56	49	75

Source: Cairns and Logan: Program management data 2010-2012

Notes: Normative score reported for PWI-A 18-25 years. Normative score reported is calculated from Survey Mean Scores, decimals rounded (Cummins et al 2012).

These findings demonstrate that TOHI reached the target population of young people whose wellbeing and life circumstances could have had an impact on their mental health. The comparatively very low PWI results also demonstrate that TOHI participants were appropriate for the program, as they needed support to improve personal outcomes and community inclusion, including social relationships and feeling part of the community.

Mental health

Comprehensive data about participants' mental health were not available. The Cairns program data showed that at least a third of the young people received case management support from a local mental health or acute care team while they were being supported through TOHI. Many of these young people had a diagnosis, some more complex than others, ranging from depression, anxiety, schizoaffective disorders, to early psychosis. A number of Cairns participants also used community mental health providers (psychologist, psychiatrist or counsellor).

TOHI staff reported that most of the young people in Cairns identified mental health support as a need at entry to the pilot, and many were dealing with ongoing problems. This was also evident from their needs assessments. Most Cairns participants (with information on the CANSAS assessment; 63%) reported they wanted more support with psychological distress, and 27% identified support for their condition and treatment (psychotic symptoms) as a priority (Table 4.2). Around 20–30% of participants identified dealing with substance and alcohol use as a need. Comorbidity of mental health and substance use is usually high among young people (Lubman et al., 2007, Teesson & Proudfoot, 2003).

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In Logan, young people using TOHI also identified mental health support as a key need. In the needs assessment, most participants (with information recorded; 30/58) nominated mental health as a priority. Mental health was the most commonly identified need as the first priority, followed by education and training (11 people nominated this as their first priority need (Table 4.3). According to staff in Logan many participants were dealing with high prevalence disorders like depression and anxiety, although few had had a mental health diagnosis or were case managed through a local mental health team. This finding probably reflects the different governance and integration with local mental health services in Logan compared to the Cairns. In Logan staff also reported that they actively linked young people to community mental health supports as needed.

Many TOHI participants also reported experiences associated with poor mental health outcomes, including domestic violence or abuse; mental illness and substance use in the family; an unstable home environment; and family conflict. Some young people had left school or their family home early or were disengaged from schooling and work. Only a few of the young people who shared their story had positive family relationships. For those who did get on well with their family, some still felt socially isolated or had few friends and limited social support in the community.

Overall the TOHI target group in both locations remained relatively consistent throughout the evaluation. Most young people presented issues stemming from marginalisation, disadvantage and social isolation, which had or may have contributed to their emotional instability and mental ill health.

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3 Outcomes for TOHI participants

The evaluation analysed the outcomes and effectiveness of the pilot program for individual participants, and where data were available, also for their informal supporters, families and friends (Section 3.4). In this section, we first present the outcomes for young people in three domains:

- promote wellbeing and mental health self-efficacy of young people experiencing circumstances that have had an impact on their mental health now or, if unaddressed, are likely to have an impact
- enhance social connectedness and community inclusion of young people involved in the program and
- improve paths and links to relevant community services such as, youth and adult services, health, mental health and other clinical and non-clinical services.

The analysis in this section was based on case study narratives from participants and interviews with young people, their supporters, and service providers (Table 1.2). The qualitative data were supplemented with quantitative data from the instruments the two service agencies collected and program management data (Table 1.1).

Findings are discussed for the TOHI pilot as a whole, and where appropriate, we also draw out differences from the service models in TOHI Cairns and Logan.

3.1 Wellbeing and quality of life

TOHI aimed to enhance wellbeing and quality of life of young people. A small number of young people using TOHI service completed two PWI surveys (19/115 in Cairns and 13/77 in Logan). Table 3.1 shows the mean PWI scores of the longitudinal respondents at entry and during the pilot. The sample is too small to be representative of the full TOHI group and too small to measure change over time. The findings indicate an average slight improvement in wellbeing.

In Cairns average scores for life as a whole increased from 54 to 59% points, in Logan from 47 to 54%. In both locations and across most other life domains participants' PWI scores improved. Young people's average subjective wellbeing outcomes remained low compared to other young people in the community (Table 3.1 and Table 2.3).

There are several possible explanations for these mixed findings, including the comparatively low PWI scores at entry into the pilot (Table 2.3), which demonstrate that TOHI participants were marginalised or socially isolated, many dealing with more entrenched disadvantages and mental ill health. It is possible that the short term intervention of the TOHI pilot might have limited the ability of some young people to experience changes in their life. Second the time of recording the follow up measure might have been too early for some young people. Last, the data are unlikely to be reliable due to the small sample and missing dates.

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Table 3.1 Personal Wellbeing Index scores of longitudinal respondents

	Cairns (n=19)		Logan (n=13)	
	Survey 1 Mean	Survey 2 Mean	Survey 1 Mean	Survey 2 Mean
Life as a whole	54	59	47	54
Standard of living	48	61	47	55
Health	53	52	38	53
Achieving in life	50	56	30	45
Personal relationships	50	57	37	50
Safety	67	64	39	52
Feeling part of the community	57	51	38	44
Future security	54	61	42	52
Spirituality	65	72	10	36
Overall score (Q2–Q8 above)	45	47	28	39

Source: Cairns and Logan PWI data collections 2010–2012

Notes: Logan did not provide any survey dates. For the purpose of this table, if two surveys were provided, lower scores were assumed to be Survey 1 and higher scores were counted in Survey 2. This presents a bias and will not be correct for all 13 longitudinal Logan respondents.

While the quantitative wellbeing data were mixed, the evidence from the qualitative data was consistently positive. Young people in Cairns and Logan who used either outreach or residential support said their emotional and overall wellbeing improved. Many young people reported that they were more positive about their life and several had hopes and plans for the future. Overall participants felt that the program was positive, supportive and empowering, because as one said, TOHI 'helps you in the long run, builds confidence and makes you better at life.'

Most young people reported they had gained a range of outcomes as a result of their involvement in TOHI, which had advanced their wellbeing. The key ones were increased confidence and self-worth; skills and knowledge to better deal with everyday life situations and their mental wellbeing; identifying or clarifying their goals; and working step-by-step towards achieving them.

Young people said that an important support mechanism was the intensive case management support that all participants using TOHI had received. Participants confirmed that having someone to talk to who understood their situation and could assist them with 'getting back on track' had been pivotal in their recovery process. Linking young people to a range of community supports and services, including general health, mental health, educational and welfare services had been critical in the process of improving their sense of wellbeing and belonging.

Another outcome of this case management support was improvements in young people's physical and emotional health that contributed to their overall wellbeing. In both locations TOHI staff reported young people making changes to their lifestyle, such as substance use, weight management, becoming more active, or simply

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accessing GPs and other community health providers, including mental health services.

In both locations, staff were active in linking young people to social outlets and offering a range of recreational activities as part of the TOHI pilot (Section 2.4). Participants and staff reported that these efforts had significantly reduced social isolation for many young people and allowed them to work on their interpersonal skills and build new, more supportive relationships with peers.

More young people in Cairns than in Logan stayed in the Time Out house (Table 4.1). Young people in both locations were generally positive about their experience of staying in the house. The two sites differed in the way the houses operated (Section 4.4). In Cairns the young people using TOHI reported benefits from living in a safe, youth friendly, highly supportive and structured environment. The house provided them a break from their stressful life, such as living with their family in conflict, or getting away from abusive relationships. Staying at the house enabled these participants to settle emotionally and either work on addressing the problems in their relationships, or, with the support of their worker, finding alternative living arrangements more conducive to their mental health and wellbeing. Daniela, a young woman with substance abuse issues and experiences of self-harm, who had been involved with TOHI for around a year said,

> I did know how to look after myself. I felt like I had the social skills but I did not know ... how to put them into play. Because my head was so mixed up ... I was a bit worried that without having family close and so much time alone I might hurt myself ... I came in [the TOHI house] because it was a supportive environment ... to maintain a stable routine in my life. Just learn how to cope by myself again, how to interact with others.

Peter, a young man in Cairns with depression moved into the TOHI house. He described his situation before coming to the house and during his stay,

> I just kept bottled up inside and spoke to no one [when I was living at home] ... things got worse this time. I started lashing out at my family in aggression. I felt alone and secluded, struggling to cope with everything ... I was in no mental condition to find a job. I was lazy. I was easily angered and was not very pleasant to be around ... [Then] I met my [TOHI] case worker two days later and was finally able to let go some of my aggression and talk to someone about everything that was going on in my life.

After moving to the house and receiving intensive one-on-one support, Peter said he had managed to make new friends, work on his interpersonal skills and eventually this helped him to find a job and move out into his own accommodation. Moving out from home had also improved his relationships with his family.

Finding alternative and affordable housing was a major concern for some participants in Cairns. Young people who were at risk of becoming homeless used the house as a safe haven, until they could secure more permanent housing. Once they felt more

confident about their independent living skills, thanks to the supported home environment and structured lifestyle the house offered, this assisted some young people to secure and maintain their own housing in the community. For example, Melissa, a young woman aged in her early 20s who had stayed in the house during a very stressful period in her life said,

> The Time Out program has been a huge part of my recovery. In a time of my life, where to be frank, I needed time out and some support when I had no other options. This is a one-of-a-kind program that gives [support to] youth with mental health problems.

In Logan, the few young people who stayed in the house said it provided them time out from whatever was going on in their life. Most participants who used the residential services benefited from one-on-one intensive support, learning new skills, making friends and participating in the day-to-day household duties. Annabelle, a teenager who was a full-time carer for her sick mother, said that the house had provided her with rest and increased her social contacts,

> The program enabled me to use the time out house ... for some very much needed rest ... I met a few people in the time I stayed at the house, and made a couple of friends as well. I experimented with cooking, and the staff were supportive – helped me create a resume, search for jobs, and training for myself ... getting out having fun and mingling with others is not something I get to do often enough.

Many, but not all Logan participants were content with their stay in the house and the support structures in place. Some of the participants raised concerns about the TOHI house and suggested improvements for future program development, such as having more activities and structure in place (Section 4.4).

3.2 Social and economic participation

TOHI pilot participants completed a measure of social and economic participation, the Activity and Participation Questionnaire (APQ6). About half of TOHI participants in Cairns (56/103) and most in Logan (69/77) completed the survey when they entered TOHI. Some people did not complete a survey, some surveys were incomplete, the date of administration in Logan was missing and few repeat surveys were available to measure change over time.[3]

[3] The surveys had gaps, where some questions were not answered, so the total number of responses varies to each question. The Logan data did not included any dates so it was assumed that it was collected upon entry to TOHI, which may not be correct for all respondents. Logan had no longitudinal APQ6 data, and in Cairns only 10 young people out of the 103 who were actively using TOHI services completed a second APQ6 survey.

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Social activity, friends and family

For most participants in Cairns and in Logan, making new friends and reducing social isolation was a primary concern, including for those who were already active in some social networks or activities. The PWI data at entry showed that TOHI participants were most unhappy with their personal relationships (Table 2.3). Some young people wanted to improve their relationships with their families, but this was not a priority for all the young people. Strengthening their social networks was a longer term process for some young people, particularly those who identified overcoming social isolation as a key goal.

Most young people using TOHI services, who responded to the APQ6, were engaged in some form of social activity when they entered the pilot (Table 3.2). Commonly they mentioned activities including visiting relatives and friends, participating in sports or physical activity, going out for a meal, or socialising with friends face-to-face, by phone or on the internet. A small number of young people were not engaged in any social activity (five in Cairns and 11 in Logan).

Table 3.2 Participation in social activities

	Cairns		Logan	
	Young people	%	Young people	%
Engaged in some form of social activity	51	91	58	84
Did not engage in any social activity	5	9	11	16
Total responses	56	100	69	100

Source: APQ6, Cairns and Logan Program management data collection 2010–2012

TOHI Logan staff reported that most young people using the pilot were socially isolated; they had few friends or other people they trusted in the community, and many had no means or links to access social and recreational activities. In Cairns, several young people reported difficulties engaging with strangers, communicating effectively and making themselves understood, as well as socialising with peers. Some of the common reasons they mentioned included their mental health, and its impact on their self-esteem and ability to engage with others; moving and leaving behind social networks; or just not having had the opportunity to develop good social skills. Three-quarters of the Cairns participants (39 people) said they wished to increase their social and recreational activities as part of their involvement with TOHI (Table A1; the Logan data were unreliable on this measure). In Cairns and Logan, many young people reported strained family relationships before coming to TOHI.

The changes young people experienced in their social and family relationships as a result of using TOHI Cairns and Logan were mixed. More young people noticed improvements in their social interactions than those who had not. Several of the young people in Cairns reported that they felt more outgoing, confident and talkative as an outcome of their involvement in the pilot. This had helped them to develop new relationships, strengthen old ones and overall improve their social life and wellbeing. For others the involvement with TOHI meant that they found the strength to get away

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from harmful relationships and meant that they were prepared to rebuild their social networks. Erik a young man with schizophrenia said,

> Being with TOHI has made a difference. It made me a lot happier. I have found new friends and I feel more relaxed in myself. My worker is also helping me with my 'staring problem', so I am being taught how to make proper eye contact.

The young people staying in TOHI Cairns said that the residential stay contributed to reducing their social isolation and stabilising the mental health of some vulnerable young people who had no or very little social support, family and friends in the community. For other young people, moving out of the family home into the house, or independent accommodation successively, had helped them to repair strained family ties.

The Logan participants had less information about the extent to which the program had enabled them to sustain or improve their family relationships. In a few cases, participants reported that TOHI had helped them to learn better communication or anger management skills, which had a positive impact on their relationships overall, but in particular with their family. Young participants said that being able to go to the 'Time Out house' also helped to 'cool down' an escalating family problem.

Overall, in both locations, the participants and staff said that the social activities and age appropriate outings for TOHI users was a major success of the pilot. Reducing social isolation had helped these young people in many ways, beyond simply having 'something meaningful to do'.

Education and work

One aim of the TOHI pilot was to increase socio-economic participation and community inclusion of young people. Many participants using TOHI were disengaged from work and study before and during the program. The program data confirmed this problem. Most TOHI participants who completed the APQ6 survey were neither engaged in school and other forms of study, or employment. Table 3.3 shows the proportion of young people in Cairns and Logan who were disengaged and not participating in education and work. In Cairns 80% (45/103 participants) and 55% (34/77 participants) in Logan were not enrolled in study or school. This might include some young people over school age. The low proportion of young people in employment (18% in Cairns and 16% in Logan) indicates that most young people were neither at school nor working when they entered TOHI. Some of these findings must be read with caution because responses could not be analysed by age. For example, the larger proportion of young people aged 15–17 years in Logan might explain the higher number of young people neither in employment (84%) nor looking for work (59%). Also, only half of the total TOHI cohort completed this survey.

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Table 3.3 Participation in school, study and employment

	Cairns		Logan	
	Young people	%	Young people	%
Education status				
Yes, enrolled in school or study	11	20	28	45
No, not enrolled in school or study	45	80	34	55
Total number of young people	56	100	62	100
Employment status				
Employed	10	18	11	16
Not Employed	46	82	57	84
Total	56	100	68	100
Actively looked for employment				
Yes, looked for full or part time work	35	64	9	13
No, did not look for work	20	36	59	87
Total	55	100	68	100

Source: APQ6, Cairns and Logan Program management data collection 2010-2012

Of the ten young people in Cairns with longitudinal employment status data (10% of the Cairns participants), three had either kept or gained a job, and two had lost or stopped their employment. Five of the ten young people in Cairns did not have job after some time of receiving support through TOHI. These socio-economic participation outcomes must be read with caution due to the small sample of participants who had completed two surveys with information on their employment status. These findings cannot be interpreted as representative of the total TOHI group. They do however demonstrate the mixed results for young people in this area.

The economic participation qualitative data from participants, their supporters, and staff in Cairns and Logan showed that some young people had reengaged in work, education or volunteering as a result of their involvement in TOHI. Others were taking active steps towards achieving this goal and had moved towards greater independence. Others were still working on stabilising their emotional wellbeing, securing housing, or other goals, before they felt ready to address their socio-economic goals.

Some young people commented that they felt more motivated and positive since their involvement in the pilot, so they were confident to begin to plan their future economic participation options. Most of these young people probably required ongoing formal and informal support to assist them to achieve these plans. An example was a young man from Cairns who took part in a job training course during his stay in the house. After he had left the TOHI house his support changed from daily to weekly contact with his worker, but without the intensive support, after only a few days he stopped attending his job training course.

Several participants reported that they when they first entered TOHI, they were about to or had disengaged from their study or school, but they had re-engaged after receiving TOHI outreach support. Several participants needed only the little extra

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support to get them through their exams or remain focused on their studies while other things were taking over in their life.

The external stakeholders and the staff reported that the ongoing intensive and person-focused support played an important part in assisting young people to achieve their study and work goals. The support linked them to relevant community services, and supported them throughout the process and during 'tough times'.

3.3 Mental health self-efficacy

A core aim of the TOHI pilot was to create paths for mental health recovery and ongoing support for young people experiencing circumstances that were likely to have an impact on their mental health.

In both sites, the qualitative data from young people showed that the person-centred planning process, mental health recovery focus and flexible case management approach worked well to improve their wellbeing and identify ongoing support, beyond the TOHI pilot (Section 4.2).

In particular in Cairns, young people reported the TOHI support model had a positive impact on their mental health self-efficacy, such as ability to cope and manage their mental health needs. Many young people in Cairns were dealing with complex issues. Most were already receiving case management support through community mental health services; waiting for a formal mental health assessment; or they were connected to community mental health providers, psychologists and counsellors as a result of their involvement with TOHI (Section 2.5).

About three-quarters of the Cairns participants completed a sub-scale of the Recovery Assessment Scale (RAS) related to personal confidence and hope for the future (Table 3.4). The responses for the first survey show that young people in Cairns were facing difficulties coping with their mental health and many felt their symptoms were interfering with their life (Q16–17). Most young people felt that their mental health problems were out of their own control (Q13).

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Table 3.4 Recovery Assessment Scale, Cairns

	Young people		
	n=71	n=18	
	Survey 1 mean	Survey 2 mean	Change
1. I have a desire to succeed	3.2	3.6	0.4
2. I have my own plan for how to stay or become well	2.7	3.1	0.4
3. I have goals in life that I want to reach	3.2	3.6	0.4
4. I believe I can reach my current personal goals	2.6	3.1	0.5
5. I have a purpose in life	2.6	3.3	0.7
6. Fear does not stop me from living the way I want	2.2	2.4	0.2
7. I can handle what happens in my life	2.3	2.5	0.2
8. I like myself	2.5	2.8	0.3
9. If people really knew me, they would like me	2.8	3.0	0.2
10. I have an idea of who I want to become	2.8	3.2	0.4
11. Something good will eventually happen	3.0	3.1	0.1
12. I'm hopeful about my future	2.8	3.1	0.3
13. My mental health problems are completely out of my own control	3.1	2.2	-0.9
14. I continue to have new interests	2.7	3.1	0.4
15. I can handle stress	1.9	2.3	0.4
16. Coping with mental illness is no longer the main focus of my life	2.1	2.3	0.2
17. My symptoms interfere less and less with my life	2.1	2.9	0.8
18. My symptoms seem to be a problem for shorter periods each time they occur	2.3	2.7	0.4

Source: Recovery Assessment Scale, subscales related to hope and confidence, Cairns program data 2010–12. No data available for Logan.

Notes: The RAS (short) measures personal confidence and hope on a 5-point likert scale, with responses between 'strongly agree' to 'strongly disagree'. For the purpose of this table answers were 'reverse coded', with the exception of Q13 to be able to represent higher scores as positive outcomes—'strongly disagree' (1), 'strongly agree' (5).

Eighteen participants (out of the total 103 participants) completed a second RAS survey in Cairns. The results showed an overall average increase in scores in areas related to personal confidence and hope (Table 3.4). However, the results are not representative of the whole TOHI population due to the small repeat sample, and as a consequence no statistical testing can be conducted. On average, positive changes across the young people who completed two surveys were observed. The largest average change was participant ability to better cope with their symptoms, so that they interfered less with their life (Q13 and Q17). Also, on average, the participants had greater hopes for the future (Q5), which is an indication of improved mental health. These findings are an indication of likely positive mental health outcomes for the young people using the TOHI pilot in Cairns.

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In the interviews with Cairns participants, many young people, especially those that stayed in the house, felt they were learning the skills and strategies and receiving the right information to address their mental health needs. For example, participants reported that they benefited from alternative forms of stress relief, anger and mood swings management, such as through recreational activities (art, yoga and gym); assistance and information to lead healthier lifestyles (nutrition, physical activities and relaxation techniques); as well as encouragement to get a mental health assessment, including review or change in medication, or access to mental health services, if they were not yet seeing anyone.

Also in Logan, young people using TOHI Logan services reported that it helped them to better understand themselves and the issues they were facing; find strategies to better manage their emotions that affected their wellbeing and relationships (e.g. improved sleeping patterns); overcoming barriers to 'opening up'; and gaining confidence to seek help from community mental health providers. TOHI Logan received fewer referrals from community mental health services and therefore young people were more an early intervention group, with less complex mental health needs.

Overall TOHI participants reported that they felt empowered, more aware and confident to seek out help on their own as needed. Staff and external providers highlighted one of the main strengths of the TOHI, in both locations, was workers' ability to make young people comfortable to connect and access a range of community services, including mental health support, which could provide specialised and ongoing assistance and information. Some staff reported that it was more difficult to observe mental health self-efficacy outcomes for participants who only used the outreach support.

3.4 Outcomes for supporters

TOHI aimed to also support families, when the young person had contact with them, and to support young people to re-engage with supporters when that was constructive for the young person's wellbeing. Many of the young people in the Cairns and Logan TOHI did not have contact with their family members or other informal adult supports, or they had strained relationships with them. The data presented here are from five informal supporters (three in Cairns and two in Logan).

Family members and friends of TOHI participants viewed the pilot as generally positive. They found that it had helped the young person in a number of ways, such as to develop more independent living skills, confidence, focus and reinforce their talents and strengths. They reported a range of positive outcomes for the young person's wellbeing, emotional health, social participation, and involvement in work or education.

In some cases young people and supporters reported that the pilot also had a positive impact on the family relationships. The young people's improved emotional wellbeing and engagement in activities had an indirect positive impact on family

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relationships, for example, less arguments between carers and the young person. According to staff, families and supporters gained a better understanding of the young people's problems, whether they had a mental illness or not. The informal supporters also perceived TOHI as a relief because support was available and accessible. They said this knowledge gave them a sense of stability, reduced their stress and took some of the pressures as carers off them.

Most families were highly supportive of the residential component of the program. They felt it was a good place for young people to have their own space and time and receive timely, intensive support to re-focus and get them back on track. One mother in Cairns however felt that her child had not been suitable for the house and felt that she had been talked into it by her worker. In this case, the carer was pleased to remain in steady contact with the young person and their worker.

Cairns TOHI had a stronger focus on supporting the family as a whole, where this was in the best interest of the young person and when they gave their consent. They established links to the local Carers' Hub where parents and other supporters of people dealing with mental health issues could receive support, advice and respite services as needed.

3.5 Implications of the outcomes

The pilot partly achieved its outcome objectives. It improved the wellbeing of some TOHI participants. Young people using TOHI services had very low PWI scores at entry to the pilot, which shows that the pilot was reaching its target group, marginalised young people whose circumstances either have had an impact on their mental health now or, if unaddressed, were likely to have an impact.

The findings indicate an average slight improvement in wellbeing, although the quantitative sample is too small to be representative of the full TOHI group and too small to measure change over time.

Young people had mixed outcomes in socio-economic participation. Some young people with positive changes in this area were at risk of losing this progress when they moved out of the house. This was a particular risk for young people with limited social networks and support structures. For some outcomes areas there was not sufficient longitudinal data available to determine the extent to which young participants benefited from the pilot.

Most young people who participated in the evaluation and contributed to the interview and narrative case study data felt that both the outreach and in house support were responsive and effective in helping them develop the skills, confidence and a plan to address hurdles in their lives. They also benefited from increased confidence and skills managing their mental health and wellbeing. All participants who stayed in the Cairns house and many who stayed in the Logan house reported outcomes from a short term, safe and youth friendly residential program' and intensive case management support.

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The proportion of young people in the TOHI Cairns who had mental health support or who were case managed by mental health providers increased over time. This was a result of the close coordination of TOHI with a range of community mental health services and other agencies.

All stakeholders reported that the successful implementation of the TOHI pilot was due to its flexibility, the planning and coordination of young people's needs, linking them to relevant clinical and non-clinical services and supports, and the person centred service delivery and empowerment approaches.

The TOHI Logan pilot program design changed during the implementation. The program emphasised the outreach and case management component because the residential component was not as relevant to young people's early intervention needs, and demand for it was low throughout the evaluation period (Section 4.4).

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4 Service use and effectiveness of service delivery

This section addresses the effectiveness of the pilot support model, and draws implications for program improvement, including the responsiveness of the model to meet participants' needs; the extent to which the TOHI pilot facilitated pathways to recovery and connections to a range of services; and the use of strengths-based and person-centred approaches. We also examine how the TOHI fits into the wider service system in the two communities.

The sources of data to address this part of the evaluation were interviews with stakeholders, including young people using TOHI services. The quantitative findings were drawn from the program management data collections in Cairns and Logan.

4.1 Service use and participant needs at entry

Service needs

Over 180 young people received outreach and case management support from 2010 to 2012 in Logan and Cairns.[4] Table 4.1 summarises the hours and occasions of support provided to young people in each location.

Table 4.1 TOHI participants service use (2010–2012)

	Cairns*		Logan**	
	Outreach	**House**	**Outreach**	**House**
Total occasions of support	1815	5046	n/a	n/a
Total hours of support	2747	40178	1703	664
Number of young people	82	33	62	15
Average hours support per person	34	n/a***	27	44
Total young people supported	115		77	

Source: Cairns and Logan program management data 2010–2012

Notes: *Cairns data are from program reporting. The data used for analysis in the remainder of the report are based on program management data provided to the researchers end of 2012, based on 103 young people who engaged in the TOHI Cairns pilot.

**Logan outreach hours were calculated by adding the number of 'Outreach 'contacts' from the administrative data, assuming that each contact was one hour. House contact hours were counted as any outreach contact provided to a young person who had an 'In House' indicator of either 'Y' or 'Yes'. No information was provided in Logan to indicate the difference between outreach hours or occasions of support.

*** not applicable because hours of support in the house also included other activities

[4] Evidence from internal reporting in Logan suggests that they had engaged a greater number of young people. For this report however data were only available for 77 young people.

In Logan, an additional ten non-TOHI participants who fitted the age criteria and could benefit from this type of support also stayed in the house. These young people were participants of other YFS programs. This strategy was to ensure that TOHI participants had the company of other young people while they were in the house. These ten participants are included in Table 4.1.

Participants reported that case management support and information they received was 'practical and useful', such as tools they received to help them better manage their mental health and wellbeing. Most TOHI participants in Cairns and Logan were positive about the quality and frequency of outreach and case management support provided. In a few cases young people reported that they would have liked to see their outreach worker more frequently and that a weekly get together was not enough for them.

Support needs

Young people entering the TOHI program completed a needs assessment with staff. In Cairns, staff used the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS), and in Logan an internal needs assessment tool was used across all YFS programs. In Cairns, data were available for 100 young people about the types of needs they identified on entry to TOHI, together with their support worker (Table 4.2).

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Table 4.2 Support needs of Cairns participants at entry to TOHI

Type of need	Young people	Unmet need %	Met need %	No need %
Psychological distress	97	63	28	9
Daytime activities	98	60	32	8
Company	98	53	36	11
Intimate relationships	87	51	24	25
Sexual expression	76	36	26	38
Money	95	33	43	24
Psychotic symptoms	95	27	29	43
Accommodation	100	27	52	21
Drugs	96	27	21	52
Safety to self	96	24	38	39
Physical health	100	23	50	27
Transport	100	23	44	33
Alcohol	97	21	27	53
Looking after home	99	21	44	34
Basic education	98	20	35	45
Safety to others	96	15	32	53
Benefits	98	14	47	39
Self care	99	14	48	37
Information on condition and treatment	97	14	47	38
Child care	98	8	9	83
Telephone	99	7	47	45
Food	100	6	68	26

Source: Camberwell Assessment of Need Short Appraisal Schedule. Program data 2010–12
Note: CANSAS data not available for Logan.

Nearly two-thirds of participants identified psychological distress as a key need (63%). The second most frequently identified need was more opportunities for daytime activities, and more support with social interactions (company, intimate relationships). Around a third of the participants needed more support with their mental health issues (psychotic symptoms). This reflected the relatively high proportion of young people referred to TOHI by community and other mental health services. Cairns participants also identified basic needs, such as accommodation (27%), food (6%) and support around self-care (14%) or their independent living skills (looking after home, 21%).

Thirty-three young people in Cairns completed a CANSAS survey twice. The analysis examined if there was an increase in the number of met needs between survey 1 and survey 2, and if this change was statistically significant. The analysis showed that the

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median number of met needs per young person increased significantly from 9 to 12, out of a possible 22 needs assessed in the CANSAS tool (Table A2).[5]

In Logan participants rated their needs by first to fourth priority. No data were available on young people who did not have a need in a particular category. Mental health was the highest priority for the greatest number of people; 77% said mental health was a need for them (priority 1 to 4). The next highest need was for education and training.

Table 4.3 Types of support needs identified by Logan participants

	Need				YP with identified need	
Type of need	**1st**	**2nd**	**3rd**	**4th**	**Number**	**%**
Mental health	30	6	6	5	47	77
Education/ training	11	10	12	6	39	64
Increasing employment	4	9	8	2	23	38
Accommodation	7	7	4	3	21	34
Social network	2	9	5	5	21	34
Goal setting	2	5	2	3	12	20
Financial	0	5	3	0	8	13
Health	0	6	4	3	13	21
Not listed	3	0	13	24	–	–
Other	2	4	4	10	20	33
Total needs	58	61	48	37	58	–

Source: Logan program management data collections 2010–2012
Notes: Missing data for 19 young people; Data not available for Cairns

The identified needs in Logan and Cairns were similar, particularly in the qualitative data. Most TOHI participants reported they wanted support for their mental health, social and recreational activities, social relationships and everyday coping and living skills.

In both locations, some young people identified stable, affordable and safe housing as a need. Some young people had lived temporarily with friends and relatives or lived on the streets. TOHI service providers clearly stated the pilot was not suitable for purely emergency housing or people who were longer without stable housing.

4.2 Referrals and early intervention

Referrals

Young people came to TOHI from a wide range of referral pathways, which varied between the two locations (Table 4.4). In Cairns, most young people were referred to TOHI by youth services (30), mental health services (25), and community services

[5] A Wilcoxon Signed-Rank test compared the median scores of surveys 1 and 2 within each client. The analysis indicated that the reduction in needs was significant (N=33, W=359, p<.05).

(21). In Logan, most young people self-referred (20), many were coming through the YFS youth services (11) and other internal programs run by the YFS (8), and only a few participants were referred through external community services (9). In Logan only a small number of young people (5) entered the pilot through a mental health service referral.

Table 4.4 Referral sources in Cairns and Logan

Referral source	Cairns Young person (n=103)	Logan Young person (n=77)
Youth service	30	11
Mental health service	25	5
Community service organisations	21	9
Self-referral	7	20
School	7	3
Family, parent/carer	5	7
Internal	0	8
Qld Health/other government	4	3
General practitioner	2	0
Other not specified	0	8
Unknown	0	3
Total	103	77

Source: Cairns and Logan program management data 2010–2012

Cairns TOHI successfully used a number of strategies to engage participants and promote the service to the potential target groups and referring services. They worked with their consortium partners and other local community services to ensure a range of referrals to the pilot, including from schools, families, community and government services. They also worked closely with local mental health services. In several cases young people were case managed by a mental health provider while they concurrently received support through TOHI.

Over the evaluation period the number of community health and mental health referrals in Cairns increased to over 30%. These referrals reflected the integration of the pilot with the local community mental health and wider service sector. TOHI Cairns also ran a number of community development projects, for example, TOHI staff involved in the delivery of early intervention workshops in schools. According to staff, such projects assisted in raising awareness of the TOHI service and the type of support it could provide to young people and their supporters.

In Logan, TOHI staff promoted the pilot from the beginning through a number of ways. However the referral sources remained largely focused on in-house referrals. Young people mainly came to TOHI Logan through the YFS existing services or adjacent programs for youth, families, people with disability and other support groups. In Logan, fewer young people, compared to Cairns, were referred through mental health providers and external community organisations. The low diversity in referral sources and low up-take of the Time Out House, remained a challenge for

the TOHI Logan even though they worked closely with the Qld Health Department to increase awareness in the sector among relevant services.

A likely explanation for the different referral patterns was the difference in the governance and service background of the two lead agencies implementing the pilot (Logan YFS as a youth service and Cairns Aftercare as a mental health service) (Sections 2.4 and 4.5).

Mental health early intervention

Both TOHI sites focused on mental health early intervention, although in different ways, again reflecting the service background of the agencies. Cairns TOHI focused on providing services to young people who identified mental health as a priority. Some of them had a diagnosis, a mental health case manager or no contact with mental health services. Cairns staff were clear about not being a step-down service for people coming directly from a mental health unit. Hospitalisation was not an exclusion criteria, but they needed to be stable and not in crisis at the time of entering the TOHI house.

The Logan TOHI worked from a whole-of-health perspective and did not make mental health a primary focus of their engagement approach. Young people generally did not have a mental health diagnosis and most had little or no experience using mental health services prior to coming to TOHI. These characteristics were also a result of the lower integration of the TOHI Logan with the local mental health service sector (Section 4.5). Nevertheless, the program data showed that referring young people to community mental health services was a key aspect of TOHI Logan support model, and the majority of young people's identified mental health support as their highest need (Table 4.3).

4.3 Youth friendly and person-centred service delivery

Planning and goal setting

An objective of the TOHI pilot was to deliver appropriate services to young people, for example, by using strengths-based and person-centred planning and goal setting approaches. All the young people who participated in the interviews and case studies were linked to other services and supports, and had activities and plans in progress or completed.

In Cairns and Logan, TOHI worked closely with the young people to identify their goals and develop a plan to meet these goals step-by-step. The staff used participant driven, values based approaches which sought to build on strengths, evaluate the commitment of the young person to working towards goals and sub-goals. In both locations the approach included regular reviews of the plan and back up plans to maintain the support processes during expected and unexpected challenges.

Most young people were satisfied with the goal setting and planning process, and found it useful, clear, and empowering. Some elements of the planning process were

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harder for some participants to understand than others. Some people found the process clear and, and liked having a copy of the plan on paper. One young person from Logan reflected on the usefulness of the planning and goal setting process,

> I feel a lot more confident [TOHI workers are] helping me break down little sections of my life and doing each goal at a time, instead of doing everything at one time.

Staff commented that empowerment and person-centred planning and goal setting were also dependent on the workers' understanding and commitment to using this approach and that more training in these areas was necessary.

Overall young people using TOHI services in Cairns and Logan benefited from the flexible approach that allowed them to revisit their plans and make amendments as needed, and they valued being recognised as experts in their own needs, rather than being 'told what to do'. This person-centred approach made the young people feel 'respected and understood' which ensured they felt comfortable and engaged with the pilot.

Flexibility and empowerment

All stakeholders agreed that the flexibility of the program and empowerment of young service users were the pilots' main strengths and key to success. Flexibility was important for the young people to respond to their changing needs, in particular in the planning and goal setting process. From the TOHI staff perspective, flexibility was equally important so that they could deliver services in a person-centred way, with a focus on the individual person rather than the pilot guidelines.

In both locations staff had, in consultation with the funding body, refined the original guidelines, for example, to engage with young people for longer time in the outreach support. In Cairns the pilot moved from an early intervention target group to including young people with diagnosed mental health conditions or who were more likely to have more complex needs. The Cairns TOHI staff reported that the flexibility of the pilot drove their success working with the partner agencies, engaging the young people and meeting their needs.

Empowerment was another key element of the service approach in TOHI. Many young people commented that TOHI had helped them to be more confident and self-aware, for example, assisted them to better manage their health and mental wellbeing. This included identifying issues they were facing, have a better understanding how to deal with challenging situations, or where to get help.

Many young people appeared to have gained skills and knowledge that empowered them as a result of being involved in the pilot. However, achieving more independence was not easy for all young people. Staff in Cairns commented that they focused on 'breaking the co-dependency model' in their case management support. However, especially for young people with little support in the community, moving out from the house could pose a challenge and risk. Cairns staff reported several examples of young people who stopped following up on medication, health

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appointments, education or other scheduled activities once they had left the house. They had not managed the transition 'from daily check in [and intensive support] to a weekly check in'. Staff in Cairns adopted an outreach–in house–outreach support model to alleviate the risks associated with the transition.

A finding from Cairns about empowerment and building capacity for greater self-care and independence in the long term was that many, but not all young people required more ongoing support in form of case management once they had left the TOHI house.

Relationships with staff

The young people were mostly positive about their relationships with the TOHI support workers and other staff in both locations. They frequently used words like feeling respected and valued, understood, and said that the staff were non-judgmental about their needs and capacities, and mostly 'responsive and personal' in their support. Other young people were uncomfortable with the relationships with TOHI support staff and they were not ready to discuss their circumstances. The intensity of the support was too high in the residential care and too low in the outreach support for some people.

Other aspects of the relationships with staff that most young people appreciated were consistency in care, seeing the same worker for a longer time, and staff coordinating well together. In Cairns continuity of care was highlighted by staff as a central aspect of their service philosophy. Each participant was allocated a key worker at the beginning and 'young people [especially in the house] would not go more than a couple of days without meeting *their* worker'.

The quality of the relationships between the young people and staff was a key part to engaging participants in the pilot, as well as supporting them to achieve positive outcomes. Many young people said that feeling understood and listened to was connected to being able to express their concerns freely, work towards addressing their goals. One young man explained that it made him more self-motivated to help himself.

Many participants felt that relationships with TOHI staff were better than some of the other services they had used because there was less red tape and they were more flexible. One young man in Cairns had a history of using mental health units. He was seeing a psychiatrist in the community while staying in the TOHI house and said,

> … in the mental department – there, people want you to get better so they can get rid of you. And then when you do go, you end up relapsing ... that's how I felt with mental health ... But [TOHI] here it's different, doors open, arms open ... it's a bit overwhelming!

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4.4 Residential support

The unusual aspect of the TOHI model was in-house residential support for young people. In the program design, the house was intended to be the core of the model, supplemented with case management as the young people left the house. In practice, the outreach and case management became the focus of the support for most young people, before and after using the house, or instead of using the house, particularly in Logan.

Cairns TOHI house strengths

All participants who stayed in the house in Cairns described it positively, saying they found it fun, peaceful, practical, safe and social. It was important to young people to have someone around to talk to but who did not push them too much to discuss issues they were not ready to address. Participants greatly benefited and most of them appreciated the concentrated and structured support in the house, which had helped some to make significant changes to their life they felt positive about (Section 3). The statement of a young man in Cairns summarises how most young people who stayed in the Time Out house felt,

> If I was still living where I was, I'd be drinking and I would not have an idea what to do. In different ways I did not think I would be here making new friends a lot, and having fun in different ways ... It [staying in the house] has made me feel better within myself.

Service providers in Cairns reported that they were working hard to try to 'recreate a family like environment' for young people, while providing the young person with routine and a weekly plan, which some might not have had in the past. A few young people commented that although they had benefited from participating in household work, it was also the 'annoying' part of staying in the house for them.

Running the house 'at capacity', having three to four people staying there at a single time allowed TOHI staff to run groups and recreate a more social atmosphere in the house. None of the young people said that they felt that having other young people staying was detrimental to their own wellbeing or safety. Young people also said they greatly enjoyed and benefited from the social and recreational aspect of the pilot. It provided them a range of opportunities to engage with peers in the house and beyond, and participate in creative and stimulating activities such as, crafts and arts, exercising and walking, gardening and contributing to household tasks.

A key to the success of the TOHI Cairns house was the clarity and enforcement of house rules and managing young people's expectations prior and at entry to the house. Staff reported that they had strict house rules and admission criteria (e.g. no alcohol and drugs during the stay, participation in activities and household work) and managed the young person's expectations accordingly. This approach was critical for ensuring safety for everyone and also contributed to a more cohesive environment. One staff in Cairns commented that,

> Making people understand they've got to commit ... that they have to give up certain freedoms in their lives [when they come into the house] has functioned as a selection criteria in itself.

In Cairns TOHI staff were confident that this approach helped to take in appropriate referrals, young people who were willing and ready to make changes in their lives. If necessary, young people who consistently breached rules were asked to leave.

Most young people who stayed in the house had previously engaged with TOHI outreach support and then moved into the house and continued with outreach support after they had left. This standard outreach-house-outreach model worked well for the young people and the staff managing several participants at a time.

External stakeholders and the five informal supporters were overall positive of the house and its usefulness for young people. They appreciated its location and set up, and integration and coordination with the local service sector, in particular mental health services. They all felt that the pilot could provide young people the necessary all round support they needed.

Cairns TOHI house challenges

The main challenges of TOHI in Cairns were to keep young people and staff safe, support participants' recovery process and meet their needs during their stay. Service providers and the manager felt they had the capacity to do so, and apart from an incident in the early set-up stages, there had not been any further incidents or serious risks to the participants and staff. TOHI staff were mainly from a youth work and social work background with limited capacity to support young people with more complex mental health needs.

The question of safety and appropriateness of support was most evident in the case of young people with higher or more complex needs, in particular if they had no mental health support in the community. For these young people, health needs could change rapidly at times with no specialist to turn to, except emergency services.

The following example of a young woman staying in the Cairns TOHI house illustrates the limits of the TOHI support model. She had seizures and dislocations of her arm before and during her stay in the Time Out house. According to her, all staff had been briefed about her condition. She was not satisfied that they mostly 'still reacted by simply calling an ambulance' because they felt they had reached their capacity to appropriately support her. Overall, other young people who contributed their stories and interviews did not raise many issues concerning their stay in the Cairns TOHI house.

Staff had a number of risk management processes to address the limits of the support model. They used a thorough intake process to manage expectations and assess the appropriateness of referrals into the house. They had direct communication processes with referring agencies and consortium partners to ensure they shared a good understanding of the model and which young people it could, and

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could not support. The consortium and other relationships enabled TOHI staff to quickly refer to other specialist services when the young people needed them.

Another risk for some young people staying in the house was emotional dependency. Young people could become too attached to living in the house, which made the transition out of the house more difficult, in particular if they lacked other support networks. This made them particularly vulnerable and at risk of losing the gains made in the house. Staff identified the transition stage out of the house as challenging for many young people, as they had to adapt to new support processes and circumstances. Transition planning and extensive case management after the house were strategies they employed.

Eligibility criteria for young service users had been under discussion since the commencement of the pilot program. In Cairns the staff reported that 18 to 25 years for the house was an appropriate age range and that they had few referrals who did not fit this criteria. One external provider commented that the age limit for the house could be lowered to 16 years.

Logan TOHI house strengths

The participants who had stayed in the Logan house commented that they enjoyed the experience. The house had provided them a safe get-away from whatever they were experiencing. They were able to think and focus on their goals, and be proactive to make changes and take first steps towards achieving them. Some young people were reluctant to move out because they enjoyed their stay that much, not because they had nowhere else to go. Jeremy described his experience in the house,

> It was really nice spending time at the house and getting away because all my life I have spent fighting. No one was hassling me to get up in the morning and look for a job or do what every my mother wants me to do … The staff ... asked me in a respectable way to go shopping or do things. I just wanted to relax … I find all this [the support and advice I received] very helpful, I have been very comfortable [in the TOHI house] and would love to go back.

Jeremy's description of his time in the TOHI house illustrates how young people in Logan, similar to Cairns, were involved in duties and took on tasks during their stay. Some did not like having too much involvement in the housework. Young people staying in the house also benefited from participating in the social and recreational activities organised on weekends at the YFS premises. The social aspect of the pilot provided them an opportunity to socialise with their peers, make new friends, and participate in the community and recreational activities. Overcoming social isolation was a challenge for most of the TOHI participants, who had been marginalised for various reasons. Feeling more included in their communities helped young people to address other areas of their life (Section 3.2).

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Logan TOHI house challenges

The limitation of the Logan TOHI house was how to attract young people who could benefit and wanted this type of support. In the early stages of the pilot few referrals to the house were received and these were mainly from external agencies rather than TOHI outreach and case management participants. Throughout the evaluation period the numbers of referrals increased slightly, however, Logan did not reach sufficient residential participants to be able to run the house efficiently.

A large proportion of referrals in Logan were through the lead agency, YFS and their adjacent youth and family services (Table 4.4). The limited success of Logan in reaching out to and engaging young people in the community more broadly, from diverse referral sources, might have affected their ability to operate the house. The differences in referral streams between Cairns and Logan were also a result of the different governance structures and partnership arrangements (Section 4.5).

Another problem identified by TOHI staff was the unattractive location of the house, which was in the same local area as where the participant group lived and did not provide time away from their usual living environment. This was the opposite to the Cairns TOHI house, which was located in a beautiful setting, close to the Cairns promenade.

In Logan several young people identified limitations to the way the model operated that made a stay in the house less attractive. They said the Logan house had limited structure, routines and social, recreational activities in place. Some participants commented that they would have liked to see more of that in the house. One young person said,

> I do feel the house needed more structure in regards to routines and in-house activities, as there were times throughout the week it was boring.

Some young people felt they had not been consulted enough about the daytime activities and that workers did planning without their involvement. Several other problems arose in the Logan house that were only minor questions if at all in Cairns, such as sharing between males and females, or living and sharing with the other young people, which caused frustration and arguments for some. One young mum referred through an external service commented that the house was not child proof or child friendly.

Some of these issues raised by the interview participants might have originated from the low take up of the house by TOHI participants, and the Logan house being open to young people from other services who had not gone through a thorough TOHI briefing and assessment process.

Overall in Logan staff and management were not convinced about the appropriateness of the residential intervention model for young people. They felt that marginalised young people spending time in the house may have contributed to further isolation and disengagement. Staff reported that in in some cases a young

person alone or with only one other client in the house, with 24 hour staff, exacerbated the young persons' inward focus and withdrawal from family and friends. Some staff in Logan reported that they would have liked more guidance in their role and their set-up of the house. YFS discussed with the Department about lowering the age eligibility criteria from 18 to 16 years for the house, as some of the younger TOHI participants had expressed interest in staying there.

4.5 Governance, partnerships and service sector integration

The external service providers and informal supporters praised the case management and flexible support provided through outreach work. They reported that it allowed young people to open-up and engage with services that they were unlikely to have used prior to their involvement with TOHI.

Cairns TOHI integration

In Cairns Aftercare, a community mental health agency, was the lead agency that had implemented the TOHI pilot. Aftercare had engaged a number of local service providers, including mental health and youth services, and the local Division of General Practice as consortium partners. The partners provided expertise and advice, in-kind support and resources, and joint case management for several young people. In return Aftercare shared TOHI funding with their partners and they also had shared staffing and service arrangements (co-location) with some partner agencies. For example, TOHI Cairns had two permanent outreach workers who were employed through the consortia partners.

From the qualitative data there was evidence that the lead agency, Aftercare, had pre-existing relationships and networks with local services in the area; there was trust and respect amongst the partner agencies; and a willingness to collaborate and share limited resources rather than a culture fused by competitiveness and angst. TOHI senior staff were also involved in networking and maintaining effective communication pathways with their partners and other services interested in the TOHI pilot (e.g. through the dedicated TOHI Reference Group). TOHI staff in Cairns were skilled at getting young people into appointments with specialists in the community as needed, including psychiatrists, GPs and other community mental health providers, and relying on their consortium partners and networks as needed.

External stakeholders interviewed reported that TOHI was well regarded and widely known in the community and across different sectors, including youth, health and mental health, and broader community services. Stakeholders said that the program filled a niche in the service spectrum for highly marginalised young people. It was perceived as complementary to most youth programs rather than competing for funding and clients with the existing services.

The evidence from the qualitative data and the data on referral sources indicated that the strategy used in Cairns to involve a range of organisations as consortium

partners in setting up the TOHI pilot had been effective. It contributed to a range and consistent flow of referrals to TOHI (Table 4.4). Also it enabled Cairns staff to accept and support young people with more complex mental health needs, as they had shared care arrangements and communication processes in place with some services.

While overall the consortium arrangement appeared to have contributed to the success of the TOHI Cairns, the administration of the funding for the TOHI Cairns was less effective. The funding was administrated through the lead agency Aftercare rather than the TOHI itself. One staff commented that at times this process could cause delays in approval for client related expenses and processing invoices.

Logan TOHI integration

The TOHI Logan was implemented by YFS, which has a long standing history in working with young people. YFS engaged with the Local Division of General Practice and Qld Health and had a reference group linking them with their partner agencies (Section 2.4). Logan did not share any of the TOHI funding with the partnering organisations, however, the house could be used by young people from other services who met the age criteria. Throughout the implementation of the pilot Logan had established further links to local youth mental health providers.

According to external stakeholders, the efforts from YFS to engage local services for the pilot was not sufficient to ensure full participation and referral by all partner agencies. External providers commented that YFS struggled to effectively communicate with some agencies, even though they had established relationships. It was difficult to address the absence of existing, strong relationships with some of the providers, especially since without a consortium, the funding and resources stayed with YFS. YFS reflected that they might have had more support and referrals from local services and the Division of General Practice if they had partnered with them on the funding submission.

The evidence from the qualitative and quantitative data confirms that the governance of the Logan TOHI was positive and negative. The benefit was an established youth and family service to implement the program and draw on an existing client group and other youth networks with an expertise in working with young people. On the other hand the YFS was recognised as a youth and welfare service, not a mental health service.

The looser integration with the health and mental health service sector from former relationships and referral pathways appeared to have contributed to the low referrals from external sources to TOHI Logan (Table 4.4). Amongst other reasons, this affected the viability of the residential support. In mid-2012 the Logan TOHI ceased operations.

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5 Conclusions

In this section of the report we draw conclusions of the TOHI pilot based on the data from the evaluation and program management. It also outlines implications from the TOHI pilot for similar and other programs.

5.1 Summary of evaluation findings

The objective of TOHI was to improve young people's emotional wellbeing, social participation and community inclusion, and mental health self-efficacy. The pilot targeted young people whose circumstances either have had an impact on their mental health now or, if unaddressed, were likely to have an impact.

TOHI was designed to provide early intervention in a short term, recovery focused, safe and youth friendly residential program along with outreach and case management support. Young people 15 to 25 years could benefit from approximately three months outreach support; and older young people (18–25 years) could opt to stay in the Time Out house for approximately three weeks.

The program logic (Figure 2.1) in Section 2.1 illustrates the pilots' objectives in more detail.

Young people whose circumstances have had an impact on their mental health now or in the future if unaddressed

The pilot successfully reached out to young people who had needs related to supporting their mental health. Young people using TOHI services were dealing with a range of needs that could negatively impact or had impacted on their mental health. Common needs faced by participants included social isolation or limited social networks and community support; disengagement from education and work; insecure or unsafe housing; and an unstable home environment that, for some, was characterised by family conflict, domestic violence, suicide and substance use in the family. Many young people in Cairns had a mental health diagnosis or ongoing mental health problems.

Outreach case management and referrals (~3 months) and residential (~3 weeks) intervention to address circumstances that impact on mental health

Throughout the implementation of the pilot the eligibility criteria for young people and support timeframes changed. TOHI lowered the age criteria to 15 years for outreach and case management support in both locations. In Cairns the staff reported that young people aged 18 to 25 years was an appropriate age range for the house and that they had few referrals which did not fit this criteria. In Logan few young people identified that they wanted to stay in the Time Out house. Those who did want to stay were younger than 18 years old and therefore not eligible.

The case management and outreach support appeared to be successful in both locations. Both participants and stakeholders involved in TOHI reported that it was a

useful strategy to support young people facing marginalisation that could or had affected their emotional wellbeing and mental health. The evidence on the usefulness of the residential component of the pilot was mixed. While the Time Out house worked well for the young people using TOHI services in Cairns, in Logan the house remained underutilised throughout the pilot implementation. Also, some young people who stayed in the Logan house reported that they were unsatisfied with aspects of the support. Furthermore, staff and other stakeholders in Logan questioned the usefulness of the residential support model for the target group.

The timeframe for support in practice also varied from the design. Most young people relied on the outreach support and case management before and after or instead of the house, sometimes over many months. Support in the house also ranged from days to months in Cairns.

Impact on path and links to service access, informal support networks and goal setting as needed – youth and adult services, health, mental health and other clinical and non-clinical services

Most TOHI participants had plans in place or were working to identify their goals. According to all stakeholders the planning and goal setting process was useful for breaking down and working towards a young persons' bigger goals step-by-step. Young people using TOHI services also reported that they benefited from being connected and supported to access a range of clinical and non-clinical services, including social and recreational outlets. Many young people identified participation in education and work as a priority. In both locations young people reported that they were receiving support to access the services they needed and that TOHI had helped them to build confidence to work towards achieving their goals.

Staff in Cairns identified the transition period for young people leaving the TOHI house as a critical stage, as the support mechanism changed from daily to weekly. In particular for some participants with little support in the community, this meant that they were more at risk of disengaging from the support and services they had established during their time in the Time Out house. Cairns built on their consortium contacts to strengthen referrals to and from mental health services. Logan relied on their local youth service contacts.

Improved outcomes – social connections (family, friends); community participation (education, work); self-efficacy (greater independence, recovery); wellbeing and quality of life

Most findings in this report rely on qualitative data, interviews and case narratives with young people using TOHI services and other relevant stakeholders. Participants reported a range of outcomes as a result of their involvement, including improved social relationships, a better sense of self, emotional wellbeing and increased confidence, and some also greater independence. Greater independence meant different things to young people, some re-engage in education, work or volunteering, others learned independent living skills, in particular if they were more strongly involved in the pilot (for example, some young people who had stayed in the Cairns

Time Out house). In Cairns, a small proportion of young people (n=18) who completed a second CANSAS survey reported on average improved mental health self-efficacy.

Little reliable quantitative evaluation data were available to measure changes in TOHI participants' wellbeing, socio-economic or community participation as a result of their involvement with the pilot. Some of the quantitative data showed improvements, for example, in young people's personal wellbeing outcomes, however, these findings have to be interpreted with caution. They may or may not be connected to participants' involvement in the pilot and cannot be assumed to be representative of the full TOHI cohort (in most cases quantitative data were only available for a small proportion of TOHI participants, Table 1.2).

In the remainder of the section we discuss in more detail outcomes for TOHI participants receiving outreach support (Section 5.2), and benefits and challenges in the two pilot locations for young people using the Time Out house (Sections 5.3 and 5.4).

5.2 Participant outcomes

The three priorities for TOHI participants were mental health, social relationships and activities, and education and training (Section 4.1). Social isolation and not feeling included in their communities were a common theme for many young people accessing TOHI services. Most TOHI participants and stakeholders were highly positive about the outreach and case management component of the pilot. Most, but not all, young people who stayed in the Time Out house benefited from this support and found it very useful.

Most participants who provided their stories for the evaluation (51 interviews and case studies) reported some positive outcomes as a result of their involvement in TOHI (Section 3). Young people using TOHI said it had improved their confidence, life-skills, they had gained more independence, and connection to community service and resources that helped improve their overall wellbeing. Many young people appeared to have gained skills and knowledge that empowered them. Achieving more independence was not easy for all young people, especially for those with little support in the community.

The outcome findings for many participants in the pilot were positive considering the adversities the young people were facing (Section 2.5) and their comparatively very low Personal Wellbeing Scores (PWI) at entry to TOHI (Table 2.3). In both locations TOHI participants' PWI scores improved slightly over time. However, sample sizes were too small and data quality was unreliable for statistical analysis to be meaningful (Table 3.1).

The analysis showed that young people's social and economic participation outcomes and their social and family relationships were mixed (Section 3.2). More young people noticed improvements in their social interactions and feeling confident

and well enough to pursue their education and employment goals or seek out help for themselves, than those who did not (Section 3.3). No reliable quantitative data was available to measure any socio-economic change for participants over time.

All stakeholders reported that responsiveness was a central feature of the TOHI service model that contributed to the pilots' success, such as adjusting the eligibility criteria to meet young people's needs. From the start of implementation service providers identified that the outreach and residential support for some participants required longer service timeframes than the original design of 3 months outreach and 3 weeks in house. Many young people using the services needed time to trust and engage or had goals that required more ongoing support. Most young people felt safe engaging in the pilot and reported that it was youth friendly.

The experiences and outcomes of young people using the Time Out house differed slightly in the two pilot locations. These differences in strengths and challenges are summarised below (and discussed in more detail Section 4.4).

5.3 Cairns TOHI

The house was a central component in the Cairns TOHI pilot. The community education and engagement of young people was successful and the house usually ran at the full capacity of three to four people per night. The approach to engagement and support in Cairns was an outreach–in house–outreach model. Some young people leaving the house were identified as needing greater support because to avoid relapse when their support structure changed from daily to weekly, especially if they had limited or no support in the community.

Several young people staying in the Time Out house and staff reported that participants made big changes in their life towards achieving longer term goals in a relatively short period of time (several weeks to a couple of months). These positive outcomes for young people reflected the strengths of the Cairns TOHI model, a youth friendly, safe, relaxing, structured and supportive home-like environment in the house; intensive, flexible person-centred and person-directed case management support; assistance to access a range of clinical and non-clinical services and programs, including in-house recreational and social groups (Section 4.4).

Stakeholders reported that the partnerships and the consortium approach were a factor in the Cairns success. External stakeholders spoke highly of the initiative in terms of the strength of the partnership and the referrals between the pilot and relevant service providers. Several partners regarded TOHI as filling a missing piece with the existing youth and health services (Section 4.5).

TOHI staff worked hard to position themselves away from crisis intervention for homeless young people, or step-down from the mental health unit. At the same time they were committed to providing young people with new ways to manage their wellbeing and mental health, and to use and connect to a range of supports, thereby slowly enhancing their wellbeing self-efficacy. Service providers felt that the program

met the criteria of preventing or reducing future hospitalisation, because participants received the support to remain in the community, address their needs and achieve their goals, and explore pathways to recovery.

Young people most and least likely to benefit from the Cairns TOHI

Young people over the age of 18 years seemed to be using the service more than younger people. This may be because the house was open only to the older group. Equal numbers of females and males used the program. The program was best suited for young people who were ready to address their needs, because living in the house required giving up some freedoms (no alcohol and drugs; observe a curfew; and participate in a range of activities and programs). Setting expectations with young people was successful for participants in the house who were exploring changes in their lives.

At least 30% of TOHI Cairns participants were referred from health and mental health services and many young people were case managed by a mental health provider during their time with TOHI (Table 4.4). Several of the young people who stayed in the house had mental health needs and some had a mental health diagnosis. TOHI also accepted participants who had experiences of using mental health units, but only when they were assessed as currently stable.

The TOHI pilot did not have staff with a mental health professional background and expertise to support young people with ongoing and more complex mental health issues. It appeared that TOHI could support some young people with more complex mental health issues because the model relied on integration with local community mental health services and the willingness of service providers from different professional backgrounds and agencies (mental health and youth services) to collaborate in the interests of young people.

Some external stakeholders and TOHI staff were cautious that did not have the capacity to support young people with more complex mental health issues, for example if they had personality disorders and were not case managed by a mental health service. Support from community mental health services, such as a counsellor, psychologist or GP was not always sufficient for these participants, and delays gaining access to a mental health assessment with a psychiatrist could be a problem for them.

Young people who benefitted the least from the program were aged under 18 years because they were ineligible for the house. The TOHI staff did not think the house age criterion needed to be lowered. Some stakeholders wanted to see greater outreach to Indigenous young people. Although the TOHI data showed that they were to some extent engaging these groups (Table 2.2), although it did not reflect the high proportion of Indigenous young people in the Cairns area. Employing an Indigenous worker had not increased the number of Aboriginal and Torres Strait Islander young people significantly.

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5.4 Logan TOHI

The effectiveness of the Logan TOHI model was mixed. The Logan staff made considerable efforts to set-up and promote the residential part of the pilot but up-take of the service remained consistently low. Only a small number of TOHI participants stayed in the house, and generally it remained empty or under-utilised.

Stakeholders and participants identified a number of limitations to the Logan house. Some people younger than 18 years were interested in the house but were not eligible. The house was not located in an area that provided young people time out from their community. Some young people were happy with the house support, but in a few cases young people (either TOHI participants or clients from other services) reported a number of shortcomings, such as limited structure, routines and activities in the house, lack of integration and follow up when they left the house, or it not being child friendly and safe. The Logan house remained an isolated service, rather than integrated with the outreach support component.

The low up-take of the residential component was regarded by the YFS management as a waste of resources and a risk to young people's isolation if they stayed alone in the house (Section 4.4). Logan management and staff were not convinced that the TOHI residential services met young people's needs. They reported that it was better to support young people to remain in their community and that young people with mental health needs were more likely to benefit from outreach activities and programs that helped them to change their routines and engage in social and recreational opportunities.

The Logan TOHI was less successful in integrating with the local community mental health and health services according to the referral data (Table 4.4) and qualitative interviews. The Logan TOHI established some relationships with relevant services, but the trust and collaboration were not sufficient to support the referrals and the growth of the residential component of the pilot (Section 4.5).

Young people most and least likely to benefit from the Logan TOHI

More people aged under 18 years used the Logan TOHI services than those over 18 years, in contrast to Cairns. The program was best suited for young people with lower mental health needs, who required social engagement, advice, case management and links to services. TOHI referred many young people to community mental health providers, counsellors and psychologists. Few participants in Logan, compared to Cairns, identified having more serious mental health needs or a diagnosis.

Staff reported that they engaged young people from a range of backgrounds, including Indigenous young people. They were less successful engaging young people who spoke a language other than English at home, who are overrepresented in the Logan area. Staff explained that this could be because CALD-specific services are available in the area, which these young people may prefer to use.

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Young people benefiting the least from the program were restricted by age: under 18 years for the house and under 15 years for outreach and case management support. The program did not suit young people who had goals that required longer case management support. Staff thought that most participants in the pilot had support needs and goals that went beyond the three month timeframe. Stakeholders noted the impact that homelessness had on young people's mental health and wellbeing, and thought that this group of young people could have been included in the program's eligibility criteria.

External services providers felt that TOHI successfully applied a whole of health approach rather than viewing mental health in isolation. They identified that young people could have benefited from Logan TOHI establishing stronger integration with the local service sector, including mental health services.

5.5 Outcomes for carers and informal supporters

In both locations, number of family members and supporters of young people taking part in the evaluation was low. The few that did take part reported that the pilot had provided them a break from trying to support the young person and it reduced their own stress. In some cases this had a positive impact on the wider family relationships. Staff said many young people preferred to receive support from TOHI without their carers' knowledge, because family breakdown had contributed to their emotional distress and perhaps mental health problems.

5.6 Lessons from TOHI for similar programs

Coordinated support

The TOHI outreach, case coordination and management provide lifestyle support and referral to clinical and non-clinical services for young people. Person-centred case management was a useful tool to access services for marginalised young people, who may experience early signs of mental health issues.

Other parts of the program that some young people used were residing in the house and additional clinical case management from a mental health provider. The consortium model of service providers and community partners with mental health expertise assisted with engagement, capacity and referrals.

Managing the needs of young people at risk of more severe mental health problems required staffing capacity and structured processes to link to clinical expertise and to respond to emergencies, which were developed during the TOHI pilot

Future opportunities for connections with inpatient and headspace services would require greater mental health capacity within the TOHI staff and stronger relationships with the mental health providers.

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Housing

Homelessness and precarious housing in the context of housing shortages affected many young people in the program. As an early intervention program, with the agreement of the Steering Committee, TOHI interpreted the eligibility criterion to include homelessness, since housing support can address other underlying factors affecting their wellbeing.

Support timeframes

Many young people at both sites needed longer intervention than the original plans for 3 weeks for residential support and 3 months for outreach and case management. They required sufficient time to develop trust to engage with a service. They also experienced complex needs that took a longer time to address, such as referrals for housing and mental health professionals. Some people needed 6–8 months of case-management support, depending on the complexity of their needs and goal, and the time to build trust and relationships.

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Appendix A Tables referenced in the report

Table A1 Client interest in increasing participation in activities

	Cairns		Logan	
	Young people	%	Young people	%
Employment				
Yes	30	56	25	40
Not yet	20	37	23	37
No	4	7	14	23
Total	54	100	62	100
Education and Training				
Yes	34	63	32	52
Not yet	12	22	16	26
No	8	15	14	23
Total	54	100	62	100
Social and recreational activities				
Yes	39	74	17	31
Not yet	10	19	8	15
No	4	8	30	55
Total	53	100	55	100
If yes would you like help increasing participation				
Yes	40	82	19	33
No	9	18	39	67
Total	49	100	58	100

Source: APQ6, Cairns and Logan: Program management data July 2010–Sept 2012

Table A2 Cairns participants met and unmet needs (survey 1 and 2)

	CANSAS					
	Survey 1			Survey 2		
	Mean	Median	Young people	Mean	Median	Young people
Met need	9.1	9.0	33	12.4	12.0	33
Unmet need	7.2	7.0	33	3.5	3.0	33

Source: CANSAS, Cairns Program management data July 2010–Sept 2012

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Appendix B Cost benefits of Cairns TOHI analysed by Aftercare

In the 2011–2012 financial year the TOHI house in Cairns provided support to 75 young people in need of mental health support. Twenty of these young people received 24 hour residential support for an average of 50 days, receiving more than 25,000 hours of support across approximately 3,300 occasions of service. Seventy five young people received an average of six months of service, receiving approximately 1,600 hours of service across 778 service occasions. The total cost of running this service in that year was $1,006,945, including infrastructure costs. It is not necessary to have a formal diagnosis of mental illness to be able to access support from the TOHI house.

Costs benefits of the service

As the outreach and residential components are linked it is difficult to apportion cost between outreach and residential, and no measure is perfect. However, for the purpose of comparison with other services it is beneficial to be able to split the two types of service. The ratio of the number of hours of outreach to the number of hours residential gives a 94%/6% Residential/Outreach cost split which is disproportionate. If occasions of service are used as a basis the split changes to 77% : 23% and the cost of running the TOHI outreach service approximates the cost of running a similar service in a similar location, Aftercare Cairns Personal Helpers and Mentors, for a similar number of people. Further, comparison with Queensland health costings requires that infrastructure costs not be included in calculations and as such only the costs of providing direct care staff are included. If all infrastructure costs are included in the calculations below total costs rise by approximately 1/3.

On that basis the cost is $2385 per person to give six months of outreach support. The per-person cost of the residential component is $29,110 and the average person receives 50 days of residential support. This yields a per night cost of $582, which, unadjusted for inflation is lower than the 2008–2009 cost per Queensland non-acute adult psychiatric hospital bed day reported by the Australian Institute of Health and Welfare of $692. Further, the average length of psychiatric hospital stay in Queensland, according to the Department of Health and Aging 2009 State of our Public Hospitals report, is 312.5 days (slightly higher than the 301 days in the previous report). The cost of the average public psychiatric hospital stay in Queensland is therefore approximately $216,000. Each person who receives residential support at TOHI also receives six months of follow up support at an average cost of $2385. This, again, is slightly higher than the cost of providing six months of support via a case manager with Qld Health of $1830.

Further, a large U.S. study [1] identified that although 80% of people with a mental illness eventually make contact with professionals, the average delay was 10 years before help was sought. The delay was longer in the case of less severe illness and for young people. Stigma is one of the principal reasons that people do not identify as someone with a mental illness and therefore do not seek help [2].

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Table B3 Comparison of direct TOHI costs to public health system costs

	Cost ($)
Cost per person per day TOHI residential	582
Cost per person per day Qld adult non-acute public psychiatric hospital, 2009–2010	692*
Cost of average stay of 50 days with six months support	31,500
Average annual cost to the Australian economy per person with mental illness	31,118+
Estimated cost of untreated mental illness for each young person who does not initially seek help**	311,180
Cost of average Queensland psychiatric hospital stay	216,000

Source: Cairns TOHI program data

Notes: * Report on government Services 2012, Table 12A 40. +Access Economics, The economic impact of youth mental illness and the cost effectiveness of early intervention. **Based on U.S. data regarding help seeking behaviour.

Note that although the direct costs of the outreach program are slightly higher than those of providing a Queensland Health case manager there are a number of factors to be borne in mind in this comparison. The service is designed as an early intervention service and as such offers a non-stigmatising entry to gaining support. Clients are moved into the residential program or referred to external social support services or clinical support services where appropriate. The staff/client ratio is much higher in the TOHI program than for a Queensland Health case manager, which results in more direct contact and a greater ability to deal with any issues that arise before they escalate to crisis, which in other circumstances might lead to police involvement and further indirect costs. Additionally, each of the TOHI residents receive outreach support after leaving the house and the presence of an established outreach service directly attached to the residential service allows for seamless transition back to the community and supplies economies of scale.

Table B4 Comparison of direct outreach costs compared with Qld Health direct costs

	Cost ($)
Cost per person TOHI Outreach six months support	2385
Cost per person Qld Health Case manager six months support	1830

Source: Cairns TOHI program data

Conclusions

Improved employment and study participation rates address two of the costs of mental illness that are particularly felt by the young. Over 75% of all serious mental health disorders first appear before the age of 25 [5], and over 70% of the cost of youth mental illness is due to lost productivity amongst this age group [6]. If help for these difficulties is not sought by the young person, and there is evidence that help is often not sought, the cost burden of mental illness rises far above the cost of providing early intervention. Any increase in participation in study or the workforce will lead to a significant reduction in health costs. Early intervention can increase

productivity of the individual and lower hospital use, as well as increase the wellbeing of the individuals, their families, friends and colleagues. The results suggest that the TOHI service increases community participation and wellness amongst clients, and therefore increases the earning capacity as well as the life opportunities of those that participate in the service.

Further, the non-stigmatising nature of the service is badly needed in an area of health care where stigma and ignorance prevent help seeking behaviour and the individual suffers years of socially and financially debilitating illness prior to receiving effective support.

The ability for young people to access a service that is non-stigmatising and that is able to provide as seamless a transition as possible back to the mainstream community is not only a likely cost saving to the government over crisis driven clinical based interventions, particularly in the medium term, but offers the opportunity for a dramatic improvement to each young person's life.

1. Wang, P.S., et al., *Methods Delays in Initial Treatment Contact after First Onset of a Mental Disorder.* Health Services Research, 2004. 39(2): p. 393-416.
2. Corrigan, P.W., *How Stigma Interferes With Mental Health Care.* American Psychologist, 2004. 59(7): p. 614-625.
3. InternationalWellbeingGroup, *Personal Wellbeing Index.*, 2006, Australian Centre on Quality of Life, Deakin University: Melbourne.
4. Corrigan, P.W., et al., *Examining the Factor Structure of the Recovery Assessment Scale.* Schizophrenia Bulletin, 2004. 30(4): p. 1035-1041.
5. Kessler, R.C., et al., *Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. .* Arch Gen Psychiatry, 2005. 62(6): p. 593-602.
6. Access Economics. *The economic impact of youth mental illness and the cost effectiveness of early intervention*, 2009.

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References

Cummins, R. A., & Lau, A. L. D., (2005). Personal Wellbeing Index – School Children Manual, 3rd Edition. Melbourne: Australian Centre on Quality of Life, Deakin University. http://www.deakin.edu.au/research/acqol/auwbi/index-translations/wbi-school-english.pdf

Cummins, R. A., Woerner, J., Weinberg, M., Collard, J., Hartley-Clark, A., Perera, C, Horfiniak, K., (2012). Australian Unity Wellbeing Index, Survey 28.0 Melbourne: Australian Centre on Quality of Life, Deakin University. http://www.deakin.edu.au/research/acqol/auwbi/survey-reports/

Gendera, S., Fisher, K. R., Robinson, S., & Clements, N. (2011). Evaluation Plan of the Time Out House Initiative Queensland (SPRC Report 7/2011). Sydney: Social Policy Research Centre, The University of New South Wales. Prepared for Queensland Alliance for Mental Health. http://www.sprc.unsw.edu.au/media/File/SPRC_Report_711.pdf

Gendera, S., Fisher, K. R., Clements, N., & Rose, G. (2012). Evaluation of the Time Out House Initiative in Queensland. Progress report (SPRC Report 14/2012). Sydney: Social Policy Research Centre, The University of New South Wales. Prepared for Queensland Alliance for Mental Health. http://www.sprc.unsw.edu.au/media/File/TOHI_Evaluation_Progress_Report.pdf

Gendera, S., Fisher, K. R., Robinson, S., & Clements, N. (2012). Evaluation of the Time Out House Initiative in Queensland: Baseline Report (SPRC Report 3/2012). Sydney: Social Policy Research Centre, The University of New South Wales. Prepared for Queensland Alliance for Mental Health. http://www.sprc.unsw.edu.au/media/File/TOHI_Baseline_Evaluation_report_2_May.pdf

Lubman, D., Allen, N. B, Rogers, N., Cementon, E., & Bonomo, Y. (2007). The impact of co-occurring mood and anxiety disorders among substance-abusing youth. *Journal of Affective Disorders; 103*, 105-112.

Muir, K., Powell, A., Patulny, R., Flaxman, S., McDermott, S., Oprea, I., Gendera, S., Vespignani, J., Sitek, T., Abello, D., & Katz, I. (2009). headspace evaluation report: independent evaluation headspace: the National Youth Mental Health Foundation (SPRC Report 19/2009). Sydney: Social Policy Research Centre, The University of New South Wales. Prepared for headspace. http://www.sprc.unsw.edu.au/media/File/Report19_09_headspace_EvalReport.pdf

Teesson, M., & Proudfoot, H. (ed) (2003) Comorbid mental disorders and substance use disorders. Epidemiology, prevention and treatment. Sydney: National Drug and Alcohol Research Centre, The University of New South Wales.

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YFS (2011). Heads Up – Time Out House Initiative in Logan report, prepared by YFS for the Queensland Department of Communities, Community Mental Health (unpublished document).