Evaluation Plan of the Time Out House Initiative in Queensland

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Report for Queensland Alliance for Mental Health

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Abbreviations and Glossary

APQ6	Activity and Participation Questionnaire
FNQRDGP	Far North Queensland Rural Division of General Practice
HREC	Human Research Ethics Committee
NSW	New South Wales
NHMRC	National Health and Medical Research Council
Outreach support	up to 3 months support including referral to relevant services
PWI	Personal Wellbeing Index
Qld	Queensland
Reference Group	staff of Queensland Alliance for Mental Health, TOHI providers and representatives of young people and carers
Residential support	up to 3 weeks support in a stand-alone home
Social network	family and significant friends and carers of the young person
SOFAS	Social and Occupational Functioning Assessment Scale
Steering Committee	staff of Queensland Government and Reference Group
TOHI	Time Out House Initiative
SPRC	Social Policy Research Centre
UNSW	University of New South Wales
YFS	Youth and Family Service (Logan)
YP	young people, young person

Executive Summary

The Queensland Alliance for Mental Health has commissioned an evaluation of the outcomes and cost effectiveness of the Time Out House Initiative (TOHI) in Queensland to inform future service development. The program aims to provide early intervention in a short term (up to three weeks) safe and youth-friendly residential program and three month outreach support for young people whose circumstances have had an impact on their mental health or, if unaddressed, are likely to have an impact. The evaluation is until August 2013. The evaluators are the Social Policy Research Centre (SPRC), University of New South Wales (UNSW) and Griffith University. This Evaluation Plan is an overview of TOHI, the evaluation questions and methodology which will be used to undertake the evaluation.

Evaluation questions

The evaluation uses a longitudinal, mixed methods design to address three objectives and related research questions:

- To investigate and measure the impact of services provided through the TOHI and identify outcomes for young people accessing these services and their social networks.
- To examine what works well and doesn't work as well in delivering the TOHI and understand issues that impact service delivery across different geographical areas.
- To measure whether this type of early intervention approach is cost-effective.

Research Design

The research is based on ethical and participatory research design with young people and their social networks, service providers, Qld Alliance for Mental Health and Departmental staff. The evaluation will generate information about the TOHI throughout the evaluation period to inform progressive policy and program change. The information will include outcomes and process evaluation data. In addition, the final evaluation report will draw summative conclusions about the pilot program to inform future policy development.

Timeframe

This is a longitudinal evaluation over two years. The first stage of the evaluation, design of the research plan and consultation with key stakeholders, commenced in March 2011. The final evaluation report will be delivered to Qld Alliance for Mental Health in July 2013.

1 Introduction

The Queensland Alliance for Mental Health has commissioned an evaluation of the outcomes and cost effectiveness of the Time Out House Initiative (TOHI) in Queensland to inform future service development. The program aims to provide early intervention in a short term (up to three weeks) safe and youth-friendly residential program and three month outreach support for young people whose circumstances either have had an impact on their mental health now or, if unaddressed, are likely to have an impact. The evaluation is until August 2013. The evaluators are the Social Policy Research Centre (SPRC), University of New South Wales (UNSW) and Griffith University.

This plan explains the evaluation methodology and management. It includes:

- Background information;
- An overview of roles and responsibilities of program partners;
- Conceptual approach to the evaluation and key questions;
- Evaluation framework and data collection methods;
- Data analysis process;
- Ethical considerations; and
- Project management, including reporting and timeframes.

1.1 Background to the Pilot

Youth and early adulthood are important formative years for young people. During this period young people develop more independent identities and they are also more susceptible to mental illness for a number of reasons. Important risks include individual factors, such as poor social skills, low self-esteem, self-harm and substance abuse. Peer pressures, such as engaging in risk-taking behaviours, or risk factors related to the young person's family life, their level of participation in school and academic life, as well as community factors, such as socio-economic disadvantage, may all contribute to risks to a young person's mental health and wellbeing (Department of Communities, 2010).

Another vulnerability disproportionally affecting young people is mental ill-health. For many people, the onset of mental illness occurs in adolescence or early adulthood (see, for example, Kessler et al., 2005). One quarter of young people aged 16-24 years in Australia are likely to experience a mental illness, with the more common ones being anxiety, affective (mood) and substance and alcohol disorders or a combination of these (Australian Institute of Health and Welfare, 2007; Muir et al., 2009). However, young people typically do not receive treatment until some years later (McGorry et al., 2005).

Young people's circumstances can include range of reasons that either have had an impact on their mental wellbeing in the present or, if unaddressed, are likely to have an impact in the future. To reduce the risk of young people becoming more seriously unwell and enhancing the recovery process and community connections of those who are experiencing risks to their mental health and wellbeing, the Queensland Department of Communities, Community Mental Health in collaboration with the Queensland Alliance for Mental Health have introduced the TOHI program.

A key component of the TOHI model is the recovery focus of young people experiencing or at risk of experiencing mental illness. Several factors are known to be important to supporting the recovery process of people experiencing some form of mental ill-health (Lysaker and Buck, 2008; Torrey and Wyzik, 2000). Important aspects of recovery are early intervention and psychosocial rehabilitation, which work to enhance the capabilities of people with mental health disorders to maximise their independence. Rehabilitation includes a range of social, educational, occupational, behavioural, and cognitive interventions that usually take place in four domains: skills training; peer support; vocational services; and consumer-community resource development of an array of community supports (Barton, 1999; Edwards et al., 2009).

Another key feature of the model is to ensure appropriate referrals and linking to appropriate supports and community services. This is relevant to young people in general, and in particular those whose circumstances are a risk to their mental health, who can find it difficult to access appropriate assistance and supports (Rickwood et al., 2007). Service providers working in mental health services have identified a number of issues that may hinder the provision of early and more appropriate intervention, such as poor skills and lack of confidence in working with young people, inflexibility and discontinuity in the service system, and poor linkages with other relevant services (Kiltackey and Waghorn, 2008; King and Meyer, 2006; Lester et al., 2008; McGorry et al., 2007; Munro and Edward, 2008).

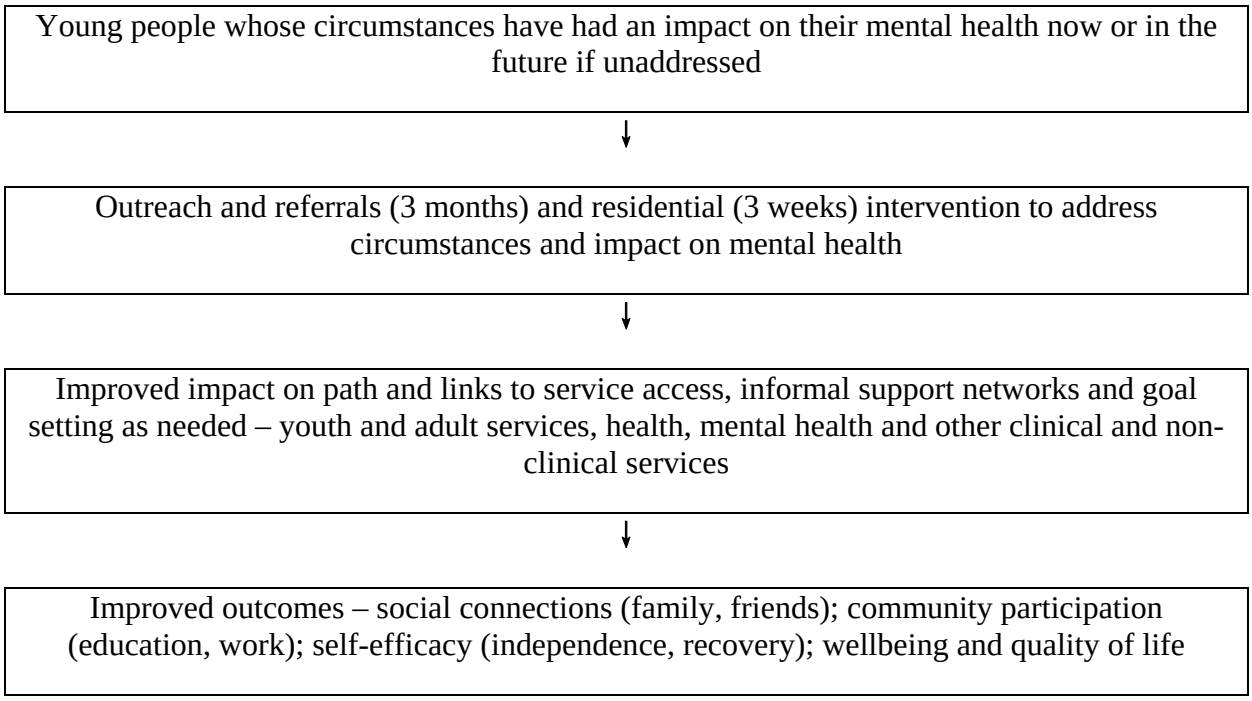
1.2 Aims of TOHI

The Time Out House Initiative (TOHI) provides approximately 3 months outreach support to young people whose circumstances either have had an impact on their mental health now or, if unaddressed, are likely to have an impact. Sometimes that support includes a short residential stay of approximately 3 weeks. The outreach support links them to other relevant youth services and mental health clinical and non-clinical services and existing community support.

The key objective is to provide early intervention in a short term (averaging three weeks to three months) safe and youth-friendly residential program for young people whose circumstances either have had an impact on their mental health now or, if unaddressed, are likely to have an impact (Figure 1.1). This recovery focused intervention approach builds on the 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). TOHI aims to achieve better outcomes for young people aged 15-25 years and their social networks through:

- Personalised, client-centred assistance through outreach support work;
- Intensive non-clinical, and where needed clinical care coordination, and lifestyle support in a recovery focused environment;
- Articulation with existing youth and adult services/networks, including mental health support, where necessary;
- Capacity to respond to changing needs of the young person; and
- Support for families and natural support networks.

Figure 1.1: Time Out Initiative Program Logic



1.3 Roles and responsibilities of the TOHI partners

Stakeholders include the young people who use the service and their social networks, family and significant friends and carers of the young person; Queensland Alliance for Mental Health which jointly manages the program; Community Mental Health, Department of Communities, which funds and jointly manages the program; two nongovernment organisations in Cairns and Logan; and other service providers for mental health and other support relevant to the young people, such as general practitioners, drug and alcohol services, youth services, education, employment, housing and social network support.

Young people and social networks

The program expects over three years to support up to 250 young people whose circumstances either have had an impact on their mental health now or, if unaddressed, are likely to have an impact. The eligibility criteria for young people to take part in the program are very similar across both TOHI sites. Young people aged 15-25 years are eligible to receive short term solution focused case management and outreach support. Young people aged 18-25 years who can benefit from a recovery focused and safe environment can stay in the TOHI house. The early intervention criterion is flexible, recognising the benefits of intervening in early stage mental distress rather than just a first episode of illness.

Exclusion criteria include young people with a long standing and severe mental illness, and those with acute mental health problems requiring hospital admission, as well as homeless and at risk of being homeless young people not associated with wellbeing (because a residential period of three weeks is considered not long enough to support young people in finding suitable housing).

Many of the young people are disengaged from their families due to family dysfunction or family violence. For some of the young people other members of their social networks such as friends and other adults are or have the potential be their sources of significant social

support. This plan refers to their family, friends and other social support as their social networks.

Queensland Alliance for Mental Health and Department of Communities

TOHI is a collaborative initiative between Community Mental Health, Department of Communities and the Queensland Alliance for Mental Health. The Disability Services and Community Care, Department of Communities has policy and financial responsibility for the design and implementation of the pilot. The Department is also a key partner on the evaluation Steering Committee. Queensland Alliance for Mental Health' main responsibility is the oversight of the design, implementation, and evaluation of the pilot.

Key responsibilities of the two stakeholders include:

- Select, allocate and administer funding to the two appointed NGOs;
- Disseminate information on the TOHI to the public and relevant advocacy bodies;
- Oversee and coordinate the initiative (eg. develop and provide documentation, resources and reporting templates for NGO's);
- Respond to questions arising in the implementation and provide ongoing assistance to service agencies; and
- Commission and contribute to the evaluation.

NGO partnerships

The Department selected two service providers to implement the TOHI. One is the Youth and Family Service (YFS) in Logan. Although the two TOHI models, Logan and Cairns, have similar features, they are governed differently. TOHI Logan is implemented by a single youth service provider. The YFS is a community run not-for-profit organisation that offers a range of family and youth services, including legal advice for people with disability, assistance to finding work, and a range of youth programs. The second is a consortium of providers lead by Aftercare. The Cairns TOHI consortium consists of the lead agency, Aftercare, Youth Link, Centacare, and the Far North Queensland Rural Division of General Practice (FNQRDGP).

The main responsibilities of the two TOHI providers include:

- Identify young people, aged 15 to 25 years who can either benefit from personalised outreach support work and/or an up to three weeks stay in a safe, youth-friendly, and recovery focused residential environment;
- Identify and set-up a recovery focused, youth-friendly residential environment for up to four young people, and staff the 'time out house' for seven days a week, 24 hours a day;
- Provide early intervention personalised case management and lifestyle support to TOHI young people, residential and off-site, that enable young people to remain in the community and commence their journey of recovery;
- Enable young people to enhance their personal skills and understanding to build and maintain emotional wellbeing and self-efficacy, and connections with family, friends, and their communities;

- Provide young people, their social networks with current information about mental health, wellbeing and other relevant services;
- Work closely with a range of stakeholders including youth and mental health service providers, and other community services, and young people's support networks;
- Implement, develop and review policies and procedures in accordance with the aims and objectives of the TOHI service;
- Measure young people's services satisfaction, goal attainment and outcomes;
- Participate in ongoing staff development and keep up-to-date with current trends of evidence based practice;
- Regularly consult with, and report to the Department and Queensland Alliance for Mental Health, and contribute to the knowledge base and future direction of the program; and
- Participate and contribute to the independent evaluation of the program.

1.4 Service delivery

The Queensland Government has allocated $6.477 million for three years. The two NGO's are funded to implement the TOHI pilot to provide support to young people between the ages of 15 to 25 years whose circumstances either have had an impact on their mental health now or, if unaddressed, are likely to have an impact.

Based on the Application Kit for the Time Out House Initiative by the Department of Communities and other key resources provided by the two NGO's, next we outline the central features of the two service delivery models:

- A strengths based practice approach (eg. person centred planning and goal setting) and individualised support, residential (up to three weeks) and in an outreach capacity (up to three months) that enables young people's emotional wellbeing and recovery from a variety or combination of psychosocial stressors;
- Supporting young people to restore and maintain connection with family, friends, other supports and their community (community inclusion);
- Collaboration with a range of community services to provide young people with support pathways, with a focus on addressing young people's emotional and mental health needs;
- Networking with a range of stakeholders to develop opportunities for socio-economic participation and community inclusion for young people; and
- Enhancing the capacity of social networks to remain supportive of the young person.

2 Evaluation Framework

2.1 Evaluation framework

A longitudinal, mixed method evaluation design will measure longitudinal outcomes for young people, their social networks (where this is possible); the program process (working relationships between services, government and nongovernment providers); and costs.

The methodological approach has been developed to fit the key attributes of the Time Out House Initiative (TOHI); the evaluation objectives and the conceptual framework outlined below to consider inputs, processes, outputs and outcomes. It is designed within the evaluation constraints such as available and prospective sources of information, budget, timeframe and respondent burden.

Outcomes and process evaluation

One of the key aims of the evaluation is to assess the impact of the TOHI on individual participants, mainly the young people, and their social networks where this is possible. To address this aim, the evaluation will analyse the experiences and outcomes of the pilot for young people and will provide an understanding of the extent to which the program has met its two core objectives to:

1. promote wellbeing and mental health self-efficacy of young people experiencing circumstances that either have had an impact on their mental health now or, if unaddressed, are likely to have an impact;

2. enhance social connectedness and community inclusion of young people involved in the program.

The evaluation will also analyse processes for Queensland Alliance for Mental Health, government and service provider governance, planning and program delivery throughout the evaluation period to inform progressive policy and program change. The process data will provide insight into how effective the support model is in meeting its key objectives, such as recovery focused, person centred support, community inclusion, and early intervention. The information will include outcomes and process evaluation data. In addition, the final evaluation report will draw summative conclusions about the pilot program to inform future policy development.

Economic evaluation

In the economic analysis we will compare the costs of the pilot to the outcomes. The aim of this approach is to understand the extent to which costs to outcomes represent value for money over a longer term. The underlying principle of economic analysis is that for the given budget, the government wishes to maximise young peoples' benefits. The economic analysis will also inform future decisions about the pilot or similar support models for young people.

2.2 Evaluation framework and research questions

This study uses a longitudinal, mixed methods design to address the evaluation questions. The rationale behind the design is discussed in this section. Table 2.1 summarises how the data sources fulfil the research objectives and research questions in the three parts of the evaluation – outcomes, process and costs. In summary the data sources include:

- Document review – policy documents and literature;

- Program data – program specifications, contracts and financial data; quantitative service provider reporting (eg. services provided, demographics, assessment and outcome measures, follow up or exit data);
- Qualitative data collection by the evaluation team and TOHI support workers – case studies, interviews and observation.

Table 2.1: Evaluation framework matched to research questions and data sources

Objectives	Evaluation questions	Evaluation methods				
		Program data	Qualitative - young people and social networks	Service interview	Observe	Documents
Outcomes - To investigate and measure the impact of services provided through the TOHI and identify outcomes for young people accessing these services and their social networks.						
Young people	What is the profile of young people who access the TOHI? What is the profile of young people who do not access the TOHI?	✓	✓	✓		✓
	What is the experience of young people who access the TOHI? (eg. youth-friendliness of outreach support and residential environment; access to appropriate clinical and non-clinical services and support)	✓	✓	✓	✓	
	What evidence is there that young people who access the TOHI benefit from this model of community support?	✓	✓	✓	✓	
	What outcomes are experienced by young people involved in the TOHI, in relation to reduced clinical services during TOHI? What are the perceived changes to the clinical services trajectory of young people who use TOHI?	✓	✓	✓		
	What outcomes are experienced by young people involved in the TOHI, in relation to social/community interaction and integration? (eg. social contact with family and friends; engagement in work, study, and volunteering etc.)	✓	✓	✓		
	What outcomes are experienced by young people involved in the TOHI, in relation to mental health self-efficacy? (eg. young people develop personal skills and understanding to build and maintain independence and emotional wellbeing, and pathways to recovery)	✓	✓	✓		
	What outcomes are experienced by young people involved in the TOHI, in relation to general wellbeing and quality of life? (eg. young person are assisted to maintain an identity beyond illness, hope for the future, and undertake valued social roles within their local community)	✓	✓	✓		
Social network	How do young people's social networks (family, friends, others) experience TOHI?	✓	✓	✓		
	What benefits do they derive from this approach to support?	✓	✓	✓		

continued

Objectives	**Evaluation questions**	**Evaluation methods**				
		Program data	Qualitative - young people and social networks	Service interview	Observe	Documents
Process - To examine what works well and doesn't work as well in delivering the TOHI; and understand issues that impact service delivery across different geographical areas.						
Service model	How effective is the TOHI service delivery model? (eg. what other services are required to complement TOHI and better meet the needs of the target group?)	✓	✓	✓	✓	✓
	What impact has TOHI made on the youth and mental health service systems in the geographic location? • How could the service model be improved and strengthened?	✓	✓	✓	✓	✓
	What are the factors that enhance working relationships and a collaborative approach between youth services and mental health clinical and non-clinical services? • Are there any factors which limit the effectiveness of the TOHI partnership model? • How can the TOHI partnership model be improved and strengthened? • How effective is the governance of the TOHI model?			✓	✓	✓
Cost evaluation - To measure whether this type of early intervention approach is cost-effective.						
	What are the costs and benefits of providing TOHI services? Are these benefits different across different geographical areas?	✓	✓	✓		✓
	At a systems level, does the provision of TOHI services result in a cost-saving across the youth and mental health systems and can this be quantified?	✓		✓		✓

2.3 Phases of the evaluation

The evaluation will be **conducted in four phases** – project plan; baseline analysis; longitudinal analysis; and final analysis. The phases align with the project schedule and are outlined below. This section also describes in summary the research instruments, sampling framework and methods of analysis.

Phase 1: Project plan

The evaluation team is working with Queensland Alliance for Mental Health and the NGO providers to refine the evaluation objectives, evaluation questions and research methodology. To minimise respondent burden, the evaluation design supplements existing reporting requirements with minimal supplementary data collection by the service providers and evaluators. As the case planning, satisfaction survey, and other program data are collected by the service providers, analysis relies on timely and comprehensive delivery of these data to the Qld Alliance for Mental Health for the evaluators.

Phase 2: Baseline analysis

A literature review will be conducted to collect and analyse evidence on other national and international early intervention, short-term recovery focused outreach and residential programs for young people whose circumstances either have had an impact on their mental health now or, if unaddressed, are likely to have an impact. This review will inform researchers on related evaluation methodology and findings for comparative purposes. We will report on the lessons that can be learnt from previous experience and adjustments that could be made to the initiative and evaluation to improve effectiveness.

Quantitative and qualitative instruments to be used in our evaluation will be developed and piloted as described below. The first wave of data collection, transfer and analysis will be conducted during this phase. The Phase will conclude with the draft first progress report for comment, amendment and finalisation and presentation to the Steering Committee.

Phase 3: Longitudinal process analysis

The TOHI program is a short term intervention of around three weeks to three months without repeat contact or further follow up with young service users. The program does not have access to mental health data from hospitals or other providers. For these reasons, the longitudinal analysis will focus on process changes to inform the process and effectiveness analysis, for example change over time about which young people are using it (demographics, mental health assessments); what services are provided; and effectiveness during the program social connections (family, friends); community participation (education, work); self-efficacy (independence, recovery); wellbeing and quality of life.

The repeated waves of qualitative, narrative and quantitative data collection and data analysis will occur during this phase. A progress report and verbal presentation of initial findings will be provided to the Steering Committee for comment and finalisation.

Phase 4: Final analysis

After Phase 3, a draft final report of the longitudinal results including the cost effectiveness analysis will be submitted. Feedback from the Steering Committee will be used to revise the draft final report. A final report will be produced, along with a brief summary of findings that is written in a language suitable for wider distribution to stakeholders, such as participating service providers, young people, their social networks and advocates. A verbal presentation of key research findings will be delivered to relevant stakeholders.

3 Methodology

This section outlines the findings from the brief literature and document review to design the evaluation. The aim of this review was to identify evaluation methods applied in previous research with young people with risks to their mental health, and early intervention models of support building on outreach and/or short-term residential recovery focused support. The review provides the rationale behind the design and the methods chosen to answer the research questions.

3.1 Research rationale

Eccles and Templeton (2002) completed a comprehensive review of experimental or quasi-experimental evaluations of community-based programs for young people. Although the programs under review differed substantially in focus and scope, they were all designed to meet the needs of young people aged 10 to 18 years. The successful programs included the following components and outcomes:

- social and emotional support from adults;
- opportunities for young people to belong;
- pro-social norms;
- opportunities to experience mastery and to engage in activities that matter;
- opportunities for skill building; and
- integration of family, schools, and community.

The authors argue that the major shortcoming of evaluation research in this field is the lack of a 'well-articulated theory of change guiding program design' which eventually has a negative impact on the evaluations of these programs (p. 30). Also Eccles and Templeton (2002) acknowledge the 'scarcity of well-validated measures', which, they argue, is partly a result of a disconnection between research and practice. Next we look at some examples of early intervention evaluation research in Australia and internationally to identify methodological approaches used to assess program outcomes in critical domains.

Longitudinal, mixed methods

It is evident that there exist a range of evaluation approaches to programs working with young people with risks to their mental health. For example, a number of outreach support programs working with young people with mental health or substance abuse problems, or experiences of violence, heavily rely on qualitative rather than mixed methods (see for example, Pead et al., 1999, for Australia; Pepler et al., 2008, for Canada). Nevertheless Durlak and Wells (1997) find in their meta-analysis of successful published primary preventative mental health studies for children and adolescents that most used longitudinal mixed methods. The authors note that well-designed research should provide evidence on outcomes beyond the single focus of the study, eg. in prevention research, to examine multiple areas of prevention (e.g. mental health, physical health, school performance etc.), as these domains appear to share risk and protective factors (Durlak and Wells, 1997). Overall mixed method designs to measure outcomes and process of early intervention initiatives, not only for young people, are growing in use due to their stronger ethical frameworks, greater practicability and application across a range of domains.

An example of a multi-method, longitudinal evaluation of an early intervention mental health program for young people is *headspace*. The evaluation consisted of repeat interviews and surveys with young people, their social network, service providers and government bodies across Australia. To assess a range of program outcomes for young people aged 12 to 25 years the evaluation used: the Kessler 10 instrument to assess psychological distress in young people; the Personal Wellbeing Index (PWI) to measure changes in young people's sense of wellbeing; the Social and Occupational Functioning Assessment Scale (SOFAS) to measure occupational, social and psychological functioning. These data were then compared to a number of secondary national data (Muir et al., 2008; Muir et al., 2009).

Outcomes of Australian residential programs, in this case, for highly vulnerable youth (eg. young people at risk of or experiencing homelessness) commonly collect qualitative data on service satisfaction, including relationship with staff, and quantitative data on service use and referrals (from program data) (see, for example, Chung and Tesoriero, 1997). However research has clearly identified the need for residential programs working with young people at risk to include longitudinal data collection on wellbeing; distinguish between young people along different levels of support received; and measure social and economic outcomes, like engagement with family, education, employment/training, and the community (Maloney et al., 2010).

In a related field, mentoring programs for young people, DuBois et al. (2002) conducted a meta-analysis review of 55 evaluations. They found that it is important to assess the 'relationships that are actually developed between mentors and youth in programs as a source of influence on outcomes' (p.192), as too often programs are found to be successful without providing sufficient evidence on the key factors that bring about change. This may be an important implication for the design of the TOHI evaluation that also strongly builds on interpersonal relationships between the young person in need of support and TOHI staff.

Participatory research methods

The use of participatory methodology is widespread in evaluation research and is increasingly regarded as 'best practice' (Fisher and Robinson, 2010). The success of evaluations strongly relies on the meaningful participation of a range of stakeholders throughout the research process: design of methodology, identification and management of potential risks, and data collection.

In the health and community care sector the discussion of the empowerment of young people and participation at program design level is widespread. Ottmann et al. (2008) argue however that for consumer directed participatory action research methods to be sustainable a range of support mechanisms (eg. community development, and capacity building initiatives) need to be built into the process early on, to ensure an ongoing meaningful interaction and integration of young people at the policy level.

The TOHI pilot evaluation design aims to enhance the participation of young people and their families and other supports in the evaluation process. This will be facilitated through qualitative data collection processes which focus on the lived experience of the young people, recompensing research participants for their contributions (interviews), and by ensuring young people and their families are represented on the committees informing the evaluation.

The Queensland Alliance for Mental Health and Department of Communities have established a project Reference Group and Steering Committee to advice the evaluators, including on data collection instruments, to act on progressive findings arising from the progress reports (formative evaluation), provide feedback on outputs (draft reports), and finally approve dissemination of research findings to participants.

Research design must take account of individual needs, capacity and barriers to participation. Most commonly research methodologies accommodate this by ensuring that questionnaires and methods used build on young people's strengths. Examples include providing questionnaires in an easy English version for people who speak English as a second language or have limited proficiency in English. Researchers and TOHI staff involved in the data collecting are trained and experienced in working with young people experiencing risks to their mental health. Implications for TOHI evaluation methods are incorporated below.

3.2 Methods and samples

The evaluation methods are summarised in Table 2.1 above and discussed in more depth below.

Quantitative program data

The evaluation will analyse cost data provided by Queensland Alliance for Mental Health and the service providers. In addition, it will analyse information collected by the service providers as part of their program management about young people's needs, goals, service satisfaction and outcomes, and their social networks.

Young people

The evaluation will use quantitative data for all young people to be collected by the service providers as part of their regular financial and outcome program management, if the young person has the capacity to consent have their data included in a de-identified form. The two providers implementing the TOHI program are using very different measures and approaches to collect data from the young people using outreach and residential support.

Table 3.1 matches the types of data collected in the two sites by the two service streams (outreach and residential) to the key evaluation questions about outcomes, and identifies possible evidence gaps. The implication of the gaps is that the two sites can be evaluated separately where the data collection is inconsistent, analysed for the program as a whole where they are consistent and general conclusions drawn where they address similar evaluation questions. The Logan site has agreed to include some of the quantitative measures used at the Cairns site so as to achieve some consistency in data collection between the two sites.

At June 2011, the agreed consistent outcome measures are the Personal Wellbeing Index (PWI), the Activity and Participation Questionnaire (APQ6) and the Recovery Assessment Scale (RAS).

Table 3.1: Evaluation questions matched to data sources by location and service type (outreach and residential support)

Evaluation framework design		TOHI outreach		TOHI residential	
Key evaluation questions	**Identified gaps in data collection – baseline and change measure?**	**TOHI Cairns**	**TOHI Logan**	**TOHI Cairns**	**TOHI Logan**
		Source and type of data collected*	**Source and type of data collected***	**Source and type of data collected***	**Source and type of data collected***
1. Profile of YP who access the TOHI; who is not using TOHI services	None	**Referral form** Demographics (age, cultural background etc.), source of referral	**Youth and family Services (YFS) database – Details** Demographics (age, cultural background etc.), source of referral	Same as outreach	Same as outreach
2. How do YP benefit from the TOHI support model? Changes in support needs etc. Profile of YP who access the TOHI;	**Logan**: repeat assessment to measure change over time?	**CANSAS** (Camberwell Assessment of Need Short Appraisal) – on **entry & exit** baseline and changes in YP's basic (accommodation, food etc), emotional, and social needs	**YFS database – Issues/Assessment** To identify YP's support needs in key domains (eg. accommodation, education/training, mental health, general health etc.)	Same as outreach	Same as outreach
3. Services used by service type (young people's and adult services, employment, education, health, mental health etc) and changes in clinical	**Logan/Cairns:** we recommend for both service types quantitative data collection on key service use pre-TOHI and referrals to other services	**Referral form** (clinical diagnosis, referring agency)	**YFS database – details** (diagnosed health condition, not diagnosed, chronic condition)	Same as outreach	Same as outreach

services trajectory of YP	as a result of TOHI				
4. Outcomes in relation to mental health self-efficacy (eg. identity beyond illness, pathways to recovery)	Mainly qualitative data available for both sites	**Collaborative Recovery Model** (Life Jet Tools) Self-determination and consumer ownership (goal setting and attainment)	YP narratives/case studies*	YP narratives/case studies	YP narratives/case studies
5. Outcomes/changes in YP's wellbeing and quality of life (hopes for the future etc.)	**Logan**: only qualitative data available	**PWI** (Personal Wellbeing Index) – on entry & exit	YP narratives/case studies We recommend PWI	Same as outreach	Same as outreach
6. Outcomes to YP's recovery and mental health; relation to reduced clinical services during TOHI	**Logan**: only qualitative data available	**RAS** (Recovery Assessment Scale) - subscale on entry & exit	YP narratives/case studies	YP narratives/case studies We recommend RAS subscale on entry & exit	YP narratives/case studies
7. Experiences of YP who access TOHI (youth-friendliness, access to information and appropriate services etc.)	**Logan**: only qualitative data available	Aftercare **Satisfaction Survey** – on entry & exit (Service experience relationships with staff).	YP narratives/case studies	Same as outreach	Same as outreach
8. Outcomes in relation to social/community interaction and integration, also connectedness with social networks	**Logan/Cairns**: limited quantitative data available; **Logan** lack of follow-up data difficult to measure change over time	PWI and CANSAS We recommend APQ6 – on entry & exit	YFS database – Assessment We recommend PWI, RAS and APQ6 on entry & exit	Same as outreach	Same as outreach

* If not explicitly mentioned all quantitative data in this table are supplemented and triangulated with qualitative data from the YP and the service providers.

TOHI Cairns has agreed to transfer quantitative data collected for their four assessment instruments (the RAS subscale, PWI, CANSAS, and the Aftercare Satisfaction survey) which the evaluators will analyse to measure longitudinal change. The measurements will provide sufficient longitudinal evidence to answer the key evaluation questions for the youth cohort, including (demographics, service use and assessment of mental health at intake and outcomes derived; follow up support or exit data; see Table 3.1: above for a detailed overview).

TOHI Logan collects data as part of their standardised Youth and Family Services (YFS) database, where they collect data on intake, assessment, issues, and closure of each young person. This information will allow the evaluation to answer some of the key questions using quantitative data relevant for young people but not all (see Table 3.1: above for a detailed overview). Most of the information is collected at a single point in time which precludes measures of change in wellbeing and resilience, socio-economic and community participation over time (longitudinal outcomes analysis).

However due to the rather short timeframes of the intervention (of around three weeks and three months) the general assumption, shared by the two providers, is that change will be difficult to measure quantitatively. We expect nevertheless to measure interim change through the qualitative data (YP narratives and case studies).

Managing possible gaps in quantitative data

To increase comparability of the two service delivery models we would suggest internationally validated survey instruments to measure program outcomes during their participation in the TOHI – young people and their social networks. Possibly measures could include the PWI (Personal Wellbeing Index), which is already in use in the Cairns TOHI site, to assess changes in psychological distress and quality of life.

The rationale behind this choice of validated instrument is that it contains specific questions on personal wellbeing as well as information on seven life domains that can be used as indicators for assessing resilience, e.g. health, material comfort, work engagement and community participation, which are the core objectives of the pilot program. In addition, the PWI is a validated instrument which uses reliable Australian scales which are short and therefore relatively quick to administer.

The current program management data collection does not directly measure outcomes for the young people's social network members such as family and friends. However, many of the young people who have entered the program so far do not have strong connections with their family and rely on social networks instead. It would be possible for the providers to consider collecting PWI data from the families, but in these circumstances of high levels of family disconnection, this may not be worthwhile.

Another gap in the program data is the shortage of direct evidence about young people's social/community interaction and integration (see Question 8. in Table 3.1). Both sites collect some data (Table 3.1). These are however inconsistent. A way to address this gap could be for both providers to consider adding the Activity and Participation Questionnaire (APQ6), alternatively the Social and Occupational Functioning Assessment Scale (SOFAS). In the absence of these consistent data collections, the evaluation would rely on the narratives and case studies.

Data collection process

Measuring change relies on the program data capturing measurements in at least two points of time, usually on entry and end of contact with TOHI. The six month data transfer from the two sites to the evaluators will take account of the progressive enrolment of young people to TOHI. When a provider enrolls a new young person, with the consent of the young person, they can submit the new data with the next transfer. Details of quantitative sample selection and process have been discussed and confirmed with the Queensland Alliance for Mental Health and service provider organizations at the beginning of the evaluation. Ideally, all young people will be offered the opportunity to be included in the quantitative data analysis if they have the capacity to consent.

We will not include follow-up surveys after young people have exited the pilot, as any subsequent changes in wellbeing or resilience will not be clearly attributable to the pilot and may be due to subsequent opportunities that young people have accessed.

Qualitative data collection and sampling

Semi-structured interviews will be conducted with the young people in TOHI, their social networks, the TOHI service providers and Department and Queensland Alliance for Mental Health staff and other related providers. In line with the evaluation objectives and research questions, the qualitative interviews will determine:

- the experience of young people who access the TOHI, and in what ways they have benefited from this model of intensive non-clinical care coordination and lifestyle support;
- young people's outcomes, particularly in relation to: improvements in wellbeing, quality of life, referral to other clinical and non-clinical services, social and community interaction and participation, and mental health self-efficacy;
- the experience of the young people's social network members with TOHI, and in what ways they have benefited from this model of support;
- effectiveness of the service model to meet the needs of its target group (eg. are further services or responses required to complement TOHI; what factors support good working relationships between TOHI providers and other relevant community partners/services);
- the impact of the TOHI model on the youth and mental health service systems in the two different geographic locations; and
- the cost effectiveness of providing TOHI services and whether this is a viable service delivery model for the Department and Queensland Alliance for Mental Health.

The qualitative sample includes ten young people, four members of their social network, two service provider staff and two other related providers in both sites and three Queensland Alliance for Mental Health and Department officials (Table 3.2). The sample size is the minimum recommended to meet the evaluation requirements within the constraints of the budget and respondent burden. It is large enough for case study data to supplement the full cohort continuous longitudinal quantitative data. If the

two TOHI providers have capacity, we recommend that the narrative sample be enlarged, as discussed below.

Table 3.2: Samples by method

	Per location	Total 2011-12
Program data – repeat measures, continuous data, 6 month transfer		
Young people – profile, outputs and outcomes	125	250
Financial and administrative data	125	250
Written narrative data from providers – 3 x annual transfer		
Young people	10 new young people per year or repeat if re-entry[a]	60
Social network members (family, friends or other significant people)	5 new members per year or repeat if re-entry	30
Interviews – 2 x longitudinal repeat collection		
Young people – case studies (repeat or replace)	5[b]	20
Workers and managers from the TOHI providers	2	8
Other clinical mental health service providers/ managers	2	4
Social network members	2	4
Central managers (Alliance and Department)		3
Total wave I and II interviews		39

Notes: a. 7 outreach and 3 residential

b. 3 outreach and 2 residential

Interviews with young people, their social networks and support workers will focus on outcomes and process. Interviews with managers and officials from partnering agencies and government will focus on policy, program and partnership management process evaluation. Repeat face to face interviews will be conducted in June 2011 and again in April 2012. Face to face interviews also facilitate opportunities for the researchers to observe the program, which will contribute to the qualitative data.

Longitudinal research with young people and their social networks

The evaluation will collect longitudinal case studies with five TOHI young people in each of the two sites. Ideally researchers will speak to the young person towards the end of their involvement with TOHI, after they have received care and support and are confident enough to attend the interview, but before they exit the program completely. This will ensure the ethical conduct of research with vulnerable populations who require access to appropriate support during and after participating in the research. This approach will also allow for a better understanding of the outcomes

and experiences the young person had with TOHI due to the short nature of the intervention. Because only a minority of young people uses the residential support in addition to the outreach support, the sample will be split approximately three outreach only and two residential and outreach.

To gain some longitudinal qualitative data for the selected case studies we include follow-up of the case studies 9-12 months after they attend the first interview. The follow-up interviews will gather longitudinal qualitative information on strength of referrals, reconnection to work or education and social relationships and the views of the young people on the impact of the program from a position of time past.

Our experience of longitudinal research with young people with risks to their mental health is that it is difficult to maintain a full sample for repeat interviews (eg. highly mobile, lose contact or unstable mental wellbeing). Some young people are already returning to TOHI after exit, so opportunities from repeat use might be incorporated in the sample. The researchers will replace young people from the baseline case study sample if they are not available for the follow up interview.

As well as providing a spread across the program cohorts, the young people and their social networks sampling framework will include people with different types and severity of support needs, young men and women and people from a variety of Indigenous, cultural and linguistic backgrounds, as relevant to the full cohort. Communication assistance including translation and interpreters will be arranged where required and the evaluators are experienced and sensitive to young people' needs relating to gender, culture, mental illness and sexuality. We will not use representative sampling because the quantitative data collection includes all young people and the qualitative case study sampling is only large enough to include at least one person with each diverse characteristic rather than a representative number, which would risk excluding people with less frequent characteristics.

To accommodate budget constraints, the young people interview data will be supplemented with longitudinal written narrative data collected by the providers with a minimum sample of ten young people per location per year. TOHI support workers will also collect a minimum five case studies from their social networks member per location per year. If any of the narrative sample of young people re-enter the program during the subsequent years, the providers will collect repeat narrative data about these young people. We will develop protocols and training with the providers to guide the narrative data collection and encourage the participation of the young people in generating the data.

Recruitment of young people and ethical considerations

To avoid selection bias and maximise the longitudinal research opportunities, the samples will be selected on the basis of the last young people and their social networks who meet the agreed sampling framework criteria who enter the program after the evaluation begins and agree to participate to longitudinal interviews or narratives. If this form of sampling does not capture the diversity of young people in the program, we will incorporate some purposive sampling in the narrative sample.

The evaluators will provide instructions to the service providers for an invitation for participation, including how to select young people who meet the sampling criteria and make an initial approach from the service provider or other trusted person to

explain the consequences of participating in the evaluation and to gain voluntary permission for the evaluators to meet them; voluntary consent to participate explained by the evaluator; and continuous opportunities to withdraw from the evaluation. Young people will be given a voucher to reimburse expenses and time for participating. All young people and social network interviews will be conducted face to face in a location preferred by the respondent.

The evaluators have research protocols to guide practice with Indigenous and culturally and linguistically diverse people, families and communities. Evaluation methods are modified to respect the needs of Indigenous young people and Indigenous researchers are engaged to adapt methodologies and research instruments and to assist with data collection where relevant.

Other ethical considerations include asking the young person where and when they want to conduct the interview, if they want a trusted person to accompany them, option not to record the interview, strengths based questions, flexible interview format (priority questions, storytelling) and disclosure protocol (see below) and referral for support about information disclosed during the interview.

Longitudinal research with key informants

In addition to the young person and social network samples, we will interview four service provider staff (two from each site), preferably staff who work with the young person samples or manage staff who do), four other related professionals from other youth support and community mental health services for young people, and three interviews with Queensland Alliance for Mental Health and Department staff who manage the program. The service provider and Department interviews will be conducted face to face or via telephone at the convenience of the respondents. They may be individual or group interviews, as agreed with the Queensland Alliance for Mental Health and service providers.

The worker and management data will be supplemented with incidental observational and discussion data from any evaluator participation in meetings and visits to the service provider facilities.

Cost effectiveness

To determine whether the program provides value for money and positive outcomes for young people and whether it is a viable service delivery program, the evaluators will analyse financial data provided by the Queensland Alliance for Mental Health and service providers in their financial and annual reports to examine the costs of the program (including management, establishment and administration and young person service costs).

Program costs will be compared to the outcomes. The aim is to compare the goals of the program with its achievements, deciding whether the program is economical in terms of tangible benefits produced by money spent. This will help to understand how effectively and efficiently the government has achieved its objectives. This component of the evaluation relies on outcome data as well as cost and expenditure data being available. Where available, the data will be compared to alternative costs if the young person was supported within the existing service system.

4 Analysis

Data from all methods will be analysed and triangulated to answer the research questions. Quantitative data will be analysed using a statistical software program, such as SPSS. Priority will be given to analysing the data to inform policy decisions and program improvement. As applied social policy researchers, the evaluation team is familiar with adapting the data collection, analysis and outputs to respond to policy changes during the evaluation period.

Qualitative data analysis will be used to critically interpret the full quantitative dataset. This will be important for understanding the partnership, policy and model questions to improve the program delivery and inform future model enhancements. It will also be important for analysing variation in experience according to the young person characteristics, such as Indigenous, cultural diversity and comparison to similar service models.

Validation methods will be three-fold, first through adopting and comparing to data from validated instruments; second, triangulating from the multiple data sources; and third, encouraging critical input from the evaluation participants. An advantage of engaging with a Reference Group and communicating draft and interim findings to evaluation participants is that the validity of the results can be challenged with the experiential information from program participants. Equally it provides an opportunity for program managers to refer participants to the program documentation and principles of the program in the event of conflicting interpretations of evaluation findings.

We recommend that to maximise the benefits of formative evaluation, public summaries of the interim results be available so that a further data source can be phone and email data from other people involved in the program.

5 Project Management

5.1 Deliverables

A timeline of deliverables is below. The content of these deliverables will be as specified in the tender brief and finalised in the Phase 1 design.

Table 5.1: Deliverables and timeframe

Item	Deliverable	Date due
1	Written Project Plan	April 2011
2	First written Progress Report and presentation	August 2011
3	Second written Progress Report and presentation	August 2012
4	Draft Final Report	February 2013
5	Final Report, Summary of Findings and presentation	July 2013

The evaluation will take a formative evaluation approach, where the progressive results of the evaluation are fed back into the pilot to improve quality management of the project.

All deliverables will be presented in draft to receive comment, amended and a final version agreed. Drafts will be discussed with Queensland Alliance for Mental Health and Reference Group and Steering Committee, before Departmental approved public versions and summaries are made available to pilot young people and other interested people. Public summaries will enhance the quality of the research relationships, elicit feedback as another source of evaluation data and to contribute to the formative evaluation approach.

With the agreement and permission of Queensland Alliance for Mental Health, the progressive results will be submitted for national and international publication during the evaluation to contribute to the evidence base on TOHI.

5.2 Evaluation timeframe

The process to fulfil the deliverables will be managed with following the timetable of activities. The timeframe can be adapted in each Phase to accommodate any additional requirements or changes.

Table 5.2: Evaluation activities and timeframe

Deliverable		Activity	
Phase 1			**2011**
1	Project plan	Sign contract	
		Meet with Reference Group and providers to refine design	Mar
		Submit **Project Plan**	Apr
		Arrange ethics approval UNSW	May
Phase 2			
2	Progress report 1	Conduct literature review	May
		Instrument development and piloting	May
		Qualitative data collection	June
		Quantitative data and narrative transfer	May
		Analyse baseline data	July
		Progress report 1 and presentation	Aug
			2012
3	Progress report 2	Qualitative data collection & analysis	April
		Quantitative data collection (analyse in Phase 3)	June
		Progress report 2	Aug
Phase 3			
	Draft final report	Analyse quantitative and qualitative final data	Oct
			2013
		Draft final report for discussion and feedback	Feb
5	Final report	Amend from feedback	Mar
		Final report and presentation	Mar
6	Summary of findings	Summarise findings	Jul
		Propose academic outputs	Jul
		Summary of findings for approval for public distribution	Jul

5.3 Evaluation team

The evaluation team is described in Table 5.3.

Table 5.3: Evaluation team

Responsibility	Researchers
Chief Investigator	Karen Fisher
Queensland services advice	Lesley Chenoweth
Data collection and analysis	Sally Robinson and Natalie Clements
Research design and policy analysis	Sandra Gendera

The evaluation team has expert knowledge and experience in empirical research, project management and conducting complex evaluations using conceptual frameworks, longitudinal mixed methods and cost analysis. The team is a group of evaluators, researchers and experts with expertise in disability studies, intellectual disability, social policy, human service delivery and program evaluation. The

evaluation team is led by the SPRC, in collaboration with Griffith University and Disability Studies and Research Centre (UNSW).

5.4 Program management

SPRC has detailed project management strategies for evaluation research, including risk management, succession planning, quality assurance and communication. The Chief Investigator, Karen Fisher and the evaluation team members are highly experienced in evaluation management and their collaborative work has successfully delivered Queensland disability research and evaluation projects since 2002.

The SPRC project management procedures meet contractual obligations and project outcomes, including project cost estimates. The project costing process aims to ensure realistic estimates of expenditure and best value for money for the commissioning Department. The evaluators have the experience and capacity to manage the timeframe expected in this project, to ensure completion on time and within budget, and to produce the required outputs in quality, reporting and budgetary terms. The evaluators have the technical skills and experience to complete the project. The contract is a fixed cost project, with the risk borne by the SPRC. The only time delays experienced in past projects with the Queensland government were due to Departmental input or feedback, which the project management is able to accommodate.

Reference Group and Steering Committee

The role of the Reference Group (Qld Alliance for Mental Health, TOHI providers and consumer representatives) and Steering Committee (government and Reference Group) is to provide advice to the research team during all stages of the research process including feedback on interim and final reports. Membership of both groups includes representatives for young people, families and carers to enhance the participatory methodologies.

5.5 Risk management

Potential risks that may impact on the management of the evaluation and collection of data are summarised in Table 5.4, drawing on the evaluation expertise of the evaluators in other Queensland research and evaluation.

Table 5.4: Preliminary risk management strategy

Risk	Likelihood	Severity	Solution
Poor quality quantitative and administrative data	High	High	Close consultation with Department, service providers and governance groups to identify and manage data quality problems. SPRC staff have experience working with Department data
Failure of service provider to recruit case study sample and complete quantitative data	Medium	High	Work actively with service providers to maximise participatory methodology and commitment to the project Recompense young people and their social networks Trained researchers will facilitate participation Interview a range of stakeholders to ensure involvement of young people and social network
Data gaps to address the evaluation objectives	Medium	Low	Triangulate data sources to adjust the outcomes, process and cost analysis. Work with the governance groups to maximise triangulated data sources.
Attrition between waves	Low	High	Protocols for follow up between waves and multiple points of communication. Ensure lessons from previous Australian and international evaluations are followed. Replacement sampling will occur if attrition is unavoidable
Poor quality data collection (inter-rater reliability)	Low	High	Use of standardised instruments which have been used in similar studies. Training for service providers and researchers and good QA systems
Psychological distress or other harm caused to young people and social network	Low	High	Stringently designed recruitment and interview procedures. Trained interviewers. Follow up and referral where necessary
Research compromised due to lack of capacity	Low	High	The research centres have a wide range of skills which could be drawn on if needed to enhance capacity of team
Poor communication between researchers and Queensland Alliance for Mental Health	Low	High	Karen Fisher, Lesley Chenoweth and the team have worked very closely with Queensland policy makers and NGOs
Research does not adhere to budget	Low	High	Budget is based on previous experience of several projects, all of which have reported on time and within budget
Research design does not meet the policy needs of Qld Alliance for Mental Health and government	Low	High	Design, detailed objectives and dissemination strategy has been developed in collaboration with Qld Alliance for Mental Health and can be amended during the project
Evaluation team fails to work effectively	Low	Low	Build on history of collaboration and protocols for accountability and communication
Evaluation team member unavailable	Low	Low	Succession plan within the evaluation team for continuity

5.6 Ethics

Ethics approval for this evaluation has been sought from The University of New South Wales Human Research Ethics Committee (HREC), which is registered with the National Health and Medical Research Council (NHMRC). The University of New South Wales is committed to the highest standard of integrity in research. All human research activities are governed by the principles outlined in The National Statement on Ethical Conduct in Research Involving Humans. The University's Code of Conduct for the Responsible Practice of Research sets out the obligations by which all University researchers must abide, including confidentiality, freedom to withdraw, privacy and voluntary participation. The SPRC and UNSW HREC have agreed processes for prompt ethics approval because we conduct many government commissioned disability evaluations within restricted timeframes.

Prior to participation in the research, all participants will be provided with clear, accessible information about participating in the research, voluntary consent to participate (with continuous opportunities to withdraw from the research), respect for individuals' rights and dignity, reimbursement for participation expenses and confidentiality. Participants will also be informed that they can decide at any time to withdraw from the study by revoking their consent. Informed consent will be obtained from pilot young people and their social networks to participate in interviews and access named administrative data collected by the service providers. Permission to interview pilot young people's social network will also be requested from young adults with disabilities taking part in the pilot.

An easy English version of the information statements and consent forms has been developed. A disclosure protocol for developing an ethical research environment and responding to participant risk will be designed before fieldwork begins. If young people agree, responses will be recorded for accuracy and transcription. All identifiable data will be de-identified in any publications resulting from this evaluation. Data from this research will be kept in secure storage at the SPRC, viewed only by the evaluation team for the purpose of the evaluation and destroyed after seven years.

The research team have extensive experience in conducting research with young people. Researchers responsible for carrying out the fieldwork component of the study have undertaken research with young people, people with mental illness, families, service providers and officials.

5.7 Communication plan

Details of the framework for engaging and working collaboratively with young people, their social networks and families, services, government and nongovernment service providers and other relevant stakeholders involved in the TOHI are summarised in Table 5.5.

Table 5.5: Communication strategy

Communication to	Form	Frequency
Project manager, governance groups, Department, service providers	Written reports, meetings, phone, email, presentations and ad hoc participation in pilot management meetings	Start and finish of each Phase and as required
Young people and their social networks and families	Written summaries of plan and progress inviting input distributed through the service providers	Start and finish of each Phase and as required, after approval
Other interested persons or organisations	Written summaries of plan and progress inviting input on SPRC website and elsewhere as agreed	After each Phase after approval

Critical stages of engagement and collaboration will involve confirming the research methods and tools with Qld Alliance for Mental Health. Meetings with the Project Manager to discuss an overview of the project, the context, and schedule meetings with the Project Manager and Reference Group, to ensure a common understanding of the requirements of the project, coordinate the project design and discuss the draft methodology. Throughout the project, we will liaise regularly with the Project Manager to design a methodology and analysis that addresses the needs of Qld Alliance for Mental Health and government.

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