Evaluation of a Community Forensic Psychiatric Support Program

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CONTENTS

ACKNOWLEDGMENTS .................................................................................. V
DECLARATION OF AUTHORSHIP ................................................................ VI
ABSTRACT ............................................................................................... VII
GLOSSARY OF ABBREVIATIONS ............................................................... VIII

CHAPTER 1
INTRODUCTION .......................................................................................... 1
  1.1 INTRODUCTION .................................................................................. 1
  1.2 THE VOSA FORENSIC PSYCHIATRIC PROGRAM .................................. 3
  1.3 THE EVALUATION ............................................................................... 4
  1.4 ORGANISATION OF THE THESIS ....................................................... 5
  1.5 TERMINOLOGY .................................................................................. 6

CHAPTER 2
LITERATURE REVIEW .............................................................................. 7
  2.1 POLICY DEVELOPMENT ................................................................. 7
  2.2 MENTAL ILLNESS AND VIOLENCE .............................................. 13
  2.3 MENTALLY DISORDERED OFFENDERS ........................................ 15
  2.4 SERVICE INITIATIVES .................................................................... 18
  2.5 RELEVANCE OF THE LITERATURE ............................................... 22

CHAPTER 3
METHODOLOGY ..................................................................................... 24
  3.1 EVALUATION APPROACH ............................................................ 24
  3.2 STRENGTHS AND LIMITATIONS OF THE APPROACH .............. 28
  3.3 EVALUATION QUESTIONS ........................................................... 31
  3.4 METHODS ..................................................................................... 32
  3.5 ETHICAL CONSIDERATIONS ......................................................... 35

CHAPTER 4
PROGRAM HISTORY AND CURRENT CONTEXT ..................................... 38
  4.1 AGENCY CONTEXT ......................................................................... 38
  4.2 DEVELOPMENT OF THE FORENSIC PSYCHIATRIC PROGRAM .... 41
  4.3 CURRENT OPERATION ................................................................. 46
  4.4 THE SERVICE SYSTEM ............................................................... 48
  4.5 SUMMARY ..................................................................................... 52

CHAPTER 5
PROGRAM DATA ..................................................................................... 54
  5.1 DATA COLLECTION ........................................................................ 54
  5.2 CLIENT DATA ................................................................................ 55
  5.3 PROGRAM DATA ........................................................................... 61
  5.4 SUMMARY ..................................................................................... 70

CHAPTER 6
CASE STUDIES ...................................................................................... 72
  6.1 DATA COLLECTION ........................................................................ 72
  6.2 SUPPORT NEEDS OF THE CLIENT GROUP ............................... 72
  6.3 THE FORENSIC PSYCHIATRIC PROGRAM ................................... 79
  6.4 SUMMARY ..................................................................................... 89
CHAPTER 7
INTERVIEWS................................................................................................................. 91
  7.1 DATA COLLECTION................................................................................................. 91
  7.2 CLIENT INTERVIEWS.............................................................................................. 91
  7.3 PROGRAM STAFF.................................................................................................. 96
  7.4 EXTERNAL PROGRAM AND AGENCY STAFF......................................................... 102
  7.5 SUMMARY............................................................................................................. 107

CHAPTER 8
EVALUATION SUMMARY AND RECOMMENDATIONS....................................................... 109
  8.1 EVALUATION QUESTION 1....................................................................................... 109
  8.2 EVALUATION QUESTION 2....................................................................................... 114
  8.3 EVALUATION QUESTION 3....................................................................................... 118
  8.4 EVALUATION QUESTION 4....................................................................................... 119
  8.5 EVALUATION QUESTION 5....................................................................................... 119
  8.6 THE EVALUATION PROCESS & FURTHER RESEARCH/EVALUATION............... 128
  8.7 SUMMARY............................................................................................................. 130

APPENDICES.................................................................................................................. 137
  1. INTERVIEW SCHEDULE-CLIENTS............................................................................. 138
  2. INTERVIEW SCHEDULE- PROGRAM STAFF........................................................... 139
  3. INTERVIEW SCHEDULE- EXTERNAL STAFF......................................................... 140
  4. CONSENT FORM- CLIENTS...................................................................................... 141
  5. CONSENT FORM- STAFF....................................................................................... 142
  6. KEY MILESTONES IN THE DEVELOPMENT OF THE PROGRAM......................... 143
  7. CASE STUDY DETAILS............................................................................................ 145
  8. INTERVIEW DETAILS............................................................................................... 146
  9. ASSERTIVE COMMUNITY TREATMENT (ACT)....................................................... 148
### LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Client Demographic Profile</td>
<td>56</td>
</tr>
<tr>
<td>6.1</td>
<td>Background Data- Case Studies</td>
<td>73</td>
</tr>
<tr>
<td>6.2</td>
<td>Key Components of the Support Model</td>
<td>82</td>
</tr>
</tbody>
</table>

### LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Evaluation Process</td>
<td>36</td>
</tr>
<tr>
<td>4.1</td>
<td>VOSA Organisational Chart</td>
<td>40</td>
</tr>
<tr>
<td>4.2</td>
<td>Typical Pathways Through the Service System</td>
<td>51</td>
</tr>
<tr>
<td>5.1</td>
<td>Hospital Admissions</td>
<td>55</td>
</tr>
<tr>
<td>5.2</td>
<td>Community Treatment</td>
<td>57</td>
</tr>
<tr>
<td>5.3</td>
<td>Most Recent Primary Offence</td>
<td>58</td>
</tr>
<tr>
<td>5.4</td>
<td>Number of Prison Terms</td>
<td>59</td>
</tr>
<tr>
<td>5.5</td>
<td>Discharge Accommodation</td>
<td>60</td>
</tr>
<tr>
<td>5.6</td>
<td>Source of Referral</td>
<td>61</td>
</tr>
<tr>
<td>5.7</td>
<td>Contact With</td>
<td>62</td>
</tr>
<tr>
<td>5.8</td>
<td>Nature of Contact</td>
<td>63</td>
</tr>
<tr>
<td>5.10</td>
<td>Nature of Contact by Who With</td>
<td>64</td>
</tr>
<tr>
<td>5.11</td>
<td>Agency Contacts</td>
<td>64</td>
</tr>
<tr>
<td>5.12</td>
<td>Duration of Contacts</td>
<td>65</td>
</tr>
<tr>
<td>5.13</td>
<td>Support Model Components</td>
<td>67</td>
</tr>
<tr>
<td>8.1</td>
<td>Support Model Components</td>
<td>115</td>
</tr>
</tbody>
</table>
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DECLARATION OF AUTHORSHIP

I, David Rose, declare that this thesis comprises only my original work, except where due acknowledgment has been made in the text to all other materials used. This thesis does not exceed 30,000 words in length, exclusive of bibliographies, footnotes and appendices.

Signed:_________________________________   Date: __________________
Abstract

This thesis reports on an evaluation of the Forensic Psychiatric Program that has operated at The Victorian Offender Support Agency (VOSA) since 1992. The program provides outreach based community support services to people with a mental illness and offending history who are also homeless or at risk of homelessness. Services provided by the program range from practical activities such as assisting with accommodation, through to providing emotional support and advocacy on behalf of the client with other agencies and services. Most clients begin contact with the program prior to their discharge from prison or secure hospital and are supported in the transition process through to the community.

The evaluation was based on an “insider” agency self evaluation approach for the purposes of program specification and development. Data was collected primarily through interviews with clients; program staff and external agency staff; case studies based on written client case records; data from the program management information system; and examination of historical program records.

Overall, the program was perceived to be providing an important component of the community support needs of mentally disordered offenders and is well regarded by clients and staff of external agencies. Program data is reported which indicates that the program is largely providing services to clients from its stated target group, and data on the outcomes of the clients’ contact with the program is discussed. The key tasks that are undertaken by the workers in their support role are identified, as are the underlying factors that appear to contribute to the support program’s effectiveness. In particular, client involvement in the program is voluntary, the service is outreach based, concrete practical support in the form of assistance with accommodation is provided, contact begins prior to discharge from prison or hospital and the support workers clearly fulfil a significant social network role in their clients’ lives.

Recommendations are made concerning the future development of the program. In summary, the recommendations relate to the need to develop further specialised support strategies for particular client groups (such as women and young people); a range of resource related recommendations; and recommendations relating to the need for further strengthening of the program’s position within the service sector through dissemination of information on the model, clarification of roles and maintenance of good communication within the sector, and the development of strategic alliances.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAU</td>
<td>Acute Assessment Unit (G Division)</td>
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<tr>
<td>ACT</td>
<td>Assertive Community Treatment</td>
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<td>BRC</td>
<td>Brunswick Road Clinic (Community Forensic Psychiatry)</td>
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<td>CAT</td>
<td>Crisis Assessment &amp; Treatment Team</td>
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<tr>
<td>CBO</td>
<td>Community Based Order</td>
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<tr>
<td>CCO</td>
<td>Community Corrections Officer</td>
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<td>CMHC</td>
<td>Community Mental Health Centre</td>
</tr>
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<td>DEPTH</td>
<td>Disadvantaged Ex-Prisoners with Psychiatric Disability Targeting Homelessness Committee</td>
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<tr>
<td>DPD</td>
<td>Department of Planning and Development</td>
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<td>ICO</td>
<td>Intensive Correction Order</td>
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<tr>
<td>MAP/AAU</td>
<td>Melbourne Assessment Prison, Acute Assessment Unit</td>
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<td>MSTT</td>
<td>Mobile Support and Treatment Team</td>
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<td>PSU</td>
<td>Psycho-Social Unit (G Division)</td>
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<td>SAAP</td>
<td>Supported Accommodation Assistance Program</td>
</tr>
<tr>
<td>VOSA</td>
<td>The Victorian Offender Support Agency</td>
</tr>
</tbody>
</table>
CHAPTER 1

INTRODUCTION

SCHIZOPHRENIC HELD OVER BIKE DEATH
The man arrested for killing a cyclist in a random knife attack in Clifton Hill last Wednesday was released from a Melbourne psychiatric hospital 14 weeks ago… Mr Nicky McNulty, 28, was stabbed in the back of the neck while taking his dog for a run along the popular Merri Creek bike track at Clifton Hill about 11 am Wednesday. He left a 400 metre trail of blood before collapsing and dying in the arms of a passerby.

The Secretary of the Police Association, Senior Sergeant Danny Walsh, said tragedies such as this would continue to happen unless the State Government put better support services in place for mentally ill people in the community.

“The Government can call it a tragedy, we call it an absolute disgrace,” he said. “This is not an isolated incident. There are more and more people in police custody who have some mental instability and our members are advising us time and time again that there is a breakdown in support.”

“If the government wants to embark upon this track of deinstitutionalisation, that’s the Government’s decision but unless they put in place a solid infrastructure to assist those out there going through the process, then tragedies will continue to occur.” (The Age, 3 August, 1997)

Senior Police Defend Latest Fatal Shooting
Victoria police yesterday defended Friday night’s fatal shooting, by a dog squad officer, of a psychiatric patient, Mr Marama Simon, in a Northern Melbourne suburb… Mr O’Loughlin said Mr Simon came out of the house with a knife in either hand, confronted a police officer in the back yard and then went on to Donnybrook Road. He said Mr Simon’s behaviour “ebbed and flowed” and police continually called on him to drop the knives. He was moving up with the knives and, when he was about four metres away, he rushed at the officer. Mr Simon was shot twice, Mr O’Loughlin said. (The Age, 13 August 1995)

1.1 INTRODUCTION

The period since the 1950’s, and in particular the last decade, has seen massive changes in the way mental health services are provided in Australia. Policies of community care which have mirrored developments in other countries such as Britain and the USA, have seen the gradual closing down of
large institutions for the mentally ill, and a shift in focus to providing mental health services in the community. While the reasons behind this policy shift are many, there can be little doubt that for the majority of people with a mental illness this change has been for the better. However, as the newspaper quotes above would indicate, this change has not been without its problems. The quotes represent two extreme examples- the random killing of a passerby by a person with a mental illness, and one of the several police shootings of people with a mental illness in Victoria in recent years. However, it is these types of events which are prominently reported in the media, and which shape the community’s views about the nature of mental illness and the efficacy of the mental health support and treatment services. They are also representative of the inherent difficulties that develop for people when they find themselves at the intersection of the mental health and criminal justice systems.

Some of the most serious questions about the viability of community care have followed breakdowns in attempts to meet the support and treatment needs of the relatively small proportion of people with a mental illness who are prone to offending, violence and other fear inducing behaviour. Meeting the support and treatment needs of this group will always be a matter of balancing the rights of the individual with the rights of the wider community.

Developing effective models of community support for people with a mental illness and an offending history is important because it can give the person with the mental illness a chance to live a meaningful life in the community. It is also clear that community perceptions about the mentally ill will be very much shaped and influenced by the high profile incidents which often occur when a person with a mental illness has committed an offence or engaged in some form of violent or bizarre behaviour. When a person with a mental illness commits a serious offence, it comes at a significant human and financial cost to the victim and their family, the offender and their family, the wider community and also to all people with a mental illness who have to deal with increased stigmatisation as a result of community perceptions about the mentally ill. Clearly community
education can play a part in informing about the nature of mental illness but this work can be quickly undone by a high profile incident involving a mentally ill person.

Evidence suggests that effective community support and treatment programs for people with a mental illness who are prone to offending and violent behaviour have the potential to significantly reduce the risk of violence and offending. This thesis will report on an evaluation of the Forensic Psychiatric Program that has operated at The Victorian Offender Support Agency Inc. (VOSA) since 1992. This program provides community based outreach support to people with a mental illness and an offending history, and continues to be the only mental health outreach service that specialises in providing support to offenders in Victoria.

1.2 THE VOSA FORENSIC PSYCHIATRIC PROGRAM

VOSA is a non-government community based agency whose mission is to provide treatment and support services to people who have been in contact with the criminal justice system. VOSA was established in 1983 as the Epistle Centre by an ex-offender, and was initially staffed by volunteers as a drop in centre for offenders following their release from prison. The agency later became known as the Epistle Post Release Service, and gradually developed a range of programs targeted at meeting the needs of offenders, and started to employ professional staff to deliver the programs. The agency currently has a staff of 120 full and part time workers, and provides a range of programs targeted at meeting the needs of offenders following their release from prison. These include general and specialist offender transitional support and accommodation services, and support and treatment programs in the areas of mental health, intellectual disability, alcohol and drug assessment and employment.
One of these programs, the VOSA Forensic Psychiatric Program began in 1992 with a sole outreach worker whose primary role was to assist prisoners with a mental illness in finding post release accommodation. Over the subsequent years, the program developed to the point where it now consists of three full time outreach support workers, access to a disability employment worker, and a range of dedicated accommodation including group homes, flats and access to beds in a range of rooming houses and a supported accommodation facility.

The program provides outreach support to people with a mental illness who have been in contact with the criminal justice system. The outreach worker visits the client in prison or secure hospital prior to their release and conducts an assessment of their post release support needs. This often involves making arrangements for post release accommodation and then picking up the client on the day of their release and assisting them to get to the accommodation. Ongoing outreach based support is then provided through a range of activities, including:

- Assistance to maintain contact with treatment services.
- Assistance with maintaining or improving accommodation.
- 24 hour crisis support availability.
- Linkage into community programs such as employment assistance.
- Ongoing emotional support.
- Advocacy on behalf of clients with other services.

1.3 The Evaluation

The overall aim of the evaluation was to review the development of the program and to document the service model that has developed. The evaluation was conducted internally with full support of the agency. The evaluation utilised a multiple method evaluation approach suited to agency self evaluation with the goal of service review and improvement, rather than an evaluation for the purposes of accountability to an external body.
The author of this thesis is VOSA's Policy/Project Officer and has developed an interest in the area of services for mentally disordered offenders through this role, and in previous employment in a direct practice capacity as a social worker with Victorian Forensic Psychiatry Services.

1.4 ORGANISATION OF THE THESIS

The thesis is organised into three parts:

Part 1- Background to the Evaluation. (Chapters 1-3)
Chapter 2 is a literature review that includes an examination of the policy context; profiles of mentally disordered offenders; the links between mental illness, violence and offending; media and community perceptions of mentally ill offenders; and service responses that have been utilised in an attempt to meet the needs of mentally disordered offenders.

Chapter 3 outlines the evaluation methodology, including issues in conducting research with mentally disordered offenders, the methodology and methods utilised in this study, and ethical considerations.

Part 2- Findings. (Chapters 4-7)
Chapter 4 outlines the program context and development, based primarily on written records and key informant interviews. An overview of the current operation of the program including staffing and logistics is also provided.

Chapter 5 provides an analysis of data based on the program management information system which includes client demographic data and worker contact information.

Chapter 6 provides the results of the case studies undertaken as part of the evaluation.
Chapter 7 reports on the results of key informant interviews conducted with clients, program staff and external staff regarding their perceptions of the program.

Part 3- The Evaluation Questions (Chapter 8)
Chapter 8 draws together the data reported in Part 2 of the thesis to answer the evaluation questions. A summary of the evaluation and recommendations for future program development is also provided.

1.5 TERMINOLOGY

People who have a mental illness and who have an offending history as a group are variously referred to as mentally ill offenders, mentally disordered offenders or forensic psychiatric clients, and may also be referred to as prisoners, patients, or clients as they move through the service system. Similarly, users of psychiatric disability treatment and support services are variously referred to as clients, consumers, patients, members, customers or participants.

The implications of particular labelling of a person’s condition or status are only too apparent when examining the situation of people with a mental illness and offending history. The addition of the “offender” label to the “mentally ill” label often has significant implications for the types of service a person will be able to access and what community perceptions of them will be, regardless of their own individual situation. Thus, the use of various labels for a person’s situation must be approached with considerable caution. With this proviso, for ease of expression the term mentally disordered offenders has been used in this thesis, as this is the general term used throughout the literature. Furthermore, people who have been supported by the VOSA program will generally be referred to as clients, as this is the term of general usage within the program itself.
This chapter will provide a review of literature relevant to the thesis. It will begin by providing an overview of the move towards community based care that has become the feature of mental health policy in most western countries, and the particular implications this has had for people with a mental illness and offending history. The links between mental illness and offending will then be examined. Finally, the community based service initiatives that have been developed to try and address the needs of these groups will be discussed, particularly as they relate to the outreach services provided by the VOSA program.

2.1 Policy Development

The most striking feature of mental health policy in western countries in the latter half of the twentieth century has been the move towards community care (Goodwin 1997). Prior to this move, the majority of people with a serious mental illness were cared for in large psychiatric institutions, or the ‘asylum’ as they were know. The large scale development of asylums for the mentally ill can be seen to have occurred from the late 19th century as a response to the proliferation of people with a mental illness wandering the streets, living in poor houses, or incarcerated in prisons, and the gradually developing view of mental illness as a medical phenomenon rather than an act of deviance (Jones 1993). The move to community care on a policy level has been similar in most Western countries even if the implementation has varied, with for example, the process
in Britain being different to that which occurred in the United states, with resultant different problems\(^1\) (Bachrach 1997).

Within Australia, a move towards community care can be seen to have began around the 1950’s, with a gradual realisation of the possibilities of non-institutionalised based care (Lewis 1988). However, it is within the last decade that there have been significant moves towards community care of the mentally ill in all jurisdictions. This stems from the endorsement of the *National Mental Health Policy* (Australian Health Ministers 1992) by all Australian States and Territories in 1992 as part of the unified *National Mental Health Strategy*. This resulted in the development of state based policies in accordance with the national strategy such as the 1994 Victorian policy, *Victoria’s Mental Health Service: The Framework for Service Delivery* (H.C.S. 1994). Implicit within both these policies is a clear emphasis on the community based provision of mental health services, the closure of existing stand alone psychiatric inpatient services, the development and ‘mainstreaming’ of smaller short stay inpatient units with primary health care facilities such as general hospitals, and the targeting of services to those people most in need.

The reasons for this move to community care in Western countries are multi-faceted and still widely debated. Goodwin (1997) argues that while there are various orthodox and radical explanations, the need to develop the best possible treatment system for people with a mental illness has not necessarily been the primary motive (although for most people with a mental illness it has clearly led to vast improvement). Orthodox accounts (1997:50) include:

- The development of new psychotropic drugs that have meant people’s mental illness could be managed in the community.
- The development of social psychiatry and associated service initiatives.

\(^1\) For example, it can be seen that in some parts of America the provision of community based services lagged far behind the closure of institutions, resulting in many people falling through the gap, or being institutionalised in other areas such as prison (Bachrach 1997).
The emergence of civil rights movements and the anti-psychiatry movement.

The poor conditions within older mental hospitals and the associated public outcry about the conditions.

Conversely, radical accounts have focussed primarily on the relationship between capitalist economies and the provision of welfare, with the implication being that the shift has been due to the high cost to government of providing large inpatient services when there is pressure on the state for increased financial restraint and accountability (Goodwin 1997: 64). Goodwin argues that while both orthodox and radical accounts to some degree explain elements of this shift, there has also been a massive expansion in the classes and types of people who are in receipt of mental health services in their broadest sense. Thus it can be seen that the move to community care has in fact been characterised by an increasing separation between treatment and care components:

the state increasingly focusing its resources on the provision of treatment to ever greater numbers of people, while at the same time devolving and delegating responsibility of care to the private sector, voluntary and charitable groups and, by no means least, the family (1997:111).

What is clear is that the competing interests inherent within the move to community care have resulted in some re-occurring service provision issues and problems in all countries that have developed community care policies. These include:

- Providing for multiply disadvantaged people with a mental illness who are characterised by chaotic behaviour, have difficulty engaging with treatment services, and other social problems such as homelessness and substance misuse (The Sainsbury Centre for Mental Health 1998; Trieman 1997).

- The potential for a drift into homelessness and related social dislocation of people with a serious mental illness (Goodwin 1997; Leff 1997; Murphy 1991).
The potential for transinstitutionalisation of the mentally ill, that is, a reduction in the number of people in psychiatric institutions but a resultant increase in the number of people with a mental illness in correctional facilities (Goodwin 1997; Lamb and Weinberger 1998).

Community perceptions of the mentally ill and the potential impact this can have on the capacity of people with a serious mental illness to live in the community (Jones 1993; Murphy 1991; Wolf 1997).

Of particular relevance to this thesis is the concept of transinstitutionalisation of the mentally ill (or criminalisation of the mentally ill as it has also been described). In practice, there are significant methodological constraints in determining the extent to which criminal justice facilities have been taking the place of mental health facilities following the move to community care. Nevertheless, in America there was early evidence that the mentally ill were more likely to be arrested for committing similar offences to people without a mental illness (Teplin 1984), and that having a mental illness and being homeless significantly increased a person’s chances of entering the criminal justice system (Belcher 1988; Michaels 1992). In a recent review of the situation of people with a mental illness within the American criminal justice system, it is argued that considerable numbers of people with a mental illness continue to be incarcerated as a result of the failure of community based mental health services (Lamb and Weinberger 1998). The situation in Britain can be seen as somewhat different due to the fact that the development of community services have kept much better pace with the closure of mental health institutions (and thus there was little move of long stay hospital patients into the justice system observed). However, there is increasing concern that mentally ill people who have a forensic history are having difficulty entering mental health facilities, and are all the more likely to end up in the criminal justice system before they get access to care and treatment (Trieman 1997). While there is a scarcity of formal studies examining the transinstitutionalisation process in Australia, and early

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2 For example, account has to be taken of people who were previously long stay patients in mental health facilities and are now in prison, and also people with a mental illness who are in prison but in the past may have been admitted to a mental health facility.
Of further relevance to this thesis is the widely recognised fact that there is a relatively small sub group of people with a mental illness for whom policies of community care have largely failed in most countries. These groups include people with a mental illness and a history of offending, people with a mental illness who are homeless or at risk of homelessness and people who have a mental illness and a substance abuse problem (Goodwin 1997; Murphy 1991; The Sainsbury Centre for Mental Health 1998; Trieman 1997; Wolff 1997). While people within these groups make up a small proportion of people with a mental illness, it can be argued that the ability, or inability, of service systems to meet their needs will have a significant impact on the long term nature of community care. This is because when things go wrong for people within this group there are often tragic consequences and high profile media coverage. Jones (1993) has argued that it was largely through a growing public outcry in England over the state of the mentally ill wandering the streets as vagrants and living in workhouses, that the wide scale development of asylums for the mentally ill took place. What is also clear is that the future viability of community care also relies very much on public perceptions and support.

Goodwin (1997) argues that community care policies have been largely based on the assumption that people within “the community” will be accepting and supportive of people with a mental illness. To this end, most countries developing community care programs have undertaken public education campaigns on mental illness, and while evaluation of these programs has mostly been limited or non-existent, what does appear clear is that they have

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3 For example, the Inquiry into the Human Rights of People with a Mental Illness (H.R.E.O.C. 1993) found that mental illness can have an impact on a person’s contact with the criminal justice system on several levels. This includes where a person’s mental illness has caused them to act in a bizarre or violent manner that brings them to police attention; social circumstances such as homelessness or substance misuse that mean they are more likely to be detected by police; or people who are homeless and mentally ill being treated differently by the Justice System such as not granting them bail, parole, or other community based dispositions because of their perceived instability.
minimal impact on changing the communities’ attitudes. What is also clear is that community attitudes to mental illness are far more likely to be influenced by the media (Wolff 1997).

In Australia there has been considerable media attention and public discussion concerning police shootings of people with a mental illness and other isolated incidents of violence by people with a mental illness. However, public concern has not really reached a level where major policy change has been considered. The British experience provides an example of the impact a few high profile events can have on public perceptions. Two single events in Britain in 1992 continue to have a significant influence on policy and service development; firstly the incident where Ben Silcock climbed into the lions cage at the London zoo believing he could communicate with the lions only to be savagely mauled; and the random killing of Jonathon Zito in a London subway by Christopher Clunnis. Both events focussed public and media attention on the situation of the mentally ill in the community, and bought widespread calls for a halt on policies of community care and a re-opening of the hospitals (Goodwin 1997; Jones 1993). The account provided by Ben Silcock’s father to the newspapers of his experiences would certainly not be unfamiliar to workers in the field in Australia, or to the families of some mentally disordered offenders (Rose and James 1996). He reported:

Of intolerable tensions at home; of short periods when Ben was in hospital, and sudden unplanned discharges without notice; of periods when he was sleeping rough; of placements in bedsits and hostels and bed and breakfast accommodation which never lasted; of his attempts to live alone in a flat, and how ‘the community’ turned hostile—his furniture was smashed and his possessions were stolen; of a hospital actually discharging him because he threatened a member of staff—though violence was a symptom of his illness, and an indicator of his need for treatment; and of the ‘smug bureaucratic evasion of responsibility’ by one hospital authority which deemed he lived outside their catchment area because his family had been forced to change the locks on the front door, ‘making him technically homeless’ (Jones 1993:241).

While the case of Ben Silcock invoked a largely sympathetic response from the public and the media in their call for a re-think of community care, the case of Christopher Clunnis invoked a sense of community fear and panic. Later
investigations of the case found that he had been in contact with several
different services and professionals in the days leading up to his random attack
on a passerby in the subway. These incidents set in train several major
inquiries, the development of supervision registers for difficult to engage clients,
and the announcement by the British government in 1996 that they would fund
the building of 5000 new beds in residential units to accommodate clients who
had failed to cope in the community (Goodwin 1997:146). Thus it can be seen
that community perceptions of the mentally ill as a whole, and the resultant
services that are provided, are likely to be heavily influenced by high profile
incidents perpetrated by the small group of people with a mental illness, who
are generally chaotic in their lifestyle and prone to violence and fear inducing
behaviour, homelessness and substance misuse. However, it is clear that with
the appropriate level of support, many people within this group will also be able
to live within the community with little risk to themselves or other people (Mullen
1997).

2.2 Mental Illness and Violence

The link between mental illness and offending has been an area of some
contention, particularly as it relates to the link between mental illness and
violence. Examining the link between mental illness and violence has been the
major focus of research efforts within the area, and although studies have
suffered from methodological and definitional constraints the picture is now
becoming clearer (Mullen 1997). In the early 1980’s the prevailing view amongst
professionals was that having a mental illness did not carry with it any increased
risk of violence, a view that had also been supported by Monahan, the pre-
eminent researcher in the area. However, Monahan was forced to come to the
‘one conclusion I did not want to reach’, that there is a link between mental
illness and violence (1992). Studies have examined the level of violent and
offending behaviour amongst people with a mental illness, the level of mental
illness amongst offender populations, and community studies with the resultant
conclusion that mental illness is a risk factor for violence (Mullen 1997; Mulvey 1994; Torrey 1994). 4

Mullen (1997) argues that some of the reluctance to acknowledge this link has been based on the reasonable desire of researchers, mental health professionals and client/carer advocacy groups to try and counter the dominant media, and thus community image that all people with a mental illness are unstable violent individuals that are a risk to the community. A negative consequence of this approach however has been the tendency of mental health professionals to minimise or deny the experiences of families/carers when reporting violent or fear inducing behaviour, and the tendency of professionals to attribute violent/disruptive behaviour to nastiness or a personality disorder, rather than the potential symptoms of mental health relapse (Mullen 1997). Thus it is important to recognise the link between mental illness and violence, and also that this link is only apparent for particular sub-groups of people with a mental illness. These are primarily where there is co-occurring substance use, where the person is actively symptomatic particularly with delusions, and where the person has few social supports (Estroff et al 1994; Mullen 1997, Mulvey 1994).

This is backed up by a recent Melbourne study which matched people convicted with serious offences in the County and Supreme Courts between 1993 and 1995 with the Victorian Psychiatric Case Register which records all contacts with public psychiatric services (Wallace et al 1998). Prior psychiatric contact was found in 25% of the offenders but this was mostly accounted for by people with a personality disorder or substance misuse. Schizophrenia and affective disorders were also over-represented in the offender group but particularly where the person also had co-occurring substance misuse. However, clear

4 The most influential community study in looking at the link between mental illness and violence was the Epidemiological Catchment Area Survey conducted in the USA (Swanson et al 1990). This study which was based on self reports of violence found a clear link between respondents who reported violent acts in the past year and who also met the criteria for a mental illness. Furthermore, the study was influential in elucidating the link between substance abuse, mental illness and violence and has been the most important catalyst for the change in opinion regarding mental illness and violence (Mullen 1997).
evidence suggests that with adequate treatment and support targeted at these sub-groups of people with a mental illness, the risk of violence can be substantially reduced (Buchanan and David 1994; Dvoskin and Steadman 1994; Mullen 1997; Rice and Harris 1992). Furthermore, this link should not be seen as an argument for a return to greater confinement of people from within these sub-groups, as their rate of offending is not significantly higher than other demographic groups within the community at increased risk of offending, such as young males (Mullen 1992; Mullen 1997; Wallace et al 1998).

2.3 Mentally Disordered Offenders

Mentally disordered offenders can be seen to often constitute two broad groups. There is a group who commit serious, often violent and/or bizarre crimes that receive a lot of attention from the media, professionals and the wider community, and another group who repeatedly commit what can best be described as less serious social nuisance crimes (Prins 1993). However, it is important to note that people in both these groups will often exhibit threatening or fear inducing behaviour even if they haven't committed a crime (Mullen 1992).

In the Australian context it is difficult to determine exact prevalence rates of mental illness for offenders. The major study of prevalence of mental illness amongst prisoners in Australia was undertaken by Herrman et al (1991) on a sample of 189 (158 men, 31 women) prisoners from Victorian prisons. However, the sample did not include prisoners who were in the psychiatric unit of the prison, and is thus an indication of hidden or less serious mental illness, rather than the rate within the whole prison population. The study found 12 percent had a current diagnosis of mood disorder (mainly depression), and three percent a psychotic disorder. Lifetime diagnosis of mood disorders was 34 percent, psychotic disorders 6 percent, and an abuse/dependence on alcohol or other illicit substances 69 percent. Furthermore, the prisoners interviewed for
the study were matched against the Victorian Psychiatric Case Register to
determine their contact with treatment services prior to prison (Herrman et al
1994). Thirty four percent of the men and 61 percent of the women had
previously been in contact with treatment services, however 64 percent of these
contacts related to alcohol and drug treatment services.

Hurley and Dunne (1991) undertook a study of the prevalence of mental
disorder in women prisoners in Queensland. In the sample of 92 women it was
found 53 percent had a current diagnosis of mental disorder (mainly adjustment
disorder with depressed mood and personality disorders) and 54 percent had a
Another study of women in Victorian prisons found that within a sample of 55,
13 percent had a current mood disorder, seven percent had a current psychotic
disorder, 61 percent had a lifetime diagnosis of substance use disorder and five
percent had a dual disorder of serious mental illness and substance use
disorder (Denton 1994).

The inquiry in the Human Rights of People with Mental Illness (H.E.R.O.C.
1993) provides further anecdotal evidence on mentally disordered offenders in
the Australian context. Overall, the inquiry found that mentally disordered
offenders as a group experienced considerable disadvantage, with factors such
as few stable relationships or other social supports, repeated terms of
imprisonment, unemployment, poor education, homelessness and learning
difficulties being common.

Similar themes appeared in the demographic profile of mentally disordered
offenders that was developed as part of the needs assessment for the National
Mental Health Program Pilot project undertaken at VOSA (then Epistle Post
Release Service) in 1995 (Rose and James 1996). In a sample of 111 clients
who had been through the VOSA Forensic Psychiatric Program in its first three
years of operation, 76 percent had a diagnosis of schizophrenia, 68 percent had
previously served prison terms prior to their most recent contact with the justice
system, and 96 percent had been an inpatient in a psychiatric hospital one or more times previously. The average age was 33.7 years, most were single (71 percent) and the average level of education reached was Year Nine. Over 50 percent of the sample’s most recent offence was against the person, and over 70 percent had a history of violence against others. Around 80 percent had a history of alcohol and/or drug abuse/dependence, and over 50 percent had been living on the streets, in crisis accommodation, or rooming houses prior to their most recent offence and imprisonment/hospitalisation.

Studies of mentally disordered offenders in other countries present the same picture. The mentally disordered offender is often marginalised in the community prior to their detention and they have significant difficulty adjusting to life in the community following release with high recidivism rates being common. They tend to be characterised by having low education levels, few social supports or significant supportive relationships with family or friends, poor work histories and high rates of substance abuse (Draine et al 1994; Feder 1991a, 1991b; Lamb and Weinberger 1998; Russo 1994).

It is also clear that there is a significant link and overlap between mental illness, homelessness, substance misuse and offending, although the exact mechanisms of this relationship are unclear (Joseph 1997; Marshall 1998). For example, the Herrman et al (1989) study of 382 homeless people in Melbourne (homeless or marginally accommodated in crisis accommodation, rooming houses etc.) found 21 percent had a lifetime diagnosis of psychotic disorders, 25 percent mood disorders, and 49 percent substance related disorders. Herrman (1990) argues that in most cases it could be seen that the mental disorder had preceded the homelessness, and thus mental illness can be seen as a significant risk factor for homelessness. Furthermore, it can be seen that substance misuse often appears to precede psychotic mental disorder, (Marshall 1998), and that mental illness combined with substance misuse and homelessness all contribute to making people more prone to offending and detection of that offending (Joseph 1997). It is also clear that people in this
situation will experience difficulty in accessing treatment and support from what is often a fragmented service system, or more specifically being able to stay engaged with services (Herrman and Neil 1997). For example, McDermott and Pyet's (1993) Victorian study documented the difficulties of people with a dual disorder (mental illness and substance use) in gaining access to treatment and support services. Overall, it is clear that this group who are mentally ill, homeless or living in marginalised accommodation, who misuse substances, and who generally live chaotic lifestyles and are difficult to engage, present significant challenges for service provision in the community (The Sainsbury Centre for Mental Health 1998; Trieman 1997). Where the person is also prone to violence, offending and fear inducing behaviour, this difficulty is even further exacerbated.

### 2.4 Service Initiatives

In responding to the community based treatment and support needs of difficult to engage groups of people with a mental illness, models based on outreach have become the preferred option, and are of most relevance to the VOSA support program. The development of outreach based programs have largely stemmed from the development of the Training in Community Living (TCL) program by Stein and Test in the 1970's in Madison, Wisconsin (Stein 1992). This model consisted of outreach based multidisciplinary teams available 24 hours, seven days a week to work on individual programs with clients. A particular emphasis was placed on assisting the client to develop living skills such as cooking and shopping, and to assisting them to enter employment or other meaningful activities. The program was not time limited and had an ‘assertive’ component, in that staff would actively follow up clients who, for example, had not arrived for an appointment.
Since that time, many Assertive Community Treatment (ACT) programs (as they are now generally known) based on the original model have been developed, with a particular emphasis on service provision to high need groups such as the homeless mentally ill and dual disorder clients (Burns and Santos 1995; Deci et al 1995; Dixon et al 1995; Drake 1998; Drake et al 1998; McGrew et al 1995; Teague et al 1995). The model has also been the basis for outreach mental health treatment teams in Australia (Dharwadkar 1994; Hambridge and Rosen 1994) and for programs such as the Mobile Support and Treatment Teams (MSTT) that operate in Victoria. While the wide distribution of the model has meant considerable variation in the way it is delivered and concerns about effectiveness of the variations (Teague et al 1998), the assertive outreach model has been shown to be more effective than other forms of case management (Morse et al 1997). While most of the outcome studies of ACT have focussed on the capacity of the model to reduce rehospitalisation, the key component of the model appears to be its capacity to initially engage and retain clients in treatment and support, as opposed to traditional clinic/hospital based programs (Herinckx 1997).

While there has been considerable research into the use of ACT models of service to difficult to engage groups such as the homeless mentally ill, there has been relatively few reports where the model has been used specifically with mentally disordered offenders. Wilson et al (1995) describe a program of assertive case management for mentally disordered offenders in Canada which was based on an outreach model. The program aimed to assist the person to maintain contact with a range of treatment and support services in the community, and to directly assist the person in a range of areas such as administration of medication, nutrition, management of finances, personal hygiene and housing. The client was visited in prison prior to release, picked up from the prison on their day of release and then visited regularly by their workers. The model worked on a team approach rather than individual workers. Results of the program showed that during an 18 month follow-up period clients on the program had spent less days in prison than a comparison group not
receiving case management, and had also spent longer in the community before becoming involved in the criminal justice system. The authors contend that the key element of the model was the structured social support elements it provided and the capacity to link the client in to other social support structures in the community, which in turn then appeared to increase the clients likelihood of not re-offending.

A program with similar elements was conducted in Rhode Island, USA (Detrick and Stiepock 1992). The model was based on a 24 hour team approach to providing outreach based treatment and support to people with a mental illness who also had substance abuse and legal problems. Services were either provided directly by the team or staff advocated on behalf of the client to gain access to other services. A key component was also that when a client did become involved with the legal system the staff would provide support and advocacy throughout the legal process. An 18 month follow-up showed clients on the program had experienced a reduction in psychiatric hospital admissions, alcohol and drug detoxification, emergency service contacts and arrests.

In Britain, Cooke et al (1994) describe a small scale study that provided outreach based case management to a group of clients where the majority were mentally disordered offenders. The major finding of the project was that while only small gains were made in reducing re-offending, significant improvement was made in assisting clients to access services. It was found that agencies were more willing to accept clients who often had histories of significant problems with service utilisation, if they knew there was a team of case managers ready to back them up if necessary. The authors also argue that the study demonstrated that there is a small group of clients who appear like they will continue to offend to some degree whatever the level of support, and thus for these clients service provision can at best be crisis response driven, and targeted at supporting the person and advocating for their diversion to the mental health system. Furthermore, it is important with all mentally disordered
offenders to target interventions towards giving them “something to lose” by re-offending, that is, providing them with a reasonable alternative to prison.

Overall, it can be seen that there is general agreement with regard to the efficacy and desirability of assertive outreach based programs which try and meet the community support and treatment needs of difficult to engage people with a mental illness, particularly where there are multiple factors such as homelessness, substance misuse, and offending. In practice, the exact composition of these teams and how they should operate is still subject to debate. For example, there is debate concerning the efficacy of individual worker versus a team approach, multidisciplinary teams versus generic outreach workers, provision of all services within the team versus linkage to existing services, and placement of the team within existing statutory services versus placement in non-government agencies (Bond 1991; Ford et al 1995; The Sainsbury Centre for Mental Health 1998; Witheridge 1991). However, within the various approaches there are some key elements of assertive outreach programs that are similar. They include:

- Services are individually targeted to meet particular client needs.
- Services take account of the needs of the whole person, such as accommodation, finances, vocational/activity needs, as well as mental health treatment issues.
- Services are based on engaging the client in a strong support relationship.
- Some level of access to services are available 24 hours a day.
- Services are provided “where the client is”, such as their home or on the streets, rather than office based.
- Services are provided on a time-unlimited basis, with the recognition that some clients may require the service almost indefinitely.

(See Appendix 9 for further outline of the key components of assertive outreach models, and variations that have developed).
2.5 Relevance of the Literature

In summarising the literature, it can be seen that:

- The key mental health policy initiative in most Western countries has been a move towards community care of the mentally ill and the closure of large institutions.

- While community care has clearly provided improved conditions for most people with a mental illness, there is a small group who are difficult to engage in community based services and who are often characterised by multiple factors such as homelessness and substance abuse in addition to their mental illness. Where they are also prone to offending, violence, or fear inducing behaviour this increases the complexity of their situation and impacts on the capacity of service systems to respond effectively.

- The most influential service response developments for these difficult to engage groups are models based on Assertive Community Treatment, although there is considerable variation in how these models have been implemented, and their use with specifically offender based groups has not been widely reported.

The VOSA Forensic Psychiatric Program is based on an assertive outreach model. However it differs from Assertive Community Treatment approaches in that, for example, it is not a multidisciplinary team providing actual treatment, and it is based in a non-government agency rather than a statutory mental health service. The program is also targeted specifically at mentally disordered offenders who universally provide service provision dilemmas, and where there are few well developed models of community support and treatment. Furthermore, reported evaluations of programs targeted at difficult to engage mentally ill people have tended to focus on experimental designs with little detail on the actual day to day working of the model or key stakeholder perceptions. Thus, this evaluation (and the evaluation questions) are focussed on examining the model of support that has developed at VOSA, how the model appears to
assist or not assist clients, and clients, staff, and the service systems perceptions of the model.
CHAPTER 3

METHODODOLOGY

3.1 EVALUATION APPROACH

Current approaches to program evaluation within the health/welfare sector are the result of a process of continual development and change, which has mirrored epistemological and methodological debates concerning research in the wider social sciences. This is demonstrated in the development of approaches from early program evaluation based primarily on scientific experimental research designs, through to more recent developments such as “fourth generation” (Wadsworth 1997) and “fifth generation” (Fox 1997) approaches. These debates have also often centred on the juxtaposition between what was defined as the either quantitative or qualitative methods primarily used in the particular evaluation approach. However, it is now generally accepted that debates based primarily on the quantitative/qualitative divide are counter-productive, and that effective program evaluation will utilise a variety of approaches and methods (Greene 1994).

At the most basic level, choosing an evaluation approach will involve addressing issues such as why is the evaluation being undertaken, who is the evaluation being undertaken for, who will utilise the results, and who will actually undertake the day to day evaluation activities (Fox et al 1996a; Owen 1993; Patton 1997; Wadsworth 1997). The current evaluation was undertaken primarily for the interest of the agency and not necessarily for any external body (with the exception that it was also fulfilling the requirements of a thesis). The

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1 Fourth generation approaches can be seen as being explicitly value driven and collaborative in nature (Wadsworth 1997) while fifth generation approaches are an emerging body of approaches with an emphasis on “internal” evaluation, collaboration, negotiated meaning of outcomes and a general need to be cost effective given shrinking levels of funding (Fox 1997).
program had been operating for approximately five years with general feedback from clients and other agencies being positive. Thus the purpose of the evaluation could be seen as being to describe and document the development of the program to the current point in time, to determine if the program was meeting its primary objectives (as defined by the program staff), and to gain an understanding of the key stakeholders experience of the program. A secondary consideration of the evaluation was also that it could be used, if necessary, to justify current funding, or as a basis to seek further funding.

The evaluation approach taken was also influenced by several factors pertinent to the nature of the program and the way it has developed. These included:

- A scientific or quasi-scientific approach using methods such as control groups would have been inappropriate due to ethical difficulties of either not providing, or providing limited services, to a control group in a climate of very limited services. It would also be very difficult to recruit a large enough treatment and control group that could be validly compared, particularly given the range of different agencies and services the client group are involved with. Consequently any changes observed would be difficult to attribute to any particular agency or service. Similarly, the often chaotic and transient lifestyles lead by the client group would mean that retaining enough clients within treatment and control groups until completion of a study would be problematic.

- A purely objectives based evaluation would have been difficult because of the nature of the way the program has developed. At the commencement of the program there were no clearly stated program objectives with related outcome measures defined, thus measurement at this stage would have been impossible. What is clear is that the program staff had largely uniform views of what they saw as the current objectives of the program and what it was trying to achieve with the client group. Part of the evaluation process was to further clarify these objectives, and to determine to what extent they
were being realised, and to allow for the further formalisation of the objectives within the program in the future.

The evaluation was also primarily conducted by an internal agency employed staff member, although they were not directly employed in the program area that was evaluated (the researcher is VOSA’s Policy/Project Officer). This factor presented both benefits and limitations to the resultant evaluation, and clearly had an impact on the type of evaluation approach that was utilised, with some approaches being more clearly aligned with the concept of an “insider” as the evaluator.

Given the above factors, the evaluation approach utilised in the project was primarily based within the Evaluate Yourself evaluation framework developed by Fox et al (1996a;1996b) for self evaluation of mental health/alcohol and drug services. This approach emanates from what can be broadly seen as responsive evaluation models (Fox et al 1996b) or pluralistic evaluation models (Cheetham et al 1992). The project also utilised elements of the open inquiry approach to program evaluation (Wadsworth 1997), and the utilization-focussed evaluation approach of Patton (1997).

Fox et al (1996a) outline the key components of the Evaluate Yourself approach as being:

- The approach is based on the notion of the evaluation being undertaken by staff within the agency. The assumptions underlying this notion are that internal agency staff are informed observers of the agency’s operation, and often in the best position to produce a meaningful account of the overall program operation. This might also be seen as the development of ‘practice wisdom’.
- The approach emphasises the importance of collaboration in the evaluation process. Thus, it is important to engage all key parties such as clients, staff members, administrators, and policy makers in
the evaluation process, and at as many stages of the evaluation process as possible.

- Multiple methods of data collection are utilised to try and gain as complete a picture as possible of the program operation and service outcomes, and so that evaluation findings are confirmed by more than one source.
- Methods of data collection should fit comfortably with existing agency practice, and be easily collected so as to cause minimal disruption to the normal program operation.

Fox et al (1996a) contend that the Evaluate Yourself evaluation approach will not be suitable for all program types or agencies, with the following factors being optimal conditions for program self evaluation:

- Staff and client interests within the agency accord.
- Staff autonomy exists.
- There are reasonable levels of staff education and training.
- There is adequate communication and coordination within the agency.

Implicit in the self evaluation approach utilised in this project is the notion that the evaluator is not a value-free independent person dispassionately evaluating the program, as may be implied in some evaluation approaches. The necessity of an acknowledgment of the self, that is, a recognition of the particular values and biases the evaluator brings to the evaluation, is implicit in contemporary evaluation approaches (Greene 1994;1997). The current evaluation was undertaken by a researcher who is employed by the agency where the program has been developed. Furthermore, the researcher was previously employed in a direct practice capacity with an external agency which provided services to mentally disordered offenders and which incorporated regular contact and liaison with the VOSA Forensic Psychiatric Program. While exposure to the program from both an external and internal perspective over a number of years provides useful insights into its operation, it also necessarily follows that the
researcher will hold particular preconceived views about the program’s relative
worth and effectiveness. Given these factors, it must be stated that based on
this experience the evaluation was approached from a position of some belief in
the worth of the program as an intervention to meet the needs of mentally
disordered offenders but also through an interest in further service development
for this highly disadvantaged client group. This was balanced by other activities
to increase the validity of findings of the evaluation such as feedback from
program staff and other workers, and the supervision process.

3.2 STRENGTHS AND LIMITATIONS OF THE APPROACH

It can be argued that many human service program evaluations limit their value
by either attempting to evaluate outcomes without first adequately addressing
program implementation/process evaluation issues; or by having unrealistic
expectations about the extent to which scientifically based experimental designs
can represent meaningful outcomes within complex multi-faceted programs
(Moskowitz 1993). Thus, the evaluation approach taken in this thesis had to
firstly take account of the fact that a process evaluation of the actual
implementation and development of the program had not taken place (that is, to
document what the program actually does); and secondly, that the nature of the
target client group and the associated service development do not lend
themselves well to a more traditional experimental design evaluation approach.

The strengths of the chosen evaluation approach are:

- The Evaluate Yourself approach is congruent with the current status
  of the program. That is, the program has developed over a number of
  years to its current point with little formal documentation or elucidation
  of its underlying theories and philosophies or the model that has
  developed. Thus, the approach was suitable for documenting
  program development to this point, gaining an understanding of how
  the program functions, and examining areas for future development
and improvement. Furthermore, it fitted with the fact that the evaluation was agency driven rather than driven by the requirements of an external body.

- The approach is suited to the status of the researcher as an “insider”. That is, both the benefits and constraints of this status are acknowledged and used within the evaluation. For example, some clients were more willing to be interviewed because they knew the researcher from when he was involved in direct practice with them, however it is also recognised that this has the potential to influence the type of information the client would provide.

- The approach allowed for use of multiple methods that were not too overburdening of the program staff. Any approach that involved any significant increase in requirements from the staff with already high workloads would have been unlikely to have the support of the staff.

- The approach allowed for the viewpoint of key stakeholders to be incorporated, and in the case of the program staff, for them to have input into the framing of the evaluation questions, conduct of the evaluation, and the evaluation results.

The limitations of the chosen evaluation approach were:

- The “insider” status of the researcher and the fact that program staff had input into the framework for the evaluation clearly will carry with it certain biases. While this is congruent with the stated purpose of the evaluation, that is, primarily for internal agency purposes and program improvement, it would limit its perceived worth with some external bodies.

- The evaluation approach focused on the how and why rather than on quantification of phenomena. For example, in looking at how the program meets its stated objectives, the focus was on describing how the staff work to meet these objectives rather than quantifying the extent to which the objectives have been met. (ie. Case studies and reports from clients, program staff and external staff describe and
show how the staff work to keep clients out of the criminal justice system, but a quantification of recidivism rates for clients in the program as compared to other ex-offenders was beyond the scope of this evaluation). However, recommendations have been made as to how quantification of these factors could be incorporated into the program and further evaluations.

- Interviews with staff external to the program and the agency were conducted on the basis of program staff identifying people who they have had significant contact with in the course of their work. While the justification of this approach is that these staff were in the best position to be able to comment knowledgeably on the program, it is acknowledged that this may miss staff who, for example, had been unhappy with the services provided by the program and thus only used it minimally.

- Interviews with clients were subject to significant practical and ethical constraints. Thus, interviews were only undertaken with clients who were in contact with the program and whose worker had identified them as being mentally well enough to undertake the interview. It must be acknowledged that clients who fitted this criteria were likely to be well engaged with the program and thus likely to view it more positively than, say, a client who was becoming unstable or who had only had a short contact with the program before disengaging. A balance had to be made between the importance of getting at least some client input into the evaluation, and conversely taking account of the often complex and unstable situations the clients on the program experience.

- A substantial part of the evaluation involved examining written case records, and the normal limitations that apply to this form of data are acknowledged. That is, parts of the records will be based on information given to the worker from a variety of sources that can not be validated retrospectively, and that the notes provide a summary of the workers actions at a particular point in time, from their own
perspective. The multiple methods utilised in the evaluation help to overcome this limitation to some extent, as any findings drawn from the written case notes were also compared with findings from other sources such as interviews and the management information system.

3.3 Evaluation Questions

The evaluation questions were developed from examining the literature and through consultation with the program staff. The key evaluation questions were:

1. What is the model of support for mentally disordered offenders that has developed?

2. What are the specific components of the model?

3. To what extent does the program meet its general objectives (as perceived by program staff) for clients?
   Specifically, how does it work:
   (i) To support clients to remain out of the justice system.
   (ii) To assist clients to maintain contact with the mental health system.
   (iii) To improve the general quality of life of the client.

4. What are the clients’, staff, agency, and other agencies’ experience of the program?

5. What are the implications for further program development within this field?
3.4 METHODS

To adequately answer the evaluation questions, multiple methods and the use of triangulation in data analysis were utilised to increase validity of findings (Cheetham et al 1992; Fox et al 1996a; Huberman and Miles 1994; Waysman and Savaya 1997). Furthermore, given the ethical and practical constraints on collecting data directly from clients, wherever possible the use of unobtrusive methods (Kellehear 1993) and methods which fitted easily with current program operation (Fox et al 1996a) were utilised. For example, elucidation of the support model and its specific components was drawn from data collected through the case studies based on written files, which could be collected with minimal disruption to staff or clients of the program. These findings were cross checked and validity further developed through information drawn from interviews with clients, program staff, external staff and quantitative data contained in the program management information system.

The primary data collection and analysis activities were:

a) Management Information System data: A computerised management information system was developed and implemented in the VOSA Forensic Psychiatric Program in March 1996. The aim of developing the system was to collect data for the purposes of program monitoring requirements, and for ongoing evaluation activities. For the purposes of this evaluation, data collected in the period March 1996 through February 1998 were analysed. Data collected is in two broad areas, being background demographic data of clients who were on the program (116 support episodes), and worker contact details with clients, families and agencies (9169 contacts).

b) Case studies: Case studies on a sample of clients who had been through the program were conducted, based primarily on written case
records. The case studies aimed to examine the reason for the client’s referral to the program, how services were provided to the client, and what was the outcome for the client at the end of their contact with the program.

A total of 61 case studies were undertaken. A Microsoft Access database was developed for collection and organisation of the data from the case studies into broad categories. The data were then aggregated in these categories and pertinent themes and trends identified. For a more detailed outline of the categories and analysis methods used in the case studies see Appendix 7.

c) Key Informant Interviews: Key informant interviews were conducted with a range of program staff, clients, and staff of other agencies. These interviews focussed primarily on their experience of the program, perceived strengths and weaknesses, and suggestions for improvement. (See Appendices 1-3 for Interview schedules). The following provides a breakdown of the interviews conducted:

- **Program Staff**: The three current program workers were interviewed.
- **Clients**: Ten clients were interviewed. Clients selected for interview were identified by the outreach workers as being mentally well enough to undertake the interview with minimal chance of any negative consequence, as per ethical undertakings.
- **Staff of other agencies/programs**: Eighteen interviews with staff of other program areas and external agencies that have contact with the program. (See Appendix 8 for a breakdown of staff interviewed).

Staff interviews were tape recorded and then written up with a combination of direct transcript and summary. Client interviews were
not recorded, however notes were taken during the interviews and they were then written up the same day.

The interview summaries were then analysed for themes and trends.

d) *Historical Review and Operation of Program:* In addition to the above data collection, further activities aimed at documenting the history of the program development and general operational issues were undertaken. These included:

- Key informant interviews with the VOSA Executive Director and other VOSA staff instrumental in identifying the need for the program, and a staff person from an external agency who was a representative on the DEPTH committee through most of its operation (4 interviews).
- Examination of minutes from the DEPTH committee meetings which oversaw the early development of the program, and reports on the program to the VOSA Council.

e) *Advisory Group:* The original evaluation plan aimed to utilise the existing program staff as an advisory group to the evaluation that would meet regularly to oversee the evaluation. Work commitment constraints on behalf of both the researcher and the program staff during the evaluation period made regular meetings difficult. However, meetings were held in the formulation phase of the evaluation, and at major points during the evaluation for feedback from the staff. Considerable informal consultation with the individual staff concerning particular findings took place. Towards the completion of the evaluation, a focus group was also held with staff to present the preliminary findings of the evaluation, and feedback from this group was utilised in finalising the results of the evaluation.
The bulk of the data collection for the evaluation took place between August 1997 and May 1998. Figure 3.1 provides a summary of the evaluation process and main data collection activities.

3.5 Ethical Considerations

Ethics approval for the evaluation was granted by the University of Melbourne Human Research Ethics Committee (Approval No. 970030).

All staff and clients taking part in interviews signed a consent form after the nature of the project and how the data they provided would be used was explained to them. (See Appendix 4 and 5 for copies of the client and staff consent forms). Where necessary, identifying data not affecting the findings has been changed in this thesis to protect the anonymity of the contributor.

The program’s client group as a whole are a particularly disadvantaged and vulnerable group, and any research involving them presents considerable ethical dilemmas. As English (1997) argues, evaluation activities with disadvantaged groups can easily jeopardise their well being or cause undue stress if their involvement in the project is not carefully thought out. Thus, particular emphasis was placed on ethical considerations concerning the use of the written client case records and client interviews.

Written Case Records

Data collected from the case records included background demographic information, and then information in broad theme areas such as what type of activities the worker undertook with the client. The information was entered into a computer database with only a code number identifying the record. All records were then combined together in broad areas and themes identified across all the records, thus ensuring that identification of a specific client’s information would be very difficult.
Figure 3.1 Evaluation Process

- Consultation with Program staff concerning scope of evaluation
- Development of Evaluation questions and proposal

Data Collection

- Program Management Information System
  - Client Data
  - Contact Data
- Interviews
  - Program Staff
  - Clients
  - External Program/Agency Staff
- Case Studies
  - Examination of written case records
  - Supplementary information from staff
- Other Data
  - Minutes of meetings
  - Historical program records
  - Ongoing consultation with staff
  - Policy Documents

Data Analysis and consultation with staff

Write-up and answering evaluation questions
**Direct Client Contact:**

Direct contact with clients in the form of interview for the purposes of the evaluation needed to be carefully undertaken, with consideration given to ensuring that the nature of the contact was fully understood, and that any potential negative consequences of the contact were minimised. Thus a guiding principle in undertaking the evaluation was that at all times the welfare of the client would be paramount over the research/evaluation process, even where this potentially placed limitations on the validity of the results. (eg. only interviewing clients deemed to be mentally well enough by their support worker, rather than a random sample of clients who had been through the program). Specific strategies that were employed to minimise potential harm to clients through the evaluation process included:

- Liaison with the clients support worker to ensure that their current mental state was likely to mean that they would be able to understand the consent process and be able to undertake an interview.

- Ensuring that should a client become distressed by the evaluation activities that appropriate measures were taken to minimise potential harm and manage the situation (eg. liaison with treatment and support staff).

- The researcher had previous research interviewing experience with this group (Rose and James 1996), and direct practice experience with the client group. Thus, he was well placed to assess if evaluation activities were proving distressing to a client, and consequently able to provide appropriate management of the situation if necessary.

- Clients were offered a copy of data collected from their individual interviews for review and comment.
CHAPTER 4

PROGRAM HISTORY & CURRENT CONTEXT

This chapter presents an outline of the Forensic Psychiatric Program’s history and development and its current operational context including the policy and legislative framework and its position within the service delivery system. This chapter is based primarily on data collected from interviews and discussions with agency and external staff, and written program records such as reports of the outreach worker to committee meetings.

4.1 AGENCY CONTEXT

VOSA was established in Victoria in 1983 by Stan McCormack as The Epistle Centre. Stan was an ex prisoner who, while in prison, had attended Salvation Army bible study classes. Part of his role in the bible classes was to produce a magazine called “The Epistle” for all prisoners in Victoria who attended the bible study classes. Following his release he continued to edit the magazine, but also found he was being contacted by several other ex-prisoners and gradually a support network was developed by Stan McCormack with assistance from several volunteers. It was recognised that to be effective in meeting the needs of people just released from prison, funding would be required and a more formal structure with input from people working in the criminal justice system would be necessary to provide support and advice. Thus, the agency was formed and given the name “Epistle” from the magazine as it was well recognised amongst prisoners in Victoria.

In June of 1984 the Epistle Centre was incorporated and a Council consisting of a Supreme Court Judge, prison chaplains, a lecturer in legal studies, a social worker and representatives of the business community was formed to oversee
the operation of the agency. The Epistle Centre operated as a drop in centre staffed largely by volunteers until 1987 when it received its first substantial government funding in the form of SAAP funding to set up a half-way house. McCormack House was established as a 13 bed supported accommodation for people just released from prison, and allowed the agency to employ support staff. Furthermore, it allowed a change in focus for the agency because, by providing accommodation immediately following release, it meant support could be planned, rather than the chaos and crisis driven activities that were often associated with the drop in centre. Around this time a full time administrator was also appointed to manage the service (later to become the Executive Director).

During the early 1990’s the agency received funding to commence establishment of its Intellectual Disability Program and Forensic Psychiatric Program, and more recently Employment Programs and the VOSA COATS alcohol and drug assessment program. While the agency has continued to provide the McCormack House program, its expansion has come primarily through funding for special needs groups of offenders such as those with a disability.

The agency changed its name to The Victorian Offender Support Agency Inc. (VOSA) in 1996. As of 1998, VOSA is the largest offender support agency in Victoria, and employs 120 full and part-time staff from a range of health/welfare professions across five program areas, one of which is the Forensic Psychiatric Program. (See Fig. 4.1 VOSA Organisational Chart). Each program area has a Program Manager who is responsible to the Executive Director. The Executive Director is responsible to the VOSA Council, which continues to be made up of representatives from the Judiciary, academia, health/welfare and business, with the President of the Council being Justice Alastair Nicholson, Chief Justice of the Family Law Court of Australia. All VOSA programs are funded by either Commonwealth or State Government sources.
Figure 4.1 VOSA Organisational Chart
4.2 Development of the VOSA Forensic Psychiatric Program

The Forensic Psychiatric Program’s origins can be traced back to several events that occurred in the late 1980’s and early 1990’s. These included the experience of McCormack House staff in attempting to meet the needs of ex-prisoners with a psychiatric disability, the establishment of the Disadvantaged Ex-prisoners with Psychiatric Disabilities Targeting Homelessness (DEPTH) Committee, the funding of research into the post release accommodation and support needs of ex-offenders with psychiatric disability, and the Inquiry into Mental Disturbance and Community Safety.

The McCormack House Experience

In the first two years operation of the McCormack House service, a re-occurring issue was difficulty in meeting the needs of ex-prisoners who had a psychiatric disability. Over this period 85 of the 255 residents who went through the house had recently received psychiatric services. This presented significant difficulties for the staff who generally were not experienced in dealing with psychiatric disability.

Staff were having quite a few problems in dealing with this group because we had no expertise in the area... We didn't have the knowledge or the background or authority to deal with medication yet we had people in our house who unless they took their medication there were quite ongoing ramifications to it- the fact that they could become destabilised and violent... And the other thing that was difficult was the fact that when it came to move people on, we couldn't move them on anywhere, because the mainstream psych institutions, as soon as you said someone was an ex-offender and had a psych disability they didn't want to know. (House Manager)

Initial efforts to address this issue involved Epistle staff approaching the Director of Forensic Psychiatry Services about their concerns. The Director was similarly concerned, especially as McCormack was continuing to accommodate a significant number of Forensic Psychiatry’s clients following release, and an interim measure was arranged whereby a psychiatric nurse and psychiatric...
registrar visited McCormack House once a week to act as consultants to the staff and to assess clients' progress. This arrangement also laid the foundation for the development of the DEPTH committee.

**The DEPTH Committee**
Following approaches to Forensic Psychiatry a committee was gradually formed to look at the post release needs of ex-prisoners with a psychiatric disability. Of note was the fact that Epistle had also been approached at this time by the Director of Richmond Fellowship (a generalist mental health accommodation and support agency) because of this agency’s concern over not being able to adequately support clients with a forensic history in their generalist mental health programs. The Committee initially consisted of the Administrator of Epistle, the Director of Richmond Fellowship, the Director of Community Corrections, the Manager of the Forensic Health Service and the Senior Social Worker of Forensic Psychiatry Services. The Committee later sought wider representation from both government and non-government agencies involved in the care of ex-prisoners with a psychiatric disability and became known as the Disadvantaged Ex-prisoners with Psychiatric Disabilities Targeting Homelessness (DEPTH) Committee. The key goal the committee set itself was to secure funding for a supported accommodation service with 24 hour staffing for the client group. To this end a submission was put into the Office of Psychiatric Services in December 1989 for such a facility.

**The Inquiry into Mental Disturbance and Community Safety**
The Inquiry into Mental Disturbance and Community Safety commenced in June 1989, with the brief to examine options to deal with people with severe personality disorders who present a danger to the community (with specific reference to the case of Gary David¹). The Inquiry highlighted the issues surrounding community support for people with a mental illness and offending

¹ Gary David was a prisoner with a severe personality disorder who had presented significant management and placement difficulties for correctional and health staff while he was in prison. Furthermore, he had made a range of specific threats as to what he would do to other people following his release, which prompted widespread debate on whether he (and others like him) should be detained indefinitely for the protection of the community.
history, which was beneficial to the aims of the DEPTH committee in their efforts to advocate for increased funding. Furthermore, the committee had submitted a copy of their proposed model of supported accommodation for people with a mental illness to the Inquiry as a suggested model for supporting people with a severe personality disorder. In the 1990 Interim Report of the Inquiry (Social Development Committee 1990:87) the proposed model was discussed favourably and appears as an appendix to the report. The Report states:

*The Committee has noted that non-government agencies are leading the way in developing a range of supported accommodation options for disturbed offenders. The Committee urges that the expertise and knowledge of non-government agencies be utilised in the development of appropriate programs.*

**Research Project**

In 1990 the Forensic Health Service was able to secure funding for a small research project to examine the accommodation and support needs of ex-offenders with a psychiatric disability. The project was based on interviews with a number of community agencies concerning their capacity to meet the needs of the client group, and on profiles and interviews with people currently in prison and hospital concerning their post release support and accommodation needs. The report of the project (Lancefield 1990) identified significant constraints on the ability of mentally ill people released from prison to secure supported accommodation. Problems included:

- The nature of the client group precluded them from many generalist mental health support services (ie. because of offending history, substance abuse etc.)
- Clients in custody were unable to participate in the referral process required by many agencies (such as visiting the facilities etc) and agencies didn’t have the resources to conduct in-prison assessments.
- Many agencies had waiting lists and/or were not able to “hold” a place which precluded prisoners who would be released on parole or other orders requiring pre-arranged accommodation.
A specialised supported accommodation facility was proposed, with the following key elements being crucial:

- The accommodation must be stable, secure and affordable and provide transitional accommodation until longer term arrangements could be made. The facility would need to be flexible enough to provide accommodation on short notice following unplanned releases.
- The service would need to be able to provide outreach support by establishing a relationship with the client prior to their release and then continuing the support until they stabilise in longer term accommodation.
- The service would need to have a community education and liaison role which could educate and support mainstream providers concerning forensic issues.

Establishment of the Program

The above factors all played a part in the overall attempt to secure funding for a specialised service for the client group. The original submission put to the Government in late 1989 for a supported accommodation facility had the following key objectives:

1. To provide transitional supported accommodation, advocacy and programs to ex-offenders with psychiatric disabilities.
2. To assist clients in accessing mainstream psychiatric services on an ongoing basis.
3. To endeavour to reduce the risk of clients re-offending.
4. To promote an understanding of the needs of ex-offenders with psychiatric disabilities within the community.

Funding of the proposal was recommended by the region, however it coincided with a period of significant financial difficulty for the Victorian State Government, and funding of all major new initiatives ceased. Pressure for funding was continued through deputations to the Minister of Health and through the Forensic Health Service. Finally in late 1991 the Forensic Health Service was
able to propose the funding of an outreach worker position as the first phase towards the establishment of a dedicated half way house, and this was accepted by the Minister. The worker was to assist clients in the transition from prison to the community, and in essence to strive for the objectives of the original proposed program as outlined above, with the obvious constraints of not having any dedicated accommodation facilities. The worker commenced in January 1992 and a mechanism whereby the worker reported to the DEPTH committee on a regular basis was set up. Key milestones in the development of the program to its current state are provided in Appendix 6.

The DEPTH committee continued to play an active role in overseeing the program for the first few years of its operation, and continued to attempt to secure funding for a supported accommodation facility. However from around 1995 the committee ceased to operate. The committee was seen to have been crucial in the early phases of the program in providing an avenue for linkage and liaison between the various agencies, and in helping to foster support for the program within the various agencies. It was generally felt that the abandonment of the committee was part of a natural process, in that the program was well established and had also gained a level of acceptance within the key agencies. In addition, key personnel with a commitment to the committee and development of services for the client group had also moved on to other areas. Nevertheless, the committee provided a unique example of co-operation and collaboration between the government and non-government sector.
4.3 CURRENT OPERATION

The following section provides a brief overview of the current operation of the program.

Staffing
The program currently consists of three positions (a Program Manager and two outreach workers). The Program Manager is responsible for overseeing the program, screening all new referrals for suitability, and also carries a caseload. One of the two outreach positions is primarily responsible for supporting clients in the program flats, but has additional clients on their caseload. All outreach staff are experienced Registered Psychiatric Nurses, as have been all previous staff in the positions. Each worker carries a caseload of 10-15 clients dependent on the needs of particular clients. The program also has significant input from the VOSA Disability Employment Program, which from 1995 was equivalent to a half time worker, and more recently equivalent to a full time position. The Disability Employment Program prepares clients for employment, assists them to find employment and then supports them in the workplace.

Resources
Accommodation resources available to the program include:

- Two group homes (two bedroom and three bedroom).
- Six one bedroom flats for individual clients.
- Access to three beds in McCormack House for clients with a well managed mental illness.
- Access to a number of beds in the Yarra Housing Group.

Given the nature of the outreach work, all staff are provided with a vehicle, a pager, and a mobile phone for communication purposes. The staff are based at the VOSA main office in West Melbourne, and are provided with administrative support from the VOSA Administration and Policy Unit located there.
**Funding**
The program is funded by a combination of Commonwealth and State Government funding directed through the Victorian Department of Human Services. The current annual funding is $142078.

**Eligibility Criteria**
Clients are accepted into the program if they meet the following criteria:
- They must have a history of being treated for a psychiatric illness.
- They must have a forensic history (ie. have had a recent and significant contact with the criminal justice system).
- They must be homeless or at risk of homelessness.

In practice, if a client fits the above criteria and is being referred from a forensic facility (eg. prison or secure hospital) they will always be accepted into the program.

**Catchment**
The program is designated as a statewide program, however in practice its activities are mostly confined to the Melbourne metropolitan area.

**Referral Process**
Clients are referred to the program from a variety of sources although the majority are in either prison or hospital at the time of referral. If a referral is deemed suitable for the program the referring agency completes a referral form outlining the client's background and needs. The client is visited by the Program Manager and introduced to the program while being given an opportunity to discuss their accommodation and support needs. An outreach worker is then assigned and will normally visit the client several times prior to their discharge from prison/hospital.
Support Work
The outreach worker provides ongoing support via a range of activities with the client (this is discussed in detail in later chapters). Individual Management Plans are now produced in consultation with each client which outline their goals and how these will be achieved. Clients’ involvement with the program is voluntary and not time limited.

Monitoring
The program now routinely collects data on contacts and client demographics, and this data is utilised for the specific reporting requirements to both Commonwealth and State Government departments on a quarterly basis.

4.4 The Service System

Mentally disordered offenders are often characterised by their involvement with a number of agencies, and thus in examining the VOSA Forensic Psychiatric Program it is important to have an understanding of the wider service system context. The service system has recently undergone significant change as Government policy on the provision of services has changed, and this has been no more apparent than in the prison system where a move towards privatisation of services has taken place. Furthermore, Forensic Psychiatry Services, which was a section of the Department of Human Services which provided the bulk of services to people with a mental illness in the criminal justice system, has recently been corporatised and will act as an independent body.2

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2 Forensic Psychiatry Services has now been renamed the Victorian Institute of Forensic Mental Health- to be known as Forensicare. The new organisation was launched in September, 1998.
Prison Based Services:

The primary entry into the forensic psychiatric system is via the Acute Assessment Unit (AAU) which is located at the Metropolitan Assessment Prison (MAP). All prisoners entering the system are initially assessed at MAP, and if a mental health issues is identified, they will be transferred to the AAU for further psychiatric assessment. The AAU, which is operated by health staff from Forensic Psychiatry Services, is intended for short term assessment only and prisoners are transferred to other prison based psychiatric services, secure hospitals or back into mainstream prison following assessment. The other main psychiatric unit in the prison system is the St Paul’s Psycho-Social Unit (PSU) at the privately run Port Phillip Prison. This is a longer term rehabilitation unit for people with a mental illness who do not require hospitalisation and its operation is currently contracted to St Vincent’s Hospital. There are also mental health professionals who provide sessional services in all prisons in Victoria. Until the closure of Pentridge Prison in 1997, the AAU and PSU were co-located as G Division and operated by Forensic Psychiatry Services.

Secure Hospitals:

The main secure hospital in Victoria is Rosanna Forensic Psychiatry Centre which is operated by Forensic Psychiatry Services. Until recently there was also the Ararat Forensic Psychiatry Centre, which has now closed and the beds temporarily transferred to the Ellery Unit, which is close to the Rosanna service. Both these services will be replaced by the Institute of Forensic Mental Health planned to open in early 1999 on the site of the old Fairfield Hospital. This purpose built unit will have 120 beds and will be operated by the corporatised Forensic Psychiatry Services. Secure hospitals provide services to people transferred from prison because they require hospital based mental health treatment, people on hospital orders (ie. where the court orders the equivalent of a term of imprisonment, to be served in hospital) and people who are detained at the Governor’s Pleasure (ie. people found Not Guilty by reason of insanity).
Community Forensic Services

Forensic Psychiatry Services operate the Brunswick Road Clinic, which provides follow up treatment services for clients discharged from forensic facilities such as prison and secure hospitals. The clinic mainly treats clients who have difficulty maintaining contact with general community mental health clinics, or where the nature of their previous offences, mean they require specialist services. Currently, there are no Forensic Crisis Assessment Teams or Mobile Support and Treatment Teams, so where clients require these services the mainstream services are utilised. The Clinic has been gradually introducing a case management model for all clients, which is likely to be further enhanced as Forensic Psychiatry Services is re-developed. 3

The Community Sector

Following release from prison or hospital, clients are often in contact with a variety of agencies in addition to specialist forensic services. These include the full range of community health and welfare providers such as accommodation services, material aid services, activity/vocational programs, alcohol and drug treatment services and employment assistance programs. Some clients are subject to ongoing orders such as parole which require them to regularly attend Community Correctional Services. Furthermore, some clients are subject to Administration Orders which means their finances are managed by a service such as State Trustees. What is clear is that with the range of treatment and support services clients are often involved in, close liaison and co-ordination between agencies is essential if effective services are to be provided to the client.

Pathways through the System

Figure 4.2 provides an outline of typical pathways through the service system. In practice, clients usually enter the system by being assessed in the AAU as needing mental health services and then being transferred to the appropriate

3 A recent review (June 1998) of the services of the Brunswick Road Community Forensic Psychiatry Services has recommended the development of a Forensic Mobile Support and Treatment Team which has been accepted and will be developed towards the end of 1998.
Figure 3. Typical Pathways Through The Service System

1 Until mid 1997, AAU and PSU were co-located as G Division, Metropolitan Reception Prison.
2 Until early 1998, Secure hospitals consisted of Rosanna and Ararat Forensic Psychiatry Centres.
unit, or receiving a hospital order and being transferred directly to the secure hospital. It is also common during the course of a sentence for people with a mental illness to be transferred between the prison based psychiatric units, the secure hospital and mainstream prison, depending on their mental state, and discharge could take place from any of these locations. It should also be noted that in the context of the VOSA program, a significant proportion of referrals come from general psychiatric hospitals where people with a significant forensic history but not currently under any sort of criminal justice order have been admitted due to their mental state.

4.5 Summary

This chapter has provided an overview of the program’s history and development, and its current operating context. Key points include:

- The need for a program to meet the accommodation and support needs of ex-prisoners with a psychiatric disability was identified through the operation of VOSA's McCormack House transitional accommodation program. The move to establish a program was born from the development of the DEPTH committee which was a multi-agency (both government and non-government) committee set up in the late 1980’s to secure funding and service development for the client group.

- Initial efforts of the DEPTH committee were focussed on securing funding for a dedicated supported accommodation facility with 24 hour staffing. While there was strong support for this idea, government funding constraints meant it could not be funded. As an initial basis for later development of an accommodation facility, an outreach support worker position was funded. While the supported accommodation facility was never funded, the program based on a outreach support basis continued to expand, based on the same general aims and objectives as envisioned for the supported
accommodation facility (ie. to assist in the transition from prison to the community, to assist the client to maintain contact with mental health services, to support the client to minimise risk of re-offending etc.).

- It can be seen that the agency itself began as a “grassroots” organisation on basically a self help model whereby an ex-prisoner identified the need for a post release support service and started to mobilise the support of other ex-prisoners and other people within the community to develop a service. While the agency’s current manifestation as primarily professionally staffed with full government funding is clearly very different to its early beginnings, the nature of the early development can still be seen to play a part in its current underlying philosophy and practice. For example, as will be discussed further in other parts of the thesis, within the Forensic Psychiatric Program the support worker often assumes very clearly a professional role, but is also often seen as a “friend” to the client.

- From the initial establishment of the one outreach worker position in January 1992, the program has grown to three support worker positions, a number of flats and group homes, and access to a disability employment worker. The program continues to operate in a rapidly changing service system which requires extensive contacts with a range of agencies, both institutional and community based.
CHAPTER 5

PROGRAM DATA

This chapter will provide an overview of the program’s operation through examining data from the program management information system. The system was implemented in March 1996, and data for the two year period to February 1998 is examined. This includes background data on the 116 clients who received support services from the program, and the 9169 worker contacts that took place in the two year period.

5.1 DATA COLLECTION

Client background data is compiled when clients first enter the program. Information is drawn from a detailed referral form completed by the referring agency, and from the workers initial contact with the client. The worker then completes a data sheet which includes background demographic information (eg. age, country of birth, education level, employment status), mental health information (eg. diagnosis, number of previous hospital admissions, concurrent substance abuse), legal information (eg. current legal status, most recent offence, number of previous imprisonments), and program contact details (eg. source of referral, date support commenced/finished, outcome of support episode).

Worker contact details are also collected. The workers record all significant client related contacts on a summary sheet. Information collected includes the method of contact (eg. direct or telephone), the duration of the contact, the nature of the contact (eg. emotional support, practical assistance, advocacy) and who the contact was with (eg. client, family, agency). All data is entered into a Microsoft Access database which then allows for a range of reports to be produced.
5.2 CLIENT DATA

Demographic Profile
Table 5.1 (overleaf) presents background demographic data on clients who have been through the program in the two year period. As can be seen, the majority of clients were male (97%), with an average age of 33 years, and single (71%). Most had reached lower (14%) or middle (55%) level secondary school and the majority were unemployed (93%) and receiving income from a Disability Support Pension (75%).

Mental Health
Diagnosis
The majority of clients had a primary diagnosis of schizophrenia (75%), with affective disorders (10%), and personality disorders (13%) also making up a proportion (Note: Does not equal 100% as some clients had a primary diagnosis in 2 categories). Figure 5.1 provides details of clients previous admissions to psychiatric hospitals. While 10% have never had an admission to psychiatric hospital, 47% have had 5 or more previous admissions.
<table>
<thead>
<tr>
<th>Table 5.1 Client Demographic Profile (n=116)</th>
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<tbody>
<tr>
<td><strong>Sex</strong></td>
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<tr>
<td>Male</td>
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<tr>
<td>Female</td>
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<tr>
<td>97%</td>
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<td>3%</td>
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<td><strong>Age</strong></td>
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<td>Mean</td>
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<td>67 years</td>
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<tr>
<td><strong>Marital Status</strong></td>
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<td>Divorced/separated</td>
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<td>Married/defacto</td>
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<td>Widowed</td>
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<tr>
<td>71%</td>
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<td>24%</td>
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<td>3%</td>
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<td>2%</td>
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<tr>
<td><strong>Number of Children</strong></td>
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<td>Three</td>
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<td>Six</td>
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<td>5%</td>
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<tr>
<td><strong>Employment Status</strong></td>
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<td>Part time/casual</td>
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<td>1%</td>
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<td>4%</td>
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<td>1%</td>
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<tr>
<td><strong>Primary Income</strong></td>
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<td>Disability Pension</td>
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<td>Employment</td>
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<tr>
<td>Other</td>
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<tr>
<td>75%</td>
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<td>11%</td>
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<td><strong>Education (n=99)</strong></td>
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<td>Grade 6 or less</td>
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<td>Years 7 to 8</td>
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<td>Years 9 to 10</td>
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</tr>
<tr>
<td>Vietnam</td>
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<tr>
<td>Iraq</td>
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<tr>
<td>Mauritius</td>
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<td>Turkey</td>
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<tr>
<td>Nine others</td>
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<td>84%</td>
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<td>2%</td>
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<td>&lt;1%</td>
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</table>
Community Treatment Services

Figure 5.2 presents data on where clients were receiving community based treatment for their mental illness. The data indicates that most (50%) of the clients were receiving treatment from the Brunswick Road Clinic (Community Forensic Psychiatry Services) followed by Community Mental Health Centres (39%).

![Figure 5.2 Community Treatment (n=98)](chart)

**Figure 5.2 Community Treatment (n=98)**

- CMHC= Community Mental Health Centre
- BRC= Community Forensic Psychiatry Services
- MSTT= Mobile Support and Treatment Team

Alcohol and Drug Use

The group of clients was also characterised by dual substance use issues. At the time of entry to the program 37% were consuming alcohol and 23% other drugs at a level likely to be problematic, while in the past 73% had problematic alcohol consumption and 77% problematic use of other drugs. (Note: Current substance use is based on the client’s situation soon after entering the program, which for a large proportion is at the time of their release from institutions where their access to alcohol and drugs is limited. Thus the extent of substance misuse within the group is potentially higher, especially given the groups general substance use history).
**Self Harm**

Thirty three percent of the clients had a history of self harm, either through suicide attempts or self mutilation.

**Mental Health Orders**

Twenty two percent of the clients were subject to some form of mental health order when they entered the program. This included 11 clients on a Community Treatment Order (CTO), 4 clients on a Restricted Community Treatment Order (RCTO), 8 clients on hospital leave and 2 on Governors’ Pleasure orders.

**Legal**

**Most Recent Offence**

Figure 5.3 presents the most recent primary offence for clients entering the program. As can be seen, the majority of clients had committed offences against the person, including homicide (4%), other person (52%) which includes offences such as assault and armed robbery, and sex related offences (10%). A significant proportion of the clients had also committed multiple offences although the graph only represents the primary offence.

![Figure 5.3 Most Recent Primary Offence (n=115)](image)

Homicide- includes murder, manslaughter
Other Person- includes assault, robbery
Property- includes burglary, theft
Other property- includes arson, criminal damage
Sex related- includes rape, indecent assault.
Breach orders- includes breach of intervention orders.
Prison Terms
While 12 percent of the clients had never been in prison, a significant proportion (42%) had served from 2 to 4 terms of imprisonment. Furthermore, 16 percent had served 5 or more terms of imprisonment. (See Figure 5.4).

![Figure 5.4 Number of Prison Terms](image)

Legal Orders
Several of the clients were also subject to ongoing legal orders when they entered the program. Of the 116 clients, 4 were on bail, 11 were on a Community Based Order (CBO) or Intensive Correction Order (ICO), one was on a Good Behaviour Bond, and 26 were on Parole.

Violence
Of the 109 clients where information on history of violence was recorded, 81 percent had a history of violence. This figure is an indication of those clients where there was a significant history of acts of violence, either through current behaviour, previous offences, or reports from workers or significant others. While this is likely to be a more valid indication of levels of violence within the group than reported offences involving violence (for example, violence against family members is reported, but not to police with the result of formal charges) the figures should be treated with caution as they are not limited to any
particular timeframe (eg. a client may have perpetrated a violent act several years ago while mentally unwell, but be quite different in their behaviour now).

**Accommodation**

Accommodation at the time of referral for most clients was prison (40%), psychiatric hospital (including Forensic Hospitals) (48%), and in boarding houses (6%).

Figure 5.5 presents data on clients’ discharge accommodation, that is, where they went to live following discharge from either prison or hospital where most of them were at the time of referral. Most clients were discharged to live in either residential support (26%), boarding houses (23%), or private housing (16%). Most of the clients who were living in the residential support were accommodated at VOSA’s McCormack House which often appears to be used as transitional accommodation when no other suitable accommodation can be located.

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**Fig. 5.5 Discharge Accommodation (n=116)**

Private consists of mainly private rental or living with family such as parents. Residential support is accommodation that includes a staffed support component. Not Applicable relates to clients that entered the program but were not discharged or were initially referred while living in the community.
5.3 Program Data

Source of Referral

Figure 5.6 provides information on the source of referrals to the program. As would be expected given the program’s referral criteria, most referrals came from the Forensic Psychiatry Service’s secure hospitals and prison unit (G Division 31%, Rosanna Forensic Psychiatry Centre 24%, Ararat Forensic Psychiatry Centre 8%). However, a significant proportion of referrals (16%) have also come from a range of general psychiatric hospitals where a client with a significant forensic history has been admitted due to their mental health. There has only been a relatively small number of referrals from the Port Phillip Prison and MAP/AAU mental health units, however both units have only been operating since 1997.

Fig. 5.6 Source of Referral (n=116)

CCO- Community Corrections Officer
CMHC- Community Mental Health Centre
MAP/AAU- Melbourne Assessment Prison, Acute Assessment Unit
BRC- Brunswick Road Community Forensic Psychiatry Clinic.
Contacts

During the two year period being examined, the program outreach workers recorded 9169 contacts. These contacts consisted of 5894 direct contacts and 3275 contacts by telephone. Figure 5.7 provides a breakdown of who the contacts were with. Fifty percent of the contacts were with the client only, and 35 percent were with agencies. A further eight percent were dual contacts with both the client and an agency. Contacts with families alone (4%) and clients and families together (1%) made up a small proportion of the total contacts.

Nature of Contacts

Figure 5.8 provides a summary of what the contacts actually involved. The outreach workers categorise each contact into a category of service, which while necessarily broad, provide a indication of what type of work is being undertaken. For example, emotional support would include activities such as counselling, having a chat over coffee and so on, while practical assistance would include activities such as assisting the client with budgeting or obtaining a food parcel. Education/information provision includes providing information to
clients on services and psychoeducation about mental illness and medication, and also consultation to agencies concerning particular clients or how to deal with the client group generally. The greatest proportion of contacts involved education/information provision (36%), emotional support (29%) and practical assistance (27%). Less contacts involved advocacy with other agencies (5%), crisis intervention (2%) and justice support (0.5%) which relates to workers supporting the client if they become re-involved with the criminal justice system.

Figure 5.9 provides a breakdown of the three most common types of contact (emotional support, practical assistance, education/information) by who the contact was with. While clients were the recipients of most of the emotional support contacts (77%) and of the practical assistance contacts (75%), agencies were by far the most often recipient of education/information contacts, although clients also made up a significant proportion (agencies 58%, clients 28%, client & agency 8%). This appears to indicate that an important element of the outreach workers role is providing information, education and liaison to other agencies, as well as direct client assistance.

![Figure 5.8 Nature of Contact (n=12465)](image_url)
**Agency Contacts**

Figure 5.10 provides a summary of which agencies the program contacts were with. As can be seen, there is broad range of agencies that the workers are required to have contact with in meeting the multiple needs of the clients.

Other category consists of agencies coded as “other” by workers and 7 other agencies which made up 1 or less percent of total contacts.
However, as would be expected given the nature of the client group, a large proportion of the agency contacts were with accommodation providers (22%) and Community Forensic Psychiatry Services (16%), where a significant proportion of clients have their follow up mental health treatment.

**Duration of Contacts**

Figure 5.11 provides details of the duration of contacts. A large proportion of the contacts are 30 minutes or less (59%), with a further 24 percent being between 30 to 60 minutes. Conversely, 3 percent of the contacts were 2 hours or longer.

![Fig. 5.11 Duration of Contacts (n=9169)](chart)

**Period of Support**

Figure 5.12 presents data on client's period of support from the program. Thirty six clients were currently receiving support at the end of the data period (February 1998) and during the period 80 clients had been supported and then exited the program.

The current clients (36) were characterised by a core group who have been supported by the program for several years. Nine (25%) of these clients had been in the program for over three years, with the maximum being over five and a half years. A further 12 (33%) clients had been in the program for one to three
years, with the balance of clients with less than one year in the program being recent entrants.

Conversely, the exited clients (80) were characterised by shorter periods of support. Thirty five (44%) of these clients were in contact with the program for less than three months, with a further 13 clients (16%) in contact between three and six months. These clients who were in shorter periods of contact with the program tended to be clients who were supported for a period while they were in hospital or prison and then did not receive any community based support from the program (eg. they were not discharged or discharged to an area where the program was unable to provide support), and clients who clearly did not engage with the program and contact was lost. However, a significant proportion of the exited clients (23%) had received support from the program for a period of one year or more, with three clients (4%) having been with the program for more than three years.

Fig. 5.12 Period of Support- Current Clients (n=36) andExited Clients (n=80)
Outcomes of Support

Figure 5.13 presents data on the outcomes of support for the 80 clients who exited the program during the data collection period. It can be seen that there are a range of outcomes which reflects the nature of the client group. However, of key importance in examining how the program operates to support clients is to examine the outcomes where contact was lost, clients returned to prison, disengaged, or died while receiving support from the program.

![Fig. 5.13 Outcomes- Exit Clients (n=80)](image)

Support Unnecessary - Worker and client decide no further services from program are required.
Client disengaged - Client decides they do not want any further support, and they are given opportunity to contact program for further support if they require it.
Relocation - Client has moved interstate or to a country area.
Contact Lost - Repeated attempts to contact client have been unsuccessful and their whereabouts are unknown.
No Community Support - Clients who received a period of support while in hospital or prison but then were not discharged to the program.
Other program - Client has moved on to another agencies program, or a client who was jointly supported by VOSA and another agency and dual support is no longer necessary.

Return to Prison

Four clients (4%) returned to prison while receiving support from the program. Two of these had been in contact with the program for less than three months, while the other two had been supported for just over 12 months. The two clients with longer support periods had both had several previous prison terms (5+ and 2 - 4) and several previous hospital admissions (2-4 and 5+), thus clearly at very high risk of re-offending. Given that one of the perceived objectives of the
program is to support people to stay out of the justice system, it appears based on these figures to be substantially meeting this objective. However, it must be noted that return to prison is an indicator of more serious crime, and does not represent other contacts with the criminal justice system where the client may have committed a less serious crime and received a community based disposition or fine. Furthermore, it is not unlikely that in situations where contact with clients was lost that a significant proportion may have re-offended soon after their contact with the program. Thus, this data appears to indicate that where clients are well engaged with the program, this means they will be less likely to commit serious offences, rather than contact with the program per se protecting against re-offending.

Death
Three clients (4%) died during the data collection period. One of these clients died on the day of release and had only had contact with the program for less than a month prior to release, another client had been supported for around three months, while the third was a long term client who had been supported for around two and a half years. Drugs were a factor in all deaths, and thus the question remains as to whether the deaths were accidental or intentional. The higher suicide rates amongst people with a mental illness have been well established, and thus some client deaths can not be unexpected, especially where the client group also has high rates of substance misuse. However, this does not negate the significant impact these deaths have on the program workers, especially where the client has been well engaged and supported for a considerable period of time.

Contact Lost
Contact was lost with nineteen clients (24%) during the data collection period. In general, this group was characterised by short periods of support, with 13 being in contact with the program for less than six months when contact was lost. However, six clients had been supported by the program between 7 and 16
months. Several factors appear to be associated with contact being lost with a client. These include:

- Some clients' general living situation in boarding houses mean they are difficult to keep track of and may move on short notice without leaving a forwarding address.
- Clients that don't become well engaged with the program worker (and other associated services the worker may link them in to).
- Clients that have been supported by the program for a considerable period of time, but factors such as rapidly deteriorating mental health mean they become unstable before appropriate strategies can be implemented, and they move on and lose contact.

In general, given the nature of the client group a proportion of contact lost outcomes would be expected, but the likelihood of this happening appears to be reduced if the client has been well engaged with the program for a period of time.

*Client Disengaged*

Seventeen clients (21%) disengaged from the program by their own choice. These were situations where the client felt they no longer required support, even if the worker may have thought they would still benefit. This can be seen as a result of the fact that clients' acceptance of support through the program is voluntary, and workers will not continue to try and contact someone if they do not wish to have support. The only proviso to this is that if the person is clearly mentally unwell, then the worker would try and take whatever steps were necessary to deal with this, prior to disengaging with the client (ie. when the client becomes more stable they are happy to have support from the worker). Of the 17 clients, six had been on the program less than three months, and thus their decision to disengage from the program was potentially related to not fully engaging with the program from the outset.
5.4 Summary

This chapter has presented an overview of data from the program management information system for a two year period. Data was examined on clients who had contact with the program (n=116), and all client related contacts (n=9169) that took place in the period.

Key findings included:

- Most clients were male (97%) with an average age of 33 years old and a mental health diagnosis of schizophrenia (75%). Ninety percent had at least one previous psychiatric admission, with many having more than five previous admissions (47%). The majority of clients most recent offence was against the person (homicide 4 %, other against person 52%, sex related 10%), and most had served at least one term of imprisonment (88%), with a proportion having served more than five previous terms of imprisonment (16%). While around 20 % of clients were discharged to live in either private or public housing, the majority were discharged to a range of less independent accommodation, including boarding houses (23%) and residential support (such as VOSA’s McCormack House) (26%).

- The majority of referrals to the program came from Forensic Psychiatry Services facilities (G Division 31%, Rosanna Forensic Psychiatry Centre 24%, Ararat Forensic Psychiatry Centre 8%). Of the 9169 client related contacts in the two year period, half were with the client only (50%), while a considerable proportion where with other agencies (35%). Most of the contacts related to education/information provision (36%), emotional support (29%) and practical assistance (27%). Where there were contacts with other agencies they were most frequently with accommodation providers (22%) and Community Forensic Psychiatry Services (16%), followed by a large range of both government and non-government agencies.
At the end of the data period examined (February 1998) 36 clients were still receiving support services while 80 clients had left the program sometime in the two year period. Of the clients still receiving support, the majority (58%) had been with the program for over a year, with the longest period of support being 5.5 years. Conversely, only 23% of the clients who exited the program had been receiving support for more than a year, with the largest proportion (44%) being in contact less than three months.

The main reasons for ceasing contact with the program included contact lost (24%), client disengaged (21%), support no longer necessary (10%) or referral to another program (11%). Four clients returned to prison, while three clients died while receiving support.
CHAPTER 6

CASE STUDIES

This chapter examines the results of 61 case studies based on written case records that were conducted as part of the evaluation. The purpose of the case studies was to develop a deeper understanding of how the outreach workers provide support services to clients, and the various issues that are apparent in undertaking this role.

6.1 DATA COLLECTION

Sixty one clients were chosen from the approximately 180 clients who had received services from the program and had a client number between January 1992 and August 1997. A Microsoft Access database was developed that allowed for the collection and storage of data from the case studies in several broad areas (eg. accommodation issues, mental health, type of work undertaken by the support worker). See Appendix 7 for information on how the cases were selected and the data organised. Table 6.1 provides background data on the 61 case studies. As can be seen, the sample includes a mix of short and long term clients, and a mix of clients who entered the program in each year of its operation.

6.2 SUPPORT NEEDS OF THE CLIENT GROUP

This section will provide a brief overview of the issues that appear to significantly impact on the client group’s capacity to live in the community, as based on data from the case studies, before examining how the program attempts to address these issues.
Table 6.1 Background Data - Case Studies (n=61)

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<td>17 years</td>
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</tr>
<tr>
<td>Exit</td>
<td>54</td>
<td>clients</td>
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<tbody>
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<td>Current Clients</td>
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<td>1994</td>
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<td>clients</td>
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<td>1995</td>
<td>9</td>
<td>clients</td>
<td></td>
</tr>
<tr>
<td>1996</td>
<td>9</td>
<td>clients</td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>9</td>
<td>clients</td>
<td></td>
</tr>
</tbody>
</table>

**Accommodation**

Clearly one of the most crucial issues facing the client group is their capacity to access quality stable accommodation, and then their ability to maintain whatever accommodation they do have. In nearly all cases the stated reason for referral to the program was for assistance with accommodation, as well as general support. Many clients appeared to have been either homeless or at risk of homelessness (ie. living in unstable accommodation) prior to their entry to prison or hospital, and they were often discharged to a similar situation.

In looking at the accommodation issues of the group there are several repeated themes. These include:
The complex interplay between having a mental illness, difficult to manage behaviour, substance misuse, and a propensity to commit crimes and how this appears to influence a person's gradually diminishing accommodation options. Within the case study sample many clients had clearly been living on a revolving circuit of rooming houses, private hotels and homeless shelters interspersed with prison or hospital for some time, while with others it could be seen that they where about to commence on this circuit.

The client group often appear to have considerable difficulty in maintaining accommodation, and complying with the conditions of the accommodation where they live. Within the case notes there were frequent examples of clients having to leave their accommodation because of falling behind in paying rent, failing to comply with house rules (such as contributing to cooking/cleaning, using substances in the residence etc.) or getting involved in a fight or other disruptive behaviour. Conversely, clients were also at times assisted to move because they were vulnerable in accommodation where there were other aggressive people or a lot of drug use.

Providing support and treatment services to clients in unstable transient accommodation is particularly difficult, especially in trying to maintain contact and ensure that the client doesn’t “fall through the net” of services.

Box 1 provides a case example that demonstrates some of the above accommodation issues.
Box 1: Case Example

John is a 30 year old client with a diagnosis of schizophrenia who was referred to the program while in a secure forensic hospital for assistance with finding post discharge accommodation. The following outlines his accommodation moves over a 1 year period.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/1/96</td>
<td>Discharged to live at McCormack House.</td>
</tr>
<tr>
<td>3/4/96</td>
<td>Moved to a VOSA group home—not able to comply with requirements in McCormack around contributing to cleaning etc.</td>
</tr>
<tr>
<td>28/9/96</td>
<td>Moved back to McCormack (as temporary measure) because unable to manage paying rent in group home.</td>
</tr>
<tr>
<td>12/10/96</td>
<td>Moved into rooming house.</td>
</tr>
<tr>
<td>21/11/96</td>
<td>Moved back into VOSA group home as temporary measure after being assaulted in rooming house.</td>
</tr>
<tr>
<td>12/12/96</td>
<td>Moved into another rooming house.</td>
</tr>
<tr>
<td>16/1/97</td>
<td>Moved to better rooming house.</td>
</tr>
</tbody>
</table>

Family/social support

In general the clients within the sample group had few social supports other than agencies and in some situations their family. Furthermore, many of the clients appeared to have difficulty in effectively utilising what social supports they did have. The following themes were identified:

- Twelve of the clients clearly had no contact with their families or any other supportive friend and thus their main supports consisted of whichever workers/agencies were involved with them.
- Many clients had some contact with their families, but the relationship was often problematic. Four of the clients’ families had intervention orders against them due to their previous behaviour, while other families had some contact but would not allow their relative to visit home because of their past behaviour.
- In situations where there was close contact between the client and their family it was clear this often presented a number of difficulties for the family in how to respond to the client’s behaviour. For example, the client may be continually asking their family for money, or threatening other family members while they are mentally unwell.
- A common theme documented in the case notes was clients expressing feelings of loneliness and isolation.
Education, Employment and Income

All clients in the sample were unemployed and most were receiving the Disability Support Pension as their main source of income. Most clients had reached around middle level secondary school before leaving and working in a range of mainly labouring type jobs, or in a few cases, apprenticeships in areas such as cooking or landscape gardening. Most of the clients had not been employed for several years at the time when they started to receive services from the program. These factors impacted on the clients in several ways:

- Clients often appeared to want to re-enter paid employment at some level, even if they were receiving a Disability Pension, however their lack of skills and employment history combined with their offending history made this very difficult to achieve.
- Lack of employment or other meaningful activity meant clients often reported feeling bored and depressed because they had nothing to do, and that this was a factor in them ‘getting in to trouble” through things like drug use.
- Most clients appeared to have difficulty with financial matters, which was a combination of limited income and an inability to budget. There were frequent entries in the case notes where clients needed assistance because they had run out of money and could not pay their rent, or needed help to obtain a food parcel because they had run out of money to buy food.

Mental Health

The majority of the clients (44) in the case studies had a diagnosis of schizophrenia, usually with a strong paranoid component, with the balance having primary diagnoses of affective disorders and personality disorders (often with associated high levels of suicidal ideations). What is also clear is the high level of substance misuse with the group, with at least 43 of the clients having abuse of alcohol and/or drugs strongly associated with their condition. The group is also characterised by displaying violent, threatening and/or fear inducing behaviour when they become mentally unwell. This can be seen to
have often been preceded by a period of gradually deteriorating mental state, refusal to comply with medication and other treatment, and attempts to disengage from treatment and support services.

When clients became mentally unwell, there was a clear pattern of them often being admitted for short periods of time to hospital where medication would be resumed, followed by discharge for follow up by community treatment and support services. While this approach appeared to be effective for some clients, others would often exhibit periods of instability with continued non-compliance with treatment that required several short hospital stays. Related to this is the difficulty the client group faces in maintaining their accommodation if they do have to stay in hospital for longer than a few days. Many boarding houses will not reserve a client’s room if they are going to be absent for longer than a week or so, and thus clients can find that their mental health relapse also leads to a potential accommodation crisis and the need to find new accommodation following their discharge from hospital.

Box 2 provides an example of some of the above issues based on a case example.

**Legal**

History of offending within the case study group ranged from clients with offences that had resulted in only a community based disposition through to clients with multiple previous convictions and terms of imprisonment (eg. a client with 50 prior convictions and 6 previous terms of imprisonment). It is also clear that a proportion of the client group even when well supported will continue to come to the attention of police and sometimes receive minor charges. These crimes range from things like petty thefts, minor property damage, failure to pay fines, through to possession of drugs, and will often result in the person receiving a bond or fine. This offending often appears
### Box 2: Case Example

Joe is a 27 year old man with a diagnosis of schizophrenia (with several prior hospital admissions) and an offending history related to property crimes. At the time of referral he was an inpatient in a psychiatric hospital and required assistance with finding accommodation following his discharge. The following dates outline his mental health admissions for a period of several years:

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<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19/7/93</td>
<td>Discharged to live in rooming house.</td>
</tr>
<tr>
<td>15/8/93</td>
<td>Assaulted rooming house staff following deterioration in mental state-thrown out of accommodation and admitted to psychiatric hospital.</td>
</tr>
<tr>
<td>16/8/93</td>
<td>Discharged to live in private hotel.</td>
</tr>
<tr>
<td>(Contact Lost)</td>
<td></td>
</tr>
<tr>
<td>15/6/94</td>
<td>Re-referred from Forensic Hospital where had been admitted following re-offence. Discharged to live in rooming house, then VOSA flat.</td>
</tr>
<tr>
<td>16/10/94</td>
<td>Admitted to psychiatric hospital after deteriorating mental state.</td>
</tr>
<tr>
<td>17/10/94</td>
<td>Discharge on CTO</td>
</tr>
<tr>
<td>19/10/94</td>
<td>Admitted to hospital and CTO revoked-client had become paranoid and threatening, had to be taken by police to hospital as refused to go with anyone else.</td>
</tr>
<tr>
<td>9/11/94</td>
<td>Discharged on CTO</td>
</tr>
<tr>
<td>7/8/95</td>
<td>Admitted to psychiatric hospital after smashing up accommodation and threatening behaviour.</td>
</tr>
<tr>
<td>4/9/95</td>
<td>Discharged on CTO</td>
</tr>
<tr>
<td>13/1/96</td>
<td>Admitted to hospital after becoming very paranoid, abusive and refusing medication.</td>
</tr>
<tr>
<td>17/1/96</td>
<td>Discharged on CTO</td>
</tr>
<tr>
<td>11/7/96</td>
<td>Admitted to hospital after becoming agitated over being charged with an offence.</td>
</tr>
<tr>
<td>23/7/96</td>
<td>Discharged on CTO</td>
</tr>
<tr>
<td>27/7/96</td>
<td>CTO revoked after bizarre behaviour-re-admitted to hospital.</td>
</tr>
<tr>
<td>4/8/96</td>
<td>Discharged on CTO</td>
</tr>
<tr>
<td>11/10/96</td>
<td>CTO revoked and re-admitted to hospital after threatening behaviour.</td>
</tr>
<tr>
<td>14/10/96</td>
<td>Discharged on CTO</td>
</tr>
</tbody>
</table>

To be related to either situational factors (ie. related to poor accommodation, lack of money, substance misuse etc.) or to a deteriorating mental state. It is clear that support and treatment staff can have a role in ensuring that people in this situation are diverted into the mental health system wherever possible, and in responding to ensure that the offending does not escalate to a more serious level, particularly where it involves a deteriorating mental state.
The preceding discussion examined data from the case studies to identify several of the major issues confronting mentally disordered offenders in their move back to the community following discharge from either hospital or prison. A key objective of undertaking the case studies was to gain an understanding of the ways the program attempts to deal with these issues, and more generally meet its objectives for the client group. Based on data from the case studies, an examination will now be made of how support is provided to clients.

**Reason for Referral**

The initial referral form completed by the referring agency was examined, as were the notes from the workers initial contact with the client/referring worker to establish the reason for referral. Of the 61 clients, 24 had been referred from prison based services, 14 from secure hospitals, 11 from general psychiatric hospitals, five from McCormack House, four from community mental health services, two from Community Forensic Psychiatry services and one from Community Correctional Services.

The main reasons for referral to the program was for assistance with finding accommodation and for post release support. Thirty eight referrals listed accommodation, 32 ongoing support and several a combination of both. Referrals in the earlier years of the program tended to more often list accommodation as the only reason for referral, which may be indicative of the fact that until staff numbers increased in the program in later years the capacity to provide much support beyond assistance with accommodation was limited. Other reasons identified for referral to the program (often in combination with accommodation/support) included:

- To fulfil a liaison/linkage role between the client and mental health treatment services, and assist the client to get to their appointments. (Five clients).
- Assistance with travel training. (ie. helping client to learn how to use public transport etc. so they could get to appointments) (1 client).
- Providing psychoeducation and support to parents who would be caring for a discharged client. (One client).
- To be available as a back up if a client’s post discharge accommodation arrangements with families/friends failed and new accommodation/support was needed. (Three clients).
- To provide psychiatric input where the client was to be supported dually by VOSA and another agency. This would include consulting with the other worker on mental health issues, assisting the client to get to mental health treatment appointments, and liaising with mental health treatment staff. (Two clients).

**Work Undertaken with the Client**

In each case study the client’s case notes were examined and notes were taken on all documented worker activities throughout the client’s support period with the program. The notes from each case study were then merged and the key components of the work undertaken with the clients were identified.

The support work the program provides can be categorised into the following key roles or areas:

1. Discharge Support.
2. Relationship Building with the Client.
3. Accommodation Support.
4. Mental Health Support.
5. Justice Support.
7. Practical Support.
8. Vocational/recreational Support
10. Education/Consultation.
Table 6.2 provides a breakdown of the above areas with the actual tasks undertaken by the outreach worker. Categorising the tasks undertaken by the support workers is a somewhat artificial activity, as in practice many tasks they undertake with clients involve more than one category. (eg. Driving a client to the clinic for their appointment may include elements of mental health support, practical assistance and relationship building). However, identifying the categories allows for the essential components of the support model to be elucidated.

It can be seen that the key tasks performed by the support workers cover a broad range of activities, and reflect the range of needs within the client group. It is also clear that the approach to working with the client group is holistic and attempts to address needs in all areas of the clients’ life. While the type of support provided to clients will obviously vary based on their particular situation and needs, the importance of the relationship building component is very clear. Much of the other support work appears to be dependent on the worker developing a strong supportive relationship with the client. For example, unless the client has some level of trust in the worker, they will be unlikely to call them if they are having difficulties. The capacity of the worker to develop these relationships will obviously be dependent to a large extent on the workers personal characteristics and skills but it also appears important that they can offer practical and tangible support from the beginning of their contact with the client (eg. somewhere for the client to live).
<table>
<thead>
<tr>
<th>Table 6.2 Key Components of the Support Model</th>
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<tbody>
<tr>
<td>1. Discharge Support</td>
</tr>
<tr>
<td>a) Visit client to assess needs and develop relationship prior to discharge.</td>
</tr>
<tr>
<td>b) Liaison with prison/hospital staff re: discharge plans.</td>
</tr>
<tr>
<td>c) Attendance at discharge planning meetings (where applicable).</td>
</tr>
<tr>
<td>d) Arrange post discharge accommodation.</td>
</tr>
<tr>
<td>e) Accompany on leave to see accommodation (where applicable).</td>
</tr>
<tr>
<td>f) Continue to visit client until discharge and reassure re: discharge plans.</td>
</tr>
<tr>
<td>g) Meet client on day of release and take to accommodation, ensure first Social Security payment organised etc.</td>
</tr>
<tr>
<td>2. Relationship Building with Client</td>
</tr>
<tr>
<td>a) Regular visits to client to “have a chat” and coffee.</td>
</tr>
<tr>
<td>b) Taking client out to a café for coffee, or to a park.</td>
</tr>
<tr>
<td>c) Offering client practical, tangible assistance from the beginning.</td>
</tr>
<tr>
<td>d) Being available and responding if client is having difficulty.</td>
</tr>
<tr>
<td>e) Offering long term contact if required.</td>
</tr>
<tr>
<td>f) Maintaining contact with client wherever they move regardless of region etc. (within metropolitan area).</td>
</tr>
<tr>
<td>3. Accommodation Support</td>
</tr>
<tr>
<td>a) Arranging discharge accommodation.</td>
</tr>
<tr>
<td>b) Assisting client to look at further accommodation options.</td>
</tr>
<tr>
<td>c) Assisting client with application forms etc for accommodation.</td>
</tr>
<tr>
<td>d) Taking client to look at possible flats for rental.</td>
</tr>
<tr>
<td>e) Advocate on clients behalf for supported accommodation options.</td>
</tr>
<tr>
<td>f) Arrange crisis accommodation when client accommodation fails.</td>
</tr>
<tr>
<td>g) Arrange for payment for crisis accommodation or for a bond where necessary through VOSA resources or external.</td>
</tr>
<tr>
<td>h) Assist client to set up accommodation and obtain furniture etc.</td>
</tr>
<tr>
<td>i) Capacity to provide accommodation in flats and group homes of a quality clients would not normally be able to access through normal rental market.</td>
</tr>
<tr>
<td>4. Mental Health Support</td>
</tr>
<tr>
<td>a) Take client to treatment appointments.</td>
</tr>
<tr>
<td>b) Initiate service response if client mentally unwell (eg. arrange for assessment by CAT or treating clinic).</td>
</tr>
<tr>
<td>c) Drive client to hospital if being admitted.</td>
</tr>
<tr>
<td>d) Regular liaison with treating staff concerning client’s mental health, and the client’s overall progress (eg. stability of accommodation etc.)</td>
</tr>
<tr>
<td>e) Assist client to manage medication (dosette box, take to get prescriptions filled etc).</td>
</tr>
<tr>
<td>f) Psychoeducation with client, particularly around medication issues, encouragement to maintain treatment plan, and on the mental health implications of using illicit drugs.</td>
</tr>
<tr>
<td>g) Information and assistance in matters concerning Mental Health Review Board and client rights.</td>
</tr>
<tr>
<td>h) Counselling with client when they are feeling down, or dealing with a particular crisis such as death of a family member.</td>
</tr>
<tr>
<td>5. Justice Support</td>
</tr>
<tr>
<td>a) Ensure client has legal representation.</td>
</tr>
<tr>
<td>b) Drive client to court to ensure they appear (if applicable).</td>
</tr>
<tr>
<td>c) Support client at court.</td>
</tr>
<tr>
<td>d) Write letter of support to court and appear in court to outline client’s situation and available community options.</td>
</tr>
<tr>
<td>e) Liaison with police if client taken into custody.</td>
</tr>
<tr>
<td>f) Ongoing support to client if they return to prison for a short period and will be requiring discharge support.</td>
</tr>
<tr>
<td>6. Crisis Support</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>a) 24 hour availability by pager offered to clients and workers.</td>
</tr>
<tr>
<td>b) Respond to calls from client when they are feeling mentally unwell, suicidal or other crisis.</td>
</tr>
<tr>
<td>c) Respond to calls from accommodation providers etc. when concerned over clients behaviour and arrange appropriate intervention.</td>
</tr>
<tr>
<td>d) Respond to calls from treatment services where crisis accommodation needs to be arranged.</td>
</tr>
<tr>
<td>e) Respond to crisis calls from families concerning client’s behaviour.</td>
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<tr>
<th>7. Practical Support</th>
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</thead>
<tbody>
<tr>
<td>a) Drive to various appointments.</td>
</tr>
<tr>
<td>b) Travel training to increase client independence (eg. accompanying client on a tram to an appointment so they can do it independently).</td>
</tr>
<tr>
<td>c) Assist with shopping for clothes, food and furniture as necessary.</td>
</tr>
<tr>
<td>d) Assist client to obtain food parcels.</td>
</tr>
<tr>
<td>e) Assist client to obtain/replace identification, medicare card, pension card etc.</td>
</tr>
<tr>
<td>f) Assist client to complete social security forms.</td>
</tr>
<tr>
<td>g) Assist client with budgeting and management of finances.</td>
</tr>
<tr>
<td>h) Liaison with client’s administrator (where applicable) re client’s finances and need for money to make purchases.</td>
</tr>
<tr>
<td>i) Assist client with developing cleaning, cooking, personal hygiene skills where necessary.</td>
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<thead>
<tr>
<th>8. Vocational/Recreational Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Linkage and encouragement for client to take part in recreation groups/ day activity centres etc.</td>
</tr>
<tr>
<td>b) Attendance at groups with client until they are comfortable.</td>
</tr>
<tr>
<td>c) Linkage and information provision on TAFE courses and other activities.</td>
</tr>
<tr>
<td>d) Referral to VOSA Disability Employment Support Program and other supported employment activities.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. Linkage and Liaison</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Linking client into range of accommodation, support and treatment services available.</td>
</tr>
<tr>
<td>b) Liaison and information provision between all services and individuals involved with client including treatment providers, accommodation providers, other health/welfare providers, State Trustees, Community Corrections Officer, families and the client.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. Education/Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Educating clients about mental illness treatment issues, medication and the service system.</td>
</tr>
<tr>
<td>b) Educating families about mental illness and forensic issues.</td>
</tr>
<tr>
<td>c) Education/information to inpatient facilities on community support issues and resources.</td>
</tr>
<tr>
<td>d) Education/consultation to general accommodation providers etc. on dealing with clients with mental illness and forensic history.</td>
</tr>
</tbody>
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<table>
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<tr>
<th>11. Family Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Support for the family in supporting their relative.</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>12. Advocacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Advocating on clients behalf for access to services.</td>
</tr>
<tr>
<td>b) Advocating on clients behalf concerning legal issues.</td>
</tr>
</tbody>
</table>
Other Factors Underlying the Support Work

The above discussion has identified the key tasks that are performed by the support workers in providing a service to mentally disordered offenders in the community. From the case studies it is also clear that there are several factors that underpin the support work role. These include:

- **Voluntary service**: The client’s decision to initially accept and continue to receive support services from the program is at their own choice, and they are free to disengage from the service at any time. If a client disengages, they are encouraged to contact the service at any time in the future if they need support.

- **Assertive outreach**: The services are provided on an outreach basis, and assertive efforts are made to, for example, encourage a client to get to their mental health treatment appointment, or to locate the client if they appear to have gone missing. However, there is also the potential for a tension between this assertive approach and the voluntary nature of the service.

- **Accommodation**: The importance of the program having access to its own range of accommodation is clear. Nineteen of the 61 clients in the case studies were discharged to live in McCormack House, and several others were accommodated there as a crisis measure at times when other accommodation options had fallen through. Furthermore, the use of the flats and group homes as both a method of stabilising a client in longer term housing, and also as a means of crisis accommodation, was apparent.

- **Capacity to “follow” the client**: Within the Melbourne metropolitan area, the worker can continue to provide services to the client wherever they move, and are not bound by regions (as are many regional mental health treatment services).

- **Skilled Mental Health Staff**: From the case studies it is clear that the support workers often undertake mental state assessments of clients to ascertain their need for assessment at a treatment service,
and provide consultation to a range of non-mental health trained staff such as accommodation providers on mental health issues. Similarly, they educate clients and their families about medications and mental health treatment.

- **Pre-Discharge support:** The importance of beginning the relationship with the client prior to their discharge from prison or hospital and thus being able to provide intensive support in the transition process.

**Meeting the Perceived Program Objectives**

The case studies were also examined to determine the ways in which the workers appeared to be working towards the perceived objectives of the program:

1. **To support clients to remain out of the justice system.**

Key activities undertaken by the workers relevant to this objective included:

- Providing the range of support activities, from assistance with accommodation through to assistance to keep appointments that are aimed at helping the client to maintain stability and thus lessen their chance of re-offending.

- Acting as an “early warning” system by being able to monitor the client’s mental state in their normal living situation, and then to take appropriate action before the client becomes very unwell and more likely to re-offend.

- If a client does re-offend, maximising their chances of being deferred from the justice system back to the mental health system. For example, providing information to the court on community support options, and where applicable information on extenuating circumstances concerning the offence, that mean the client may be more likely to be managed by the mental health system.
2. To assist clients to maintain contact with the mental health system.

Key activities undertaken by the workers relevant to this objective included:

- Driving clients to their appointments at the mental health service to ensure they get there (and consequently get their regular injection of medication etc).
- Providing a link between the treatment services and the client.
- Providing psychoeducation around issues such as medication, and encouragement to maintain treatment plans.
- Responding to crisis calls from clients, families and workers when the client is mentally unwell, making an assessment, and initiating the appropriate service response.

3. To improve the general quality of life of the client.

Key activities undertaken by the workers relevant to this objective included:

- Attempting to support clients in moving on to higher quality, stable, accommodation.
- Linking the client to recreational and day activity programs and other similar social activities.
- Linking clients to services that can assist in training and employment preparation.
- Being a “friend” to often isolated clients. (eg. going out for a coffee).
- Assisting clients to maintain relationships with families and significant others in a appropriate way.

Two case studies are now presented which provide a practical demonstration of how work towards the objectives is undertaken.
Steve is a 40 year old man who has spent a considerable proportion of the previous 20 years in either prison or psychiatric hospital following being diagnosed with paranoid schizophrenia. He has been convicted of over 50 previous offences (mostly thefts and assaults), and has experienced periods of heavy alcohol and other drug abuse. He was referred to the program by a psychiatric hospital for assistance with discharge accommodation and support, and was supported for a period of approximately 1.5 years (during which time there was at least weekly direct contact with Steve and considerable interagency liaison).

Support Work:

**Accommodation:** Accommodation was arranged at a boarding house and was maintained throughout the support period through extensive liaison by the worker who convinced the management to reserve Steve’s room during three extensive re-admissions to hospital. The worker also regularly liaised with the accommodation workers when they had concerns over Steve’s mental health.

**Mental Health:** Steve was initially driven to his follow-up mental health appointments and then accompanied on the tram for travel training until he could get to his appointment independently. The worker also responded to several crisis calls from the boarding house which resulted in the worker taking Steve to hospital for admission on 3 occasions. On one of these occasions Steve was intoxicated and had become very paranoid and threatened accommodation staff before locking himself in his room - the worker was called and was able to convince him to go to hospital, which averted the accommodation staff calling the police to have him evicted from the accommodation.

**Relationship building:** The worker regularly visited Steve for a chat and would take him out for a coffee or to a park to get away from the boarding house environment.

**Recreational Support:** Over the period of support Steve was assisted to make contact with several local drop-in centres and accompanied on his first visits. (Of note was the fact that the workers attendance was also initially requested by the drop-in centre because of staff fears about Steve’s potential disruptive behaviour).

**Practical Assistance:** Assistance to go shopping for clothes on several occasions, including liaison with Steve’s State Trustee Administrator for approval and money for the purchases.

**Linkage/Liaison:** Steve’s situation required extensive ongoing liaison between all agencies involved, especially following his re-admissions to hospital. The worker played an ongoing central linkage role between the inpatient services, the Community Mental Health Services, the accommodation staff, the client and other services such as State Trustees.

**Outcome:**

Support from the program was ceased when Steve had become well linked in with the local community based mental health services (clinic and mobile team) and drop-in centre etc. and well established in his accommodation.
Box 4. Case Example 2

Brian is a 38 year old man who has a diagnosis of paranoid schizophrenia with several prior admissions to psychiatric hospitals, secure hospitals and prison. He has a long history of offending including attempted murder and several assaults. He has also experienced periods of heavy alcohol abuse. He was referred to the program by a psychiatric hospital following a long admission, for assistance with accommodation and support. He has been supported by the program for approximately 5 years.

Support Work:

Accommodation: Brian was taken on leaves from hospital to find a flat and was assisted in the application process and setting it up with furniture. Following approximately 2 years there he was assisted to move on to a better flat where he remains at present.

Mental health: Brian is taken by the support worker to his fortnightly appointments at the mental health clinic and assisted with management of his medication. The worker has also responded to crisis calls from Brian over the years when he has become paranoid to an extent where he is unable to leave his flat for several days- the worker talks him through this and where necessary takes him to the mental health clinic for review.

Relationship building: The worker had continued to visit Brian regularly over the years for a chat and coffee.

Recreation support: Brian was linked into a day supported activity program fairly early in the support period, which soon became his primary place of social interaction.

Practical Support: The worker regularly assists Brian to go food shopping and with budgeting plans. He has also been assisted to get food parcels and other material aid such as furniture for his flat.

Outcome:

Brian continues to be supported by the program with regular visits by the support worker and assistance to get to his clinic appointments. He is coping well in his flat, maintains the treatment plan, and has not committed any offences during the whole support period.

Other Issues

This review of the case studies has focused on identifying the key components of the support model that have developed, and on demonstrating through some case examples where it has been used very effectively to support clients. Examining the case studies has also of course identified difficult issues that impact on the effectiveness of the model, examples where the support workers face significant dilemmas in undertaking their work, and examples where the model did not appear to meet the needs of the clients so well. As these issues
were for the most part also addressed in key informant interviews, they will be discussed in more detail in Chapter 8. They include:

- Responding effectively to the needs of female mentally disordered offenders.
- Responding effectively to the highly transient sub-group of clients where contact is lost.
- Agency roles and boundaries when several agencies are involved in the care of the client.
- Issues where the agency is both landlord and support provider to a client.
- Worker safety issues (as sole workers when with client).
- Potential for contradiction between the voluntary nature of client’s involvement and the assertive outreach nature of the program.

6.5 SUMMARY

This chapter has presented data on 61 case studies of a sample of clients who had received support from the program since its establishment. Based on the case studies, the type of issues experienced by the client group in the areas of accommodation, employment/activities, mental health, offending and family/social support were examined. The type of work the support workers carry out with clients was discussed, and a range of key tasks they undertake in their support worker role identified. The key areas were:

1. Discharge Support.
2. Relationship Building with the Client.
3. Accommodation Support.
4. Mental Health Support.
5. Justice Support.
7. Practical Support.
8. Vocational/recreational Support
10. Education/Consultation.

The way the support workers aim to meet the perceived objectives of the program through undertaking the above activities was examined, and demonstrated through two case examples.
CHAPTER 7

INTERVIEWS

This chapter presents data from key informant interviews carried out with clients, program staff and staff of other programs and agencies. The purpose of the interviews was to examine the nature of the support model from the view of different key informants, and to determine their opinions on the current operation of the program and future directions.

7.1 DATA COLLECTION

Interviews were conducted with ten clients (nine current, one exited), the three program staff (Program Manager and two outreach workers) and with staff from other program areas and external agencies that have had significant contact with the program (18 interviews). (See interview schedules in Appendix 1-3). The interviews were written up from either notes or tape, and then analysed for general themes and trends. Further details on the interviewees and the analysis is provided in Appendix 8.

7.2 Client Interviews

Client interviews were relatively unstructured with questions being asked in four broad areas:

1. Background data
2. Experience of discharge from prison/hospital to the community.
3. Experience of the VOSA Forensic Psychiatric Program.
4. Other general observations/suggestions.
**The Discharge Experience**

Nine of the clients had been referred to the program prior to their discharge, with one being referred a few months following release by McCormack House staff where he was staying. In general most clients expressed satisfaction with the assistance they were given by both the referring agency and the support worker in planning for their discharge. This was especially related to the fact that accommodation was arranged and they had somewhere to go, and that the support worker assisted them to get to their accommodation. The one exception was the client who had been referred to the program following his release, who thought the prison staff had not really helped him at all, other than arrange for his accommodation at McCormack House. Three of the clients had also been discharged from the Ararat Forensic Psychiatry Centre, and spoke of the extra constraints being discharged from a rural location had on making arrangements (in most cases contact with the support worker could only be by phone prior to discharge).

All clients spoke of the difficulties they experienced on discharge to the community, and how easy it was for things to go wrong. They all spoke of the need to have somewhere decent to live, and how it could be very helpful to have support to get through the initial phase following discharge. Particular problems mentioned by several clients included:

- Having to live in low standard, depressing accommodation.
- Having nothing to do, nobody to talk to, and feeling lonely.
- Trying to stay away from drugs/alcohol.
- Sorting out problems with medication, and mental health problems generally.
- Being treated badly by other people because they have been in prison.
- Trying to stay away from old friends who they get into trouble with.
Experience of the Program

When clients were asked what sort of things the support worker does with them, there was a clear emphasis on emotional support/relationship activities and practical support activities. The following activities were mentioned (with number of clients):

- Visiting regularly for a coffee and to talk about any problems. (10)
- Assisting to get accommodation and then get furniture etc. (9)
- Driving the client to the clinic and assisting them to talk to staff. (7)
- Helping to deal with government departments, write letters etc. (5)
- Assisting with medication problems. (4)
- Helping with shopping. (4)
- Linking into employment program. (3)
- Helping to get a grant to buy furniture/electrical items. (3)
- Responding to pager when needed. (2)
- Assistance with budgeting. (2)
- Assistance to get legal representation and support at court. (1)

In general all the clients interviewed were very positive about the support they had received from the program. All clients mentioned that they found it very helpful to have the regular visit from the support worker where they could have a chat and talk over any problems. Some clients saw this visit as like a ‘friend’ who was reliable and who they knew would turn up. Three of the clients felt that the only significant contact they had with anyone was with the support worker, and as such this was their only real social interaction.

‘I like it, he’s (the support worker) the only person I see.’

‘I rely on it, he’s always reliable and will come if I need him.’

Going out for a coffee or similar activities was also frequently mentioned as a positive thing, as it meant they could be away from their sometimes isolated and/or depressing living conditions.
Assistance to initially secure some form of accommodation following discharge, and then assistance to try and get into better accommodation (eg. flat), was also seen as a way the support program had been very helpful. Most stated that having just come out of prison or hospital, they would not have been able to secure this accommodation without the assistance of the support worker, and all spoke of the importance of somewhere reasonable to live if they were going to stay out of prison. Also of note were two clients who were actually quite unhappy with VOSA services generally as they had both been asked to leave VOSA accommodation following incidents, (both felt they had been wrongly asked to leave), but were happy that their support workers had ‘stuck with them’ despite what had happened. Even though they had been asked to leave the accommodation, their worker had still kept supporting them and found further accommodation. As one client put it, ‘I would be living in The Gill (homeless shelter) without his help. He has stuck through thick and thin.’

In general, it was clear that the clients’ interviewed perceived that the support worker had played a central role in their life since discharge to the community. Several mentioned that the support worker played a significant role in keeping them in contact with mental health treatment services. This was through activities such as explaining about the medication and encouraging them to keep taking it, and taking them to the clinic. Two clients felt that the main reason they had kept up with treatment was the fact that the support worker came each time they had an appointment and took them to the clinic. They did not like attending the clinic and felt that they wouldn’t go if it was just left up to them to attend. Furthermore, several clients felt that this support had been an important factor in them not returning to prison. Two clients felt that because the worker quickly responds when they are feeling mentally unwell, (eg. becoming very paranoid), and comes and talks to them this averts the problem before it gets worse. Another two clients felt that seeing the support worker regularly reminded them that there were alternatives to going back to their old friends who they get into trouble with. Another client (the client who had left the program) felt that having the support worker, in combination with the VOSA
Disability Employment Worker, had been the support he needed to build confidence in his own abilities and move on to independent living and full time employment (which he had). Two clients clearly felt that having the support worker this time as they came out of prison had been an improvement on other times they had come out of prison and re-offended.

‘Without him, chances are I’d be back in there (prison), there’s nobody else at this time.’

‘Without their assistance, I wouldn’t be here.’

‘Without it I couldn’t have kept going.’

**Improvements**

When asked about potential improvements in the program, five clients felt they were very happy with how it is and could not think of any way to improve it. From the other clients, suggested improvements revolved around two main issues:

- It was suggested that the workers should be able to spend more time with them, and that the workers generally seemed to be overworked with too many clients. This was related to the fact that the worker could often not stay with the client as long as they would like, or would arrive and stay for a short time before being paged to some crisis and having to leave.

- That there should be more group recreational activities as part of the program (such as a group of clients going fishing with the worker, or meeting for a BBQ or counter lunch). Related to this was the perceived difficulty some clients had in fitting in to organised recreational programs because of their offending history.

Of note is the fact that both these recommendations further relate to clients feeling isolated and wanting more social interaction. Also one client (who had been asked to leave VOSA accommodation) also felt that there should be some mechanism by which clients could appeal these sort of decisions.
The clients interviewed also believed there needed to be some improvements in the system more generally for people coming out of prison. The improvements related mainly to two areas:

- The need for better accommodation options as an alternative to the boarding/rooming house type accommodation that many people coming out of prison have to spend at least some time in.
- The need for greater access to financial resources. Nearly all clients mentioned that a major difficulty they experienced was not having enough money (even when trying to be careful and not spending money on drugs etc.).

As one client put it, if you are living in a rundown boarding house with a lot of other people who have also been in places like prison and have no money to do anything other than pay for the most basic necessities such as rent and food, then the difference between prison and being out is not that much. That is, people need to be able to see that there is something to lose by re-offending and going back to prison.

7.3 Program Staff

The three program staff were interviewed with the following broad areas:

- Background data.
- Experience of the program.
- Suggested Improvements.
- Overall impressions/observations.

Data was also drawn from discussions/focus groups with the program staff throughout the evaluation period.
Core elements of the program

The program staff reported performing similar day-to-day tasks with clients as has been outlined in other parts of the thesis (eg. case studies, client interviews), and thus will not be discussed further. What is important to examine is some of the key factors the workers believe underpin the program, and how these factors contribute to their capacity to effectively support clients. These factors were summed up by the worker who has worked in the program for most of its years of operation:

I would make contact with the person, go and offer my service, and make it very, very clear that it is a voluntary service- that we were a non-government organisation, we were a welfare agency, and even though we worked closely with the established forensic service, we were not part of it. To me that was the key thing, very much so, establishing that early on. Number two, establishing with the client what it was we had to offer. Another words, the big thing is that we find people accommodation and then we offer them support and follow-up for as long as was necessary. There’s no fixed period on it. And that it was a very individual thing, and that we helped people in the transition period, when they are likely to have sort of crises… And obviously the other thing was the timeframe to establish a relationship

Thus the key factors mentioned by all workers were:

- The program is voluntary, and this is made very clear to clients from the outset.
- The program is based in a non-government agency, and separate to treatment and other statutory services.
- Support is not time limited.
- Contact with the program is commenced while the person is in prison or hospital, and begins with the offer of concrete practical assistance (ie. accommodation).
- The support work is based on developing a relationship with the client.

In particular, relationship development with the client and its relationship to the voluntary nature of the program were seen as crucial to the model. That is, effective support work with the client had to be based on development of an effective relationship with the client as there was no other legal requirement to maintain contact with the program. The nature of the relationship developed with the client was also seen as multi-faceted. As one worker said, ‘For our client group, it is a type of support they are not accustomed to- being able to call
your support worker your friend, your advocate, your counsellor’. While there was the normal worker-client support relationship, all workers felt that they played a significant role in many of their clients' social networks as well. It was felt that the client group was characterised on several levels by their lack of a supportive social network, and the support workers had a role in providing some of this social support, and in attempting to link the client into improved networks. The clients’ relationships with their families had often broken down or become very strained, they tend to have few supportive friends, and often have trouble even fitting in with other people in the boarding houses etc. because of being perceived as ‘different’ due to their mental illness. Thus workers all felt that elements of their role often involved being a ‘friend’ or ‘family’ to the client, which served to provide the very real need for ongoing social support, but also to model appropriate ways of developing and maintaining relationships with family and friends. It was generally felt that the capacity to develop these type of relationships with clients was very dependent on the voluntary nature of the program, and on workers’ ability to provide tangible concrete support from the beginning of their contact with the client (eg. accommodation).

**The Program Objectives**

All workers agreed the primary objectives of the program were to minimise the chance of clients re-entering the criminal justice system, to assist the client to maintain contact with the mental health treatment and support services, and to improve the client’s general quality of life. Within these objectives a clear hierarchy is also apparent:

1. The primary objective is to assist clients to not re-offend, and in particular to not re-enter the prison system.

2. If clients do re-offend, the workers aim to wherever possible assist the client to be diverted to the mental health system or to a community based disposition with appropriate mental health follow-up. This process was assisted by the support worker ensuring the client has legal representation, attending at court and speaking on the client’s behalf, etc.
3. Contact with the inpatient mental health services is seen as preferable to contact with the criminal justice system. Unlike most other assertive outreach based programs described in the literature which have as their primary aim a reduction in hospitalisation, a return to hospital is actually seen as a positive event if it means the client is treated and allowed some ‘time out’ before they become very unwell and re-offend.

Improving the client’s overall quality of life was also seen as particularly important. It was seen that this was achieved through activities such as assisting the client to move on to independent accommodation, assisting them to improve family relationships, and assisting them to link into other community supports such as employment training. Workers also felt that while the support work was based on building a strong relationship with the client, this had to be balanced by continually encouraging the client to develop other areas of support and integration into the community with the ultimate aim of them being able to live independently.

**Interagency Issues**

_The Role of the support worker._

While workers appeared clear on what their role was and how this differed from a case manager’s role, they also acknowledged that it was an area of some confusion with other agencies with them often being mistaken for being the client’s case manager. It was generally felt that clear communication between all parties involved in the client’s care usually overcame any potential problems in this area. As one worker put it, ‘I suppose if they were the bricks, we are the mortar’. That is, while the case manager was responsible for overall co-ordination of the client’s care, the support worker could be seen as the communicator between all parties, and the organiser of the client to help keep them in contact with the services. It was also noted that many of the clients supported by the program did not have a designated case manager from a mental health treatment service, although this is becoming less common.
Nevertheless, it was acknowledged that there was the potential for overlap of roles, and the need for clear communication to establish responsibilities for client care.

Agency Relationships
Workers generally felt that the program had a good relationship with other agencies, although this had taken some years to develop. For example, it was felt that while the program had gained a strong relationship with some units of the Forensic Psychiatry Services from its establishment through support from some social work staff who advocated for the program, in other areas this relationship had taken much longer to develop as the program was potentially perceived as a threat to other services that were being provided by those units. Similarly, in the current climate it was felt that considerable work was sometimes required in clarification of roles with other non-government disability agencies when both services were involved with a client’s care. However, examples were also given of where a model of joint support between the program and another disability support agency had worked very effectively, because the roles of each service had been clearly defined from the outset. ¹

Program Improvements
When asked about potential improvements in the program, suggestions related mainly to resource issues and development of specific services for sub-groups of clients. They included:

- **Staff resources** - it was felt that the number of clients referred to the program was increasing and the program has a policy of not refusing service to a client who has been through the forensic system and is unable to be picked up by other services. However, this must be balanced by being able to spend sufficient time with clients or the overall program effectiveness would be reduced. In relation to this

¹ For example, another agency provided supported accommodation and access to activities and vocational training, while the VOSA worker concentrated on issues in relation to the mental health system and offending. Regular meetings were held between the two workers and the client to ensure co-ordination and clarity of roles.
area, while staff clearly felt that their workload was high and there was considerable pressure and stress in being able to meet the needs of clients on their caseload (a perception mirrored by clients and external staff), they felt their level of professional supervision and support was adequate and that the team worked well in supporting each other through formal mechanisms (such as the weekly team meeting) and informal means.

- **Other Resources**- staff felt that the program was generally under-resourced compared both to other larger programs within the agency, and to disability support programs in other agencies. This related particularly to areas such as being able to fund recreational activities for clients and provide a range of accommodation options.

- **Accommodation**- staff argued that while any increase in the level of accommodation options within the program would be beneficial, it would be particularly useful to have an increase in the one bedroom flats with an associated support worker. It was felt clients in the five flats the program already has under this model had resulted in particularly good outcomes for most clients who had been in them, compared to when they were living in boarding houses.

- **Women’s services**- It was acknowledged that the program had experienced significant difficulty in providing for the needs of female mentally disordered offenders.\(^2\) While the program has, and will continue to accept female mentally disordered offenders when no other service will take them on, the need for a dedicated female worker to meet the needs of this group was clearly identified.

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\(^2\) All support workers in the program are male, which has most likely evolved from the fact that most of the clients are male, and workers often have to work alone in areas that present safety issues for female staff (e.g. working with clients with a past history of sexual assaults). Having male workers working with female clients presents dilemmas for both the client (most are very vulnerable with histories of sexual assault by males) and for the workers who have concerns about potential false allegations against the worker. Attempts have been made to secure funding for a specialist women’s support program, with no success at this time.
Program Profile- The workers also felt the program could benefit from a higher profile and improved knowledge in the service system about what it does and the model of support it provides.

Future Development
Areas where the workers thought future development issues would be important included:

- Maintaining a presence and established relationships in a service system that is rapidly changing through privatisation, while developing relationships with new organisations entering the area. (eg. new private prison providers).
- Developing a clear profile of the support role and communicating this with other agencies.
- Being prepared for potential contracting out of the services the program provides, and the need to tender along with other agencies.
- The issue of specialisation of services versus generalisation. For example, a general disability support program may be able to provide services to the client group without the associated labelling that is involved with being a client of a program specifically for offenders. There is a need for the program to be able to identify both the strengths and the weaknesses of the specialist approach it takes.

7.4 External Program & Agency Staff

Interviews were conducted with a total of 18 people from other program areas in VOSA (6) and external agencies (12). The staff were interviewed within the following broad areas:

- Background data.
- Experience of the program.
- Suggested Improvements.
- Overall impressions/observations.
Information provided by the interviewees on the tasks undertaken by the support workers and the way they work towards the program objectives generally concurred with data provided elsewhere and will not be repeated. Thus, data reported in this section will concentrate on the interviewees’ impressions of the program and suggested improvements for the future operation of the program.

**Strengths of the program**

There was general agreement by all interviewees that the program had developed to the point where it now played a very valuable and necessary role in the provision of community support and treatment services to mentally disordered offenders. Particular strengths of the program cited by most people included:

- **Preventative focus:** Support workers are usually able to identify and deal with a deterioration in the client’s mental state before the client becomes too unstable and re-offends.
- **Crisis response:** The support workers always respond quickly to crisis calls for assistance from the client or staff (e.g. to find new accommodation, to assess client’s mental state etc.)
- **Outreach Based:** The support workers see clients at their accommodation, drive them to appointments, and assist with practical tasks such as shopping and this all gives them an insight into the clients’ situation that can not be gained from standard appointments at clinics.
- **Teamwork:** The staff were perceived as working very well together as a team and although they undertake individual work with clients they provide back-up to each other especially in difficult crisis situations.

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3 Most interviewees felt that the everyday tasks carried out by the workers clearly demonstrated how they were working towards the perceived objectives of the program. For example, there was general agreement that being able to respond quickly and early to a client’s deteriorating mental state played a significant role in reducing their likelihood of re-offending. Similarly, assisting clients into better accommodation and linking them to other community supports both improves their general quality of life and helps to reduce their likelihood of re-offending.
The support workers were also seen as working very well as a team with staff of other agencies, particularly in relation to providing information about the client's progress (to clinical services) and providing information on mental health issues (to accommodation, activity program staff).

- **Staff Characteristics:** The general approach the support workers take to working with clients was also seen as a major strength. It was felt that the workers demonstrated a real commitment to clients, treated them with respect, and did not ‘talk down’ to them.\(^4\) In addition, the fact that all the support workers were experienced mental health professionals was seen as crucial, even though much of the work they performed was very practical in nature (and on an initial examination the need for mental health experience may not have seem warranted).\(^5\)

Other strengths of the program mentioned by some interviewees included:

- The fact that the program will take clients that most other services refuse to take on.
- The voluntary nature of the program.
- The program is based in a non-government agency separate to formal treatment services.
- Staff flexibility to undertake a range of tasks.
- The key linkage role the support workers play between each agency.

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\(^4\) Which some staff felt was because a strong element of the worker-client relationship was like a ‘friend’, while maintaining a clear professional boundary.

\(^5\) For example, clinical staff appreciated the fact that the support workers were able to undertake an initial mental state assessment and make a realistic assessment of whether further formal assessment and intervention at the clinical service was required. The fact that the support workers were mental health trained was also seen as an advantage when they needed to advocate on the client’s behalf for entry to treatment services. In addition, staff of generalist agencies (such as accommodation providers) felt they benefited from being able to consult with the support workers on mental health issues and management strategies.
**Limitations of the program**

The main limitations of the program identified by the interviewees related to resources and the program’s capacity to meet the needs of particular groups of clients. The identified limitations included:

- Limited human resources to service the significant needs of the client group.
- Lack of financial resources to back-up the program (e.g., limited money to provide material aid or to actually pay for emergency accommodation).
- Lack of resources (both human and material) to provide more activities, recreational programs etc. for the client group.
- The program’s inability to effectively meet the needs of female mentally disordered offenders.
- The program’s general profile and lack of knowledge about how it works outside the key workers/agencies it mainly deals with. In some cases it appears this is also related to general misconceptions about the type of services provided by the agency as a whole.  

**Issues in undertaking the support role**

In discussing interviewees’ impressions of the program, several issues in how the program provides support services were also identified. They included:

- The potential overlap of roles between a support worker and a designated case manager. Some interviewees felt that the support worker was actually the defacto case manager, if not the actual case manager, while others felt that there was clearly an overlap of roles. However, on reflection there was general consensus that while many of the actual tasks performed by the case manager and support worker may be similar at times, the roles are intrinsically different.  

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6 For example, one interviewee from a community agency had thought VOSA only provided services to sex offenders prior to their close work with the Forensic Psychiatric Program, and felt this misconception was still held in some areas.

7 For example, the “friend” component of the support workers role would be difficult to perform as a case manager where there was also statutory responsibilities etc.
for ongoing clarification and acknowledgment was reiterated if misunderstandings were to be avoided.

- Some interviewees felt that the support workers often seemed to act in the role of a defacto Forensic CAT team, especially when they initially respond to crisis situations involving a clients deteriorating mental health (which was seen partly as a result of there currently being no specialist forensic CAT team, and a perception that regional CAT teams were sometimes reluctant to respond to situations involving forensic clients due to safety concerns). While this role was sometimes seen as necessary given the circumstances, the implications for the support workers safety were noted.

- Two workers interviewed from external agencies had provided support to clients on a joint support model with the VOSA support worker. Both workers felt that this method had worked very effectively and was the preferred option for some clients, so long as there was clear communication between both parties, clearly designated roles and agency support.

- Determining when a client had 'succeeded' in the program was also raised as an issue by one interviewee. This related to the fact the program had some clients who had been supported for several years and who had not re-offended and appeared very stable in their current situations. While these clients may continue to need some level of regular outreach support (by workers with an understanding of the mental illness/offending issues), it was felt there should be a mechanism for signalling to clients the significance of their achievement (eg. by moving on to a differently named “graduate” support program).

**Improvements**

General improvements in the program suggested by interviewees included:

- Development of a specialist support program from women.
Development of the public profile of the program, including more widespread information on what the program provides and its underlying philosophy, and in training/education to other service providers on how to provide services to the client group in the community.

Development of a mechanism for all key services dealing with the client group to communicate on a regular basis (in essence similar to the previously established DEPTH committee but with a different role-for communication/information sharing rather than overseeing the program etc.).

Support workers to visit inpatient units on a regular basis to talk with staff and clients about the program and what it offers.

A range of resource related improvements, including:
- Provide services to regional areas.
- More staff to better service the needs of clients.
- A specialist supported accommodation facility for people in the transition from prison/hospital to the community.
- A bail hostel where clients could be accommodated while awaiting trial, rather than the current situation where they may be remanded in custody due to lack of suitable accommodation.
- Capacity to further assist clients to engage in recreational activities. (not necessarily activities provided by VOSA, but rather resources to introduce clients to generalist activities).

### 7.5 Summary

This chapter has provided an overview of clients, program staff and other external staff perceptions of the program. In general, the program appears to be
viewed very positively and to be providing a very necessary component of the community support needs of mentally disordered offenders. A range of issues identified by the various key stakeholder groups was discussed, and a range of suggested improvements reported. Broadly speaking, the suggested improvements can be summarised as:

- A range of resource related improvements including services for women, services for rural clients, an improved range of accommodation facilities, greater staff resources to allow more time to be spent with clients and capacity to further assist clients to access recreational activities.
- Increasing the profile of the program within the service system, both at the level of services provided and in an education/consultation role.
- Improving general information sharing and clarification of roles of agencies providing services to the client group, but particularly with reference to the VOSA program as by its nature it has contact with a range of services and the potential for role conflict is increased.
CHAPTER 8

EVALUATION SUMMARY & RECOMMENDATIONS

This chapter provides a summary and discussion of the findings of the evaluation within the framework of the evaluation questions. Particular issues likely to impact on the program’s future operation are discussed, and recommendations for future program development are made.

8.1 EVALUATION QUESTION 1: WHAT IS THE MODEL OF SUPPORT FOR MENTALLY DISORDERED OFFENDERS THAT HAS DEVELOPED?

This thesis has examined the development and current operation of a model of providing community based outreach support to mentally disordered offenders. It can be seen that the model that has developed has some similarities to the range of Assertive Community Treatment (ACT) programs (see Appendix 9) that have been shown to be effective in meeting the community support and treatment needs of difficult to engage people with a mental illness. For example, the program is assertive outreach based rather than requiring the client to come into an agency, staff work with clients on a range of needs (from practical assistance with accommodation, assistance to access treatment services, through to emotional support), staff can be contacted 24 hours a day, and services are offered on a time unlimited basis. Conversely, the program does not provide treatment services, or have a multidisciplinary team working with each client as is standard with ACT programs.

However, an examination of the model that has developed can also not be divorced from the agency context within which it began. As was outlined in Chapter 4, VOSA was established as the Epistle Centre by an ex-prisoner, and was a drop-in centre staffed by volunteers. Its beginnings can be seen to have
grown from a “grass roots” acknowledgment of the difficulties faced by people in successfully re-integrating into the community following imprisonment. The initial services provided by the agency were practically focussed (such as help with finding accommodation) and often crisis driven, but were provided within a self help framework of ex-prisoners identifying that a post release service was needed to assist other prisoners coming out of prison, and acting to set one up (rather than the service being established by another agency or professional). While the agency is now clearly very different (totally government funded, with a range of professional paid staff), many aspects of the services it provides still have a strong practical support focus, and the agency still has a strong commitment to giving people released from prison every possible chance of a successful re-integration into the community (as documented in the agency Mission Statement). In this sense, while the Forensic Psychiatric Program is a mental health program staffed by mental health professionals, it is also part of an offender support service and this clearly impacts on the model of support it provides.¹

The Forensic Psychiatric Program itself can be seen to have been born out of a clearly identified need for specific practical services (ie. accommodation) for people with a mental illness released from prison. The establishment of the DEPTH Committee brought together a non-government agency (VOSA) with the responsible government service (Forensic Health Service) and other agencies interested in the client group to try and develop services to meet the needs of the client group. The Program was established within an agency which still had a strong focus on practical support for released prisoners. However, the program was staffed with mental health trained professional workers and retained considerable input from the clinical treatments services in the early years through the DEPTH Committee. It could be argued that these early

¹ This entails both positive and negative aspects. The fact that it is a mental health program within an offender support agency means it actually targets people with a mental illness and offending history, and often takes on people who have difficulty in engaging with/being accepted by other agencies because of their offending and associated behaviour. Conversely, clients supported by the program continue to carry the ‘offender’ label even if it has been several years since they last offended.
contextual factors have all played a part in the way the program has developed to its current model of operation. Just as importantly, the actual practical experience of providing the service has also obviously shaped the model as particular ways of working with the client group have proven more effective through practice.

In undertaking the evaluation, several key theme areas were apparent that characterised the nature of the model of support that has developed within the program. While these areas can be seen as the real strengths of the support model that has developed, they are also areas of potential ambiguity and sometimes competing interest that must be carefully balanced by the workers as they fulfil their support role. These areas can also be seen, to some extent, as stemming from the way the program initially developed, that is, of a mental health program within the context of an initially consumer driven offender support agency. They include:

- **Role as worker and friend:** The development of a support relationship with the client is clearly seen as an essential part of the support worker’s role if they are to engage the client and assist them to access necessary services. Given the fact that the clients that are targeted by the program often have very poor or non-existent social support networks it is clear that the worker, in developing a support relationship with the client, often fulfils a defacto friend or family member role. This role appeared to be acknowledged as a legitimate and essential aspect of the support service by all key informants. Nevertheless, the potential role conflicts this may present workers were also noted, although it was felt that the support workers had always balanced this dual role very well.

- **Assertive outreach and voluntary participation:** The voluntary nature of participation in the program was seen as a crucial element of its operation. That is, support services are only provided to those people who are willing to continue to accept them. This must be balanced by the fact that the program operates on an assertive outreach model
where workers actively try to follow-up clients who start to disengage with services. Clearly, the workers must achieve a balance between the voluntary nature of the program and assertive follow-up of clients (especially where mental health relapse is occurring). However if a client clearly says they no longer want support from the program then this request is respected (which also results in the significant proportion of “client disengaged” outcomes for clients exiting the program).

- **Role boundaries:** From the case studies and interviews it is apparent that the support worker fulfils a case co-ordination role and is often in a position to know most about what is happening with a client (by nature of the fact that they visit the client at their home and have contact with the full range of agencies the client is in contact with). The worker is sometimes viewed as being the client’s case manager, even though this is clearly not how the workers view the role they have (which was supported by some other external staff interviewed). Many of the activities undertaken by the support worker and the client’s case manager appear similar. However, the key difference in the roles appears to be related to the social support functions (ie. being a “friend”), the voluntary nature of the relationship, and practical activities that are intrinsic to the support workers role. Furthermore, given the nature of the client group, while a case manager can coordinate the client’s plan and ensure all the client’s needs are being met, the client will often require much more structured support to actually keep to the plan (eg. being picked up and taken to an appointment). In a rapidly changing service system it will be important for the program to be able to continue to communicate how the support worker role does differ from that of a case manager, and how this different role is important to the client’s overall case plan.

- **Practical support focus:** A key feature of the program is its emphasis on providing concrete practical support (such as helping with accommodation, driving to appointments, shopping, budgeting, etc.).
However, this is balanced by activities that require the skills and experience of mental health trained staff, such as dealing with clients in crisis, undertaking initial mental state assessments, and providing education and consultation to generalist workers on mental health issues. Similarly, mental health training for staff appears to be beneficial when it comes to dealing with mental health services, in that they can expedite entry into treatment services as their assessment of the client's situation will carry some weight with the treatment service staff.

- **Specialist versus generalist services.** Tension is apparent between whether services should be provided to mentally disordered offenders in the community by specialist forensic services or by generalist mental health support and treatment services. While the ideal would clearly be that offenders with a mental illness should receive the same type of services as anyone else with a mental illness, the practical reality is that there are several barriers to this happening. Mentally disordered offenders are often characterised by their inability to engage with generalist services and staff of generalist services are often reluctant to work with them. In addition some may lack the necessary knowledge/skills to work with this client group, and there is the real issue of the impact on other clients in generalist services. This is not to argue that generalist services do not provide effective services to the client group as they often do, rather that a specialist service is available that specifically targets the client group where other generalist options can not be accessed. However, it must also be acknowledged that a specialist forensic service will continue to 'label' the client as an offender, which obviously has its own negative consequences.

In general, it can also be seen that the program was established in response to a perceived need for specialist supported accommodation for the client group. While the supported accommodation facility was not funded (and appears
unlikely that it will be), the initial funded position clearly had an emphasis on being an accommodation worker, and many of the early referrals to the program were simply to find accommodation. Over the years, with increased funding, the support workers’ role has expanded to address a wide range of areas in the client’s life. However, accommodation needs still remain one of the key reasons for referral to the program, and also one of the main ways the worker can offer the client concrete practical assistance which can then be the basis for developing an effective support relationship.

8.2 Evaluation Question 2: What are the specific components of the Model?

Based on data collected through the case studies, interviews, and the management information system, a profile of the specific tasks performed by the outreach workers and the factors underlying delivery of these services were provided (See Chapters 5-7). Figure 8.1 provides a summary of this data. In addition, data on the actual infrastructure and resources of the program was outlined in chapter 4.

The key features of the model can be summarised as:

- Contact is made with the client prior to discharge from prison or hospital. This means the support worker can start to develop a relationship with the client and be involved in their discharge planning (usually in a practical sense such as finding accommodation).

- Intensive support is provided during the crucial transitional phase from the hospital/prison to the community. This often involves the worker meeting the client on their discharge and taking them to their accommodation, helping them to organise social security, and making sure they get to their first follow-up treatment appointment.
UNDERLYING FACTORS:
1. Voluntary participation.
2. Assertive outreach based.
3. Relationship based.
4. Capacity to provide concrete practical assistance.
5. Time unlimited support.
6. No regional boundaries.
7. Mental health trained staff working in an offender support context.
8. Transitional support begins prior to discharge.

KEY ROLES/TASKS:
1. Discharge Support.
2. Relationship building.
3. Accommodation support.
4. Mental health support.
5. Justice support.
6. Crisis support.
7. Practical support.
8. Vocational/recreational support.
10. Education/consultation.
11. Family support.

Support work based on engaging client through relationship.

Communicator between services. Organiser of client to access services.

Figure 8.1 Support Model Components
Support from the program is not time limited. Support continues until the client no longer requires it, moves on to other services, decides they no longer want to have support, or contact is lost. If a client returns to hospital or prison (depending on length of sentence) support will also continue.

Each client is supported by one main support worker. However, the workers have a weekly team meeting where all clients are discussed so that if a worker is absent another worker is aware of the client’s situation and can temporarily step in. In addition, in crisis or other difficult situations the worker can call on another worker for back-up.

The support is offered on a holistic basis. The worker may assist with a range of very practical tasks (accommodation, budgeting, shopping, driving to appointments etc.), help the client to maintain contact with a range of other services (particularly treatment services), provide counselling and psychoeducation to the client and their family, and provide a social network function (going for a coffee etc.). In addition, the workers also spend a considerable proportion of their time on liaison/education activities with a range of agencies.

It must also be noted that while most work with clients was undertaken on a sole worker model, there were some examples where the VOSA worker had provided support work dually with another support service. Where both services had a strong commitment to working dually with the client, and there was a good working relationship between the workers involved (and thus good communication and clarification of roles), the dual model appears to have been very effective. The use of such a model was suggested as a possible way to work with female mentally disordered offenders, in the absence of a specific targeted program. 

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2 That is, the client would be supported by a female worker from another service, while the VOSA worker provided input on forensic and mental health issues.
Overall, the key to the effectiveness, or otherwise, of the program is the capacity of the workers to engage with the client. Data presented in this evaluation has indicated that where the worker has successfully engaged with the client this has played a significant role in reducing the likelihood of re-offending, and in keeping the client linked into other services that are also likely to increase their community tenure. Conversely, the substantial proportion of contact lost and (to a lesser extent) client disengaged outcomes presented in the data demonstrate the practical difficulties of effectively engaging the client group.\(^3\) Related to this area, it is also clear that where the client has successfully engaged with the program the worker often comes to play a significant role in the client’s social network. This can be seen as a result of the fact that clients referred to the program are often very socially isolated, with little contact with family or supportive friends. Thus, from the perception of all key informants interviewed, the worker was often seen as fulfilling a “friend” or “family member” role with the client. The significance of this role is not just the much needed social contact it provides the client but also the capacity of the worker to role model alternative models of behaviour, and thus assist the client to see an alternative to the prison/hospital/boarding house circuit they are often caught up in.

\(^3\) Given the fact that one of the reasons clients are likely to be referred to the program is their history of difficulty in engaging with services and other factors such as homelessness or risk of homelessness, a significant proportion of lost contact clients would realistically be expected. It is likely that the ability of the worker to engage the client depends to a large extent on a combination of the workers skills and personal characteristics. However, while a certain proportion of lost contact outcomes will always be expected, a challenge for the program in the future will be to see if it can identify factors (if any) that can increase the likelihood of this group of clients engaging with the program.
8.3 Evaluation Question 3: To what extent does the program meet its general objectives (as perceived by program staff) for clients?

The perceived program objectives can be summarised as to support clients to remain out of the justice system, to maintain contact with the mental health system, and to improve their overall quality of life. In chapter 6 (p.85) an examination of how the support workers work towards these objectives was made. Furthermore, in key informant interviews (chapter 7) several examples of how the program does meet these general objectives were made. For example, some clients related how having the support worker had helped them to not re-offend through having someone to offer an alternative view, counselling, social contact etc. and how it had helped to keep them in contact with mental health services. Similarly, workers from other services were able to relate how the support worker would keep the client in contact with mental health services and deal with any problems with medication etc., and how they had responded to a client mental health crisis and averted possible offending.

It could be argued that where the second two objectives are being substantially met (mental health contact and improved quality of life), that this significantly improves the chances of the first objective (staying out of the justice system) also being met. The qualitative data (case studies, interviews) was able to provide strong evidence that these objectives were being substantially met. This was further backed up by the program throughput data which indicated only four clients had returned to prison during the data collection period, and only two of these could be considered to be well engaged with the program (ie. the two others had been in contact with the program for less than three months). Clients who are well engaged with the program would also generally be maintaining regular contact with mental health treatment services and often improving quality of life (eg. improved accommodation, improved social networks, activities/employment).
However, any firm conclusions about the extent to which the objectives have been met must be made with caution. Imprisonment rates relate only to more serious crime and do not indicate re-offending that results in community dispositions and/or diversion from the justice system (which in itself may sometimes be substantially a result of the support workers advocacy and a desirable outcome). Furthermore, it is also likely that a significant proportion of clients within the “contact lost” and “client disengaged” outcomes would have re-offended some time soon after leaving the program. Thus, it can more justifiably be concluded that where the program is able to fully engage the client, there is high likelihood that the program objectives will also be met with the client.

8.4 Evaluation Question 4: What are the clients’, agency and other agencies’ experience of the program?

The various key informants’ experience of the program is discussed in chapter 7. In general, all people interviewed were positive about the program and felt that it played an important and necessary role in the community support of mentally disordered offenders. The various people interviewed also made suggestions for improvements/areas of development in the program, and these are incorporated in section 8.5 below.

8.5 Evaluation Question 5: What are the implications for further program development within this field?

This section provides a summary of issues for resolution, and potential areas for development of the program in the future, based on this evaluation. While some of the areas relate only to the program itself, others also relate to the service system generally (eg. resource issues).
8.5.1. Resource Issues

A range of issues, which can be categorised as being related to the availability of particular resources within the program and the wider services system, were repeatedly identified from a variety of sources during the evaluation. These issues are discussed separately below:

- **Female Clients:** One of the key issues bought up throughout the evaluation was the difficulty the program had in meeting the needs of female mentally disordered offenders. From the perspective of the program staff, this was clearly acknowledged, as was the fact that based on this difficulty, considerable attempts had been made to try and secure funding to set up a specialist women’s program. External staff reiterated the problem of often unmet community support needs of female clients, and some held a (false) presumption that as a group they had been ignored by the program, or were not seen as a priority. A small number of women had been accepted into the program when all other support options had failed (as per the general program guideline), however staff emphasised the significant practical difficulties faced by both the worker and the client where a male worker was working with a female client. What is also clear is that the program target client group is relatively small, and of this group women make up only a very small proportion. Thus, documenting their needs, and the need for a specialist program, to funding sources is made more difficult.\(^4\) The recent establishment of a position within the program to provide outreach support to women offenders with a severe personality disorder should provide further basis for development of a model of providing outreach support to female offenders.

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\(^4\) It can be argued that while the female group is very small, their needs are often more complex and multi-faceted and require specialist worker skills (e.g. issues related to histories of sexual abuse, issues related to children etc.) However, in general the types of offences they commit are not as likely to receive the same public exposure as the more sensational ones committed by some males, and thus in public policy terms there is likely to be less community demand for services to deal with them.
mentally disordered offenders. Furthermore, the model of the VOSA worker working dually with another agency to provide support to women should also be further developed.

Recommendation 1: That the program continues, as a priority, to seek funding for a dedicated women’s service.

Recommendation 2: That further development of dual agency support for women be investigated, perhaps with the view to setting up a formal arrangement with another agency.

Recommendation 3: That further work be undertaken in documenting the particular community support needs of female mentally disordered offenders, both in routine program data collection, and in continuing to try and secure specific funding for research in this area.

Young People: There was a perception that a recent emerging trend in the program has been referrals of younger clients (often with significant dual substance misuse). As a group, these clients tend to have not experienced significant contact with mental health services and are often highly reluctant to have any form of contact with these services due to the associated “labelling”. Furthermore, they have particular difficulty in keeping occupied in meaningful activity (work or recreational), particularly as they are similarly reluctant to be involved in disability related activity programs.

Recommendation 4: That the program continue to monitor the situation of young people referred to the program, (through routine data collection and specific case examples), so as to develop a profile

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5 For example, many of the older clients have spent significant periods of time in psychiatric hospitals etc., and have considerable knowledge about what is likely to happen at a mental health service. Conversely, some younger people express (realistic) concern about the implications of being in contact even with a community based treatment program.
of their needs and any associated service developments/modifications required.

- **Accommodation:** Access to reasonable accommodation is an ongoing issue central to the program’s operation, given the nature of the client group. While over the years the program has developed a level of accommodation much greater than when the program commenced, it is also clear that further development of accommodation controlled by the program would be beneficial. In particular, there is general agreement on the effectiveness of the one bedroom flat with an associated support worker model (of which the program has five flats) for the client group. This form of accommodation has also been evaluated across a range of agencies and found to be very effective (see Robson 1995). However, it is also clearly necessary to have access to a range of other accommodation options (such as McCormack House that is often used in the initial transition phase or as an emergency measure when other options have broken down).

**Recommendation 5:** That the program, as a priority, continue to make efforts to secure a range of accommodation options within the program, and particularly options such as one bedroom flats which offer suitable clients the opportunity for significantly improved quality of life.
- **Recreation**: Clients access to recreational/social activities was identified as a particular problem by both clients and workers.\(^6\) Given suitable funding/resources, recreational activities could be provided either through the program, or the program could have funds to assist clients to access these services through other sources (or a combination of both).

Recommendation 6: That sources of funding for a range of recreational activities both within the program and external be investigated, and that ongoing evaluation of the preferred method of providing recreational activities to the client group be implemented.

- **Rural Services**: While the program is notionally statewide, in practice there are obviously severe limitations on its capacity to provide support to clients who return to live in rural areas. Furthermore, staff of inpatient units spoke of the total lack of community support services available for clients being discharged to rural areas.

Recommendation 7: That the program monitor and document issues related to rural clients support needs and difficulties, and in collaboration with other relevant services develop recommendations, strategies, and demonstration models for improved service delivery to the group.

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\(^6\) However, there were different views on how recreational activities should be best provided to the group. Some thought VOSA organised activities that would provide activities (e.g. fishing trip, art class etc.) that would be specifically for the client group would be beneficial. Conversely, others thought that these type of activities would be beneficial, but that they should take place in other services etc so that clients could mix with a different group of people (with VOSA having some resources to assist the client financially and to initially make contact with the services).
8.5.2 Program Operation

- **Staff Workload:** Some concern was expressed by clients and external staff regarding the workload the support workers carried, and the varying demands on their time. The support workers themselves also expressed some concern at their workload and the potential impact this could have on their ability to adequately support clients, however they felt the level of worker support and supervision within the program was adequate. Clearly related to this area is the underlying tension between the program’s ideal of accepting all clients who fit a certain criteria, and the need to balance this with adequate support for clients already in the program.

  Recommendation 8: That staff workload, staff support mechanisms, and professional supervision be closely monitored and reviewed, with appropriate modifications to the program operation procedures implemented where indicated.

- **Client Throughput:** The program has now supported several clients for several years and an issue that arose during the evaluation was the absence of a particular policy around this area. Even with the recognition that in reality some clients may need some level of support indefinitely, the need for some indicator of program ‘success’ for both the client (as in a recognition of their achievement in staying out of prison etc) and the program (as in a successful program outcome) is indicated.

  Recommendation 9: That the program develop specific policies concerning long term clients, including criteria for continuation in the VOSA program and methods of recognition of the client and program’s achievement if they continue receiving support.
**Program Documentation:** Given the way the program developed, it does not have a fully documented plan of its operation (eg. objectives, program philosophy etc.) In particular, formalisation of the perceived program objectives, and development of clear methods of measuring achievement of these objectives would be beneficial.

**Recommendation 10:** That the program objectives and underlying philosophy be formalised.

**Ongoing evaluation:** Given the current service climate, the capacity of the program to be able to justify its funding and clearly demonstrate the effectiveness of the work it does are crucial. This particularly relates to its capacity to demonstrate achievement of its key objectives (eg. assisting people to stay out of prison). Thus, wherever possible, evaluative mechanisms should be built into everyday practice and routine data collection. (See also Section 8.6- Further evaluation/ research)

**Recommendation 11:** That the program develop methods of routine collection of data that relate to the key program objectives, and general program effectiveness.

### 8.5.3 Program Profile

**Profile:** A clear finding from the evaluation was a general perception that the program has a low profile within the field, and/or suffers from a level of misunderstanding about what it actually does. That is, except for staff who deal very regularly with the program, knowledge about what it does and the services it provides is low. Furthermore, there was some evidence that some staff/services with little contact with the program may have views about the program influenced by other VOSA programs (e.g. that it is for sex offenders).
resources (and balanced with the obvious priority of providing services to existing clients), and targeted at several levels. These include activities to increase awareness about the services the program provides with potential clients and agencies, and activities to increase awareness and knowledge about the working with the client group (eg. education/information to other workers on the model). Increasing the profile of the program should have several benefits. These include an increased awareness of the needs of the client group, and a strengthening of the position of the program within the service system and a related reduction in the potential for misunderstandings about the program role.

Recommendation 12: That the program continues to provide current levels of information provision on the services provided by the program (such as brochure, talks to other agencies), and also examines further ways to enhance these information provision activities (such as regular visits to key hospital/prison units).

Recommendation 13: That the program develop a mechanism (eg. a quarterly newsletter) for keeping agencies within the service system informed of key program data (eg. client contacts, client numbers, etc.), the type of work being undertaken with clients and general issues in the provision of services to the client group.

Recommendation 14: That the program examine ways to utilise program expertise by providing information/professional training on the support model and general issues in working with the client group.

8.5.4 Future Place within the Service System

- **Strategic Linkages:** It can be seen that in the early years of the program’s development, strategic linkages with other services such as the Forensic Health Service were important. As the program has
increased in size (and VOSA as the parent agency has also increased in size), these type of relationships have become less formalised. However, while this evaluation has indicated the program is well regarded with the services system, the current climate of tendering out of services, moves towards generic service provision and an increasingly fragmented service system through entry of new providers (such as private prisons etc.) indicate that the program should take active measures to ensure the services it provides are deemed necessary and well supported by other key service providers.

**Recommendation 15:** That the program actively seek to develop strategic linkages/alliances with other key service providers to enhance and protect its position (and thus the services it provides to clients) in an ever changing service system.

- **Communication:** Given changes in the services system, it is also clear that if the key services providers are not to mirror the fragmented lives of the client group, that regular liaison and communication between the services is essential. It was apparent that there was a considerable level of support for the development of a mechanism similar to the role played by the DEPTH Committee which oversaw the establishment and early formation of the program. However, a newly established committee would have a primary focus on communication between agencies rather than overseeing the VOSA program. That is, all the key agencies involved in the support and treatment of mentally disordered offenders would meet regularly to communicate program developments, and to develop unified responses to emerging issues in the field.
Recommendation 16: That the program lead the development of some form of regular forum between all key agencies involved in the care of mentally disordered offenders in the community.

8.6 The Evaluation Process and Further Research/Evaluation.

Reflection on the process
This evaluation utilised the Evaluate Yourself (Fox et al 1996) framework for self evaluation of mental health/alcohol and drug services. Some general reflections on this process include:

- The evaluation methods chosen were used with minimal disruption to the program operation or significant demands on the program staff (with the exception of the reference group made up of program staff, which proved difficult to organise in a formal way due to staff workloads).

- The multiple-methods utilised produced a significant amount of data which enabled clear themes across different data mediums to be identified. However, the sheer mass of data produced from using multiple-methods, especially from activities such as interviews and case studies, meant that there was a danger of the data becoming unmanageable within the confines of the project. Similarly, significant compromises needed to be made as to what was included in the final write-up.

- The “insider” status of the evaluator had both its positive and negative aspects. Having had previous contact with the program, initially as a worker in an external agency, and then as an internal agency employed person, resulted in a high level of baseline knowledge about the program and its associated processes. Conversely, the “insider” status meant balancing between, on the one hand not being too positive about aspects of the program without critically examining how they may appear to an independent person, and on the other
hand not over-compensating and fully acknowledging clearly positive aspects.

As has been alluded to in other parts of the thesis, the involvement of clients in the evaluation process presented its own dilemmas. While it was considered important to gain the clients’ perspective of the program, this was not obtained without considerable limitation (ie. in how clients were chosen for interview etc.). Furthermore, gaining informed consent from the clients carried with it considerable difficulty, which was not to say that clients did not understand the evaluation process or why they were being interviewed. ⁸

Areas for further evaluation/research

It would be fair to say that due to the relative lack of research and evaluation into the provision of community support and treatment services for difficult to engage mentally disordered offenders generally, any further initiatives examining overall service development would be beneficial. As for the program that has been the subject of this thesis, the following areas would warrant further investigation in the future:

- Building further research/evaluation mechanisms into the everyday program operation. In particular, this may include routine recording in the program database of all client offending (not just imprisonment), hospital re-admissions etc., gaining routine consent for follow-up contact at commencement with the program (to determine outcomes following exit from the program) and quantification of attainment of individual client goals as part of the individual management plan.
- Investigation and follow-up of what happens to clients where contact is lost or they disengage from the program. This would allow for a

⁸ Even though clients had agreed to take part in the interview, the consent form often presented some difficulty. Some would see it as simply another consent type form that they regularly sign (for example, for information exchange between agencies) and would not be interested in what was actually on the form. Conversely, others were happy with what the form contained as far as it related to the evaluation process, but were extremely suspicious of actually signing a form to acknowledge this. In either case, significant dialogue sometimes had to take place to ensure informed consent and alleviate concerns regarding to the consent form, which clearly often related to the consent form process rather than the evaluation process.
greater understanding of what happens to this group, and whether there are any mechanisms which would increase their likelihood of engagement with services. Furthermore, it may allow comparison of outcomes with clients who stay engaged with the program.

- Quantification, (while methodologically difficult), of outcomes on program objectives, particularly recidivism rates, would be beneficial particularly where influence over funding providers is required. This may involve a retrospective study (ie. previous recidivism as compared to period while receiving support) or comparisons with other offender groups (both methods with significant limitations and considerable resource requirements).
- Research into the nature of the client engagement process and how engagement might be improved.

8.7 SUMMARY

This thesis began with the contention that developing effective means of community based support and treatment for mentally disordered offenders is crucial in maintaining community support for policies of community care. The thesis has described an evaluation of the development and current operation of a community based outreach support service for mentally disordered offenders in Victoria. As has been demonstrated, the program has developed to a point where it is clearly effective in meeting the community support needs of some mentally disordered offenders, and continues to fulfil a central role in the lives of many difficult to engage, socially isolated clients. However, it has also demonstrated the inherent difficulties and challenges involved in providing a support service to this highly disadvantaged client group. Consequently, it provides a clear indication of the need to not only maintain services such as the one that has been the subject of this thesis, but also for further service development which will provide benefits to mentally disordered offenders, other people with a mental illness, and the wider community.


Glasser, W., Laster, K. (1990) Are the mentally ill being criminalised? Admission of prisoners to psychiatric hospital before and after the 1986 Mental Health Act (Vic) *Australian and New Zealand Journal of Criminology, Vol 23, 230-240.*


Murphy, E. (1991) *After the Asylums: Community Care for People with a Mental Illness*. Faber and Faber Ltd. London.


Stein, L. (1992) Innovating against the current. New Directions for Mental Health Services, No. 56, 5-22.


APPENDICES
APPENDIX 1

INTERVIEW SCHEDULE - CLIENTS
(Areas to be examined)

A. Background Demographic Data
   Age, current/ex client, accommodation type, length of time since discharged from prison/hospital, length of time supported by program etc.

B. Clients experience of moving from the institution to the community
   - Where did you live.
   - What services assisted/didn’t assist you.
   - What was most difficult.
   - What preparations were made for your discharge.

C. Clients experience of the VOSA Forensic Psychiatric Program
   - What is your experience of the program.
   - In what ways did it help you.
   - What needs did you have that were not met by the program.
   - In what ways was this time different than previous discharges (if applicable).
   - What would need to change to improve the program.

D. General Observations
   - What general improvements are needed in the service system.
   - What needs are not currently being met.
   - Other suggestions, observations.
Appendix 2

Interview Schedule: Program Staff
(Areas to be examined)

A. Background Data
   Position in program, profession, length of time working in program etc.

B. Experience of the Program
   - General experience of program.
   - What are the perceived objectives of the program.
   - How does the program work towards meeting these objectives.
   - How would you describe the model of practice.
   - In what ways does the program assist clients.
   - What are the program’s strengths/weaknesses.
   - How would you measure “success” in the program.
   - How does the program operate in the general service field and link into other agencies and services.

C. Improvements
   - What could be improved in the program.
   - What factors in the general service field also need changes/improvements.
   - What are the current unmet needs of the client group.

D. General impressions
   - Overall observations
   - The future of the program and service delivery in this field.
Appendix 3

Interview Schedule: External Staff
(External agencies and other programs within VOSA)

A. Background Data
- Agency type, worker position and profession, type and length of contact with the program etc.

B. Experience of the Program
- General experience of program.
- What do you perceive as the objectives of the program.
- How does the program work/not work towards these objectives
- In what ways does the program assist/not assist clients
- What are the program strengths/weaknesses
- How does the program operate in the general service field and how does it link into your agency/program

C. Improvements
- What could be improved in the program.
- What factors in the general service field also need changes.
- What are the current unmet needs of the client group.

D. General Impressions
- Other observations
- Service gaps not currently being addressed
APPENDIX 4: Consent Form: Clients

Evaluation of VOSA Forensic Psychiatric Program

The purpose of this project is to see how well VOSA's psychiatric support program is going, how it supports people, and what could be done to make it better. We are talking to both people who have been supported by the service, and the staff, to see what they think of the program. As you have been supported by the program, we would be very interested to hear what you think, and your opinions are important.

The researcher on the project is David Rose, VOSA's Policy Officer. The project is part of his Master of Social Work degree under the supervision of Dr. Fiona Mc Dermott at the School of Social Work, University of Melbourne.

If you decide to take part in an interview it is important that you understand the following points:

- You do not have to take part in the interview, or any other part of the project. If you decide not to take part you will still receive all the services and support from VOSA that you currently get.
- If you decide to take part in the interview, you can still choose to withdraw at any time and any information you have provided will be destroyed if you wish.
- All information that you provide is confidential and will only be seen by the researchers. The only exception to this would be if you spoke about a serious crime that had not been reported to the authorities. The researcher may be obliged under law to notify authorities if the crime requires mandatory reporting.
- At the end of the project a report will be written and all the information collected will be combined together so that no individual person can be identified.
- During the interview brief notes will be taken and then more detailed notes made later. You can receive a copy of the notes to make sure that you are happy with everything that is in them.
- Before you sign this form, the researcher will explain what the interview will be about, and what is expected of you. He will also explain the information on this page, and answer any questions you may have.

I, ______________________, have read and/or had explained to me the nature of the project, and the above information, and are willing to be part of the project. I understand the information I provide will be confidential, subject to any legal requirements of disclosure.

Signed: ______________________ Date: ______________________

I, ______________________ (researcher), have explained the nature of the project, and the above information.

Signed: ______________________ Date: ______________________

Witness: ______________________ Signed: ______________________ Date: ____
APPENDIX 5: CONSENT FORM: STAFF

Evaluation of VOSA Forensic Psychiatric Program

The purpose of this project is to undertake a program evaluation of the Forensic Psychiatric Program that has operated at VOSA since 1992. The project is being conducted by David Rose, VOSA’s Policy Officer, for the purposes of a Master of Social Work degree under the supervision of Dr. Fiona Mc Dermott at the School of Social Work, University of Melbourne. The project is being undertaken with the full support and permission of VOSA.

The evaluation will aim to document the growth of the program and the model of support that has developed. It will also seek to examine in what ways the program is able to assist/not assist clients and in what ways the program should develop in the future. Data collected will include case studies based on written records, and interviews with clients, program staff, and external agency staff concerning their impressions of the program.

Before agreeing to take part in this project you should be aware of the following points:

- Your participation in providing data for the project is voluntary.
- You are free to withdraw from the project at any time, and to have any data you have supplied withdrawn from the data analysis.
- If you agree to have an interview recorded, the recording will be used only for later accurate write-up of the interview before being destroyed. Written transcripts will be identified only by a code number and will only be accessed by the project staff. You will be provided with a copy of the transcript to ensure you are satisfied with it’s contents before it is included in the data analysis. In reports on the evaluation all data will be presented so as to maintain your anonymity, unless prior permission is received from you to do otherwise.

I, ________________________ have read and understand the above information on the project, and have had explained to me the nature and content of the data I will provide through an interview /group, and freely consent to participate.

Signed: ________________________ Date: ________________________

Thank you for your participation.
APPENDIX 6

KEY MILESTONES IN THE DEVELOPMENT OF THE PROGRAM

January 1992  The first outreach worker commenced. Funding was provided for a car and a period of extensive liaison with a range of agencies commenced. The client caseload was initially set at 20 clients. Initial investigations were started on the possibility of securing a group home (2-3 bedroom house) where clients could be accommodated. By the end of February the worker had taken on a caseload of 12 clients. A reporting structure was established whereby the worker met with the DEPTH Committee monthly to report on progress and any system wide issues that needed addressing (later became every 2-3 months). The DEPTH committee also continued to pursue its original goal of securing funding for an accommodation program.

June 1992   New worker began in the position. 27 referrals had been accepted by the program, with the active case load being 20 clients. Extensive liaison with a range of accommodation and support agencies continued.

December 1992  Approval was given for the development of a 3 bedroom group home, provided by the Ministry of Housing.

April 1993  New worker began in position (and continued in program to current position as Program Manager). 3 residents moved into the group home, with ongoing support from the outreach worker. Need for fully staffed transitional accommodation still apparent, and efforts through DEPTH committee continued.

December 1993  Program had been operating 2 years and while active caseload remained at 20 clients, demand for services was increasing beyond what one worker could manage. This was partly due to an increase in referrals from mainstream (i.e. general psychiatric hospitals) whereas bulk of previous referrals were from forensic facilities.

February 1994  The Department of Health and Community Services funded a second outreach worker position and the worker commenced allowing the active caseload to be increased to 35 clients. The existing worker became co-ordinator of the program and undertook the screening/assessment role with all new referrals in addition to an active case load.

September 1994  Funding for a second 2 bedroom group home approved.
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 1994</td>
<td>Funding approved and 2 workers commenced on a 12 month National Mental Health Program demonstration project to provide outreach support to the families of mentally disordered offenders.</td>
</tr>
<tr>
<td>December 1994</td>
<td>Funding received for 6 one bedroom flats under a program where the Department of Planning and Development act as landlords and the Department of Health fund an outreach support worker to support clients in the houses.</td>
</tr>
<tr>
<td>March 1995</td>
<td>Third outreach worker appointed with specific responsibility for supporting clients in the 6 flats. A Disability Employment Worker position for the agency was also funded, with the worker being able to provide half time services to the Forensic Psychiatric Program.</td>
</tr>
<tr>
<td>February 1996</td>
<td>Family outreach project completed and report launched.</td>
</tr>
<tr>
<td>1996-1998</td>
<td>No further increases in funding have been received and the program has continued to operate with existing resources. Main development activities have been around issues such as development of data collection methods, development of Individual Management Plans for all clients, and submissions in attempts to get further funding for groups such as women mentally disordered offenders. In early 1998 notification was made that the program will be funded for a Women’s Personality Disorder outreach worker position, to work in conjunction with the new Personality Disorder Service to be operated by Maroondah Hospital. By the end of April 1998 210 clients had been accepted into the program.</td>
</tr>
</tbody>
</table>
APPENDIX 7

CASE STUDY DETAILS

Case studies based on the written records were utilised as they allowed for a detailed analysis of the work being undertaken by the outreach workers which could be compared and contrasted to the broad picture of their work developed by the analysis of data from the management information system. Furthermore, the method was relatively unobtrusive which meant the data could be collected with minimal disruption to the staff or clients.

The aim was to include a mix of clients who had received services from the program that would allow an examination of the different ways the outreach workers work with clients depending on the situation. Clients are given a client number when they enter the program, and every third number was chosen for inclusion in the case studies. Sixty clients were chosen from the approximately 180 clients who had received services from the program and had a client number by August 1997. As the number of women who have received support from the program is very small (only 4 women in the period 1992-97), it was decided to include all female clients in the case studies as the provision of services to women presented as a particular issue of concern within the program. Thus, as three of the women clients had already been included in the sample of 60, the remaining client was included to take the total number of case studies to 61.

(Note: In the early years of the program it appears some clients received services but did not get assigned a number or have extensive case notes written on them, so the actual number of clients who have had contact with the program is higher than 180. However, the vast majority of clients did receive a client number etc and thus the 180 clients represents the bulk of clients who have received services since the program commencement).

A Microsoft Access database was developed that allowed for the collection and storage of data from the case studies in several broad areas. These areas were:
- Background data (Period of support, age, referred by etc.)
- Accommodation issues.
- Family/support issues.
- Mental Health issues.
- Offending/legal issues.
- The outreach workers work with the client.
- Outcome of the client’s contact with the program.
- Any other relevant issues apparent from the particular case study.

Data was collected by reading each of the case files including relevant reports, referral forms etc. and the continuation sheets that the outreach workers complete to document their ongoing work with clients. Where necessary (and possible), the particular outreach worker was also consulted if any clarification was needed. The data was entered directly into the database within the broad areas. Data was then produced from the database which allowed for each individual case study to be examined, as well as an examination of each of the broad areas across all cases to extract relevant themes.
APPENDIX 8

INTERVIEW DETAILS

A. Program Staff
An interview was held with each of the staff currently working in the program (3 interviews). In addition, further regular informal consultation with the staff on an individual and group basis took place. The three staff have worked in the program for 5 years, 2.5 years and 1.5 years respectively.

B. Client Interviews:
Clients suitable to be interviewed were identified by the support workers (see also ethical guidelines-chapter 3). These were clients who it was deemed would be able to take part in an interview with little likelihood of any negative impact on them. The support workers then spoke to the client about whether they were happy to be contacted by the researcher. Where verbal consent to be contacted was given, the researcher then contacted the client to arrange an interview time. Prior to the interview, the nature of the interview was explained to clients and they were asked to sign a consent form.

Interviews were undertaken with 10 clients, 9 of whom where currently receiving support services from the program, and 1 who had previously received support from the program. Background demographic details of the clients interviewed are outlined below:
Client Background Details: (n=10)

- **Sex**
  - Male 10

- **Age**
  - Range 33 – 70 years
  - Mean 42.5 years

- **Period of Support**
  - 1 year or less 3
  - 2-4 years 6
  - 5+ years 1

- **Current Accommodation**
  - Rooming House 4
  - Rented House/flat 5
  - VOSA Flat 1
C. External Agency/Program Staff

Interviews with staff external to the program were aimed at obtaining a small cross-section of key informants who had significant contact with the program and could comment on its operation (given the scope of the evaluation a large scale survey of all external informants was not possible). Staff deemed suitable to be interviewed were identified in consultation with the program workers and then contacted by the researcher and asked if they could take part in an interview. The breakup of staff interviewed is outlined below:

**VOSA (6 Interviews)**
- VOSA Executive Director.
- Disability Employment Workers (2).
- Manager, McCormack House.
- Prison Support Worker/Accommodation Support Worker.
- Manager, VOSA COATS (related to previous role as Co-ordinator of Community Forensic Psychiatric Services and representative of Forensic Psychiatric Services on the DEPTH Committee for several years).

**External Agencies (12 Interviews)**
- Melbourne Assessment Prison- Acute Assessment Unit (2 staff).
- G Division (now ceased operation).
- Brunswick Road Clinic- (Community Forensic Psychiatry) (2 staff).
- Rosanna Forensic Psychiatric Centre.
- St. Paul's Psycho- Social Unit, Port Phillip Prison.
- SANS Program (Salvation Army)
- Boomerang Club (Disability day program)
- Prahran Mission (Disability day program)
- Anchorage Hostel (Salvation Army)
- Axis Employment Program (Salvation Army)

D. Analysis

Staff interviews were tape recorded and then written up with a combination of direct quotations and summary. Brief notes were taken during the client interviews and then a more detailed write-up took place following the interview. Data from the interview write-ups was then amalgamated in broad areas (related to the broad classifications in the interview schedules- See Appendix 1-3) and then key themes identified.
Appendix 9

Assertive Community Treatment

The table below outlines the key components of standard Assertive Community Treatment programs as based on the original Stein and Test model, and which would operate as a comprehensive regional mental health service.

<table>
<thead>
<tr>
<th>ACT Components</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(Adapted from Teague et al 1998: 218)</strong></td>
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<tr>
<td><strong>Human Resource Structure:</strong></td>
</tr>
<tr>
<td>▪ Small caseload: ration of 10:1</td>
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<tr>
<td>▪ Team approach</td>
</tr>
<tr>
<td>▪ Regular program meetings</td>
</tr>
<tr>
<td>▪ Team leader</td>
</tr>
<tr>
<td>▪ Continuity of staff</td>
</tr>
<tr>
<td>▪ Psychiatrist on staff</td>
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<tr>
<td>▪ Nurse on staff</td>
</tr>
<tr>
<td>▪ Substance Abuse Specialist on staff</td>
</tr>
<tr>
<td>▪ Vocational specialist on staff</td>
</tr>
<tr>
<td><strong>Organisational Boundaries:</strong></td>
</tr>
<tr>
<td>▪ Explicit Admission criteria</td>
</tr>
<tr>
<td>▪ Low client intake rate</td>
</tr>
<tr>
<td>▪ Team has responsibility for all areas (treatment, housing, support etc.)</td>
</tr>
<tr>
<td>▪ Crisis response</td>
</tr>
<tr>
<td>▪ Manage hospital admissions</td>
</tr>
<tr>
<td>▪ Responsible for discharge planning</td>
</tr>
<tr>
<td>▪ Time unlimited services</td>
</tr>
<tr>
<td><strong>Nature of Services:</strong></td>
</tr>
<tr>
<td>▪ In-vivo services</td>
</tr>
<tr>
<td>▪ No dropout policy</td>
</tr>
<tr>
<td>▪ Assertive engagement process using street outreach</td>
</tr>
<tr>
<td>▪ High intensity of service</td>
</tr>
<tr>
<td>▪ High frequency of contact</td>
</tr>
<tr>
<td>▪ Work with clients support system (ie. families etc.)</td>
</tr>
<tr>
<td>▪ Individualised substance abuse treatment</td>
</tr>
<tr>
<td>▪ Dual disorder treatment groups and model.</td>
</tr>
<tr>
<td>▪ Encourages consumers to be involved as team members providing direct services.</td>
</tr>
</tbody>
</table>

The Sainsbury Centre for Mental Health (1998) documents a wide range of variations of ACT models that have operated in Great Britain. These include various combinations of:

▪ Different staffing profiles.
▪ Key workers versus team approach.
▪ Location in statutory treatment services versus non-government agencies.
Focus on general support versus all support and treatment functions from the same team.

However, common to all approaches are an emphasis on engagement of the client through assertive outreach and a focus on meeting practical needs as well as other support and treatment needs. Of particular relevance to this thesis is the conclusions of The Sainsbury Centre for Mental Health (1998) report on the desirability of placing outreach based teams in either statutory services or the non-government sector. The report found that assertive outreach based services were the preferred mode of service delivery to difficult to engage people with a mental illness, and that it was important to have at least some of the service located within the statutory mental health service. However, the report also examined very effective examples of outreach based support teams (where the focus was on support rather than treatment) located in non-government agencies that were particularly effective in engaging the client. Thus it concludes that outreach based non-government support services can play an important role in the spectrum of treatment and support services to difficult to engage people with a mental illness. However, the effectiveness of such services will be based on there being a good working relationships between the statutory and non-government services, with the statutory services clearly having responsibility for the treatment role. Furthermore, the non-government service will often be able to engage with the client on a level that will not be possible through the statutory service, that may be required to make decisions about the client’s health/welfare (such as admitting them to hospital), often against their will.