University of Western Sydney

Yesterday, Today and Tomorrow for Young People with Co-morbidity: A Retrospective on the Richmond Fellowship NSW Young Peoples' Program

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EXECUTIVE SUMMARY

Yesterday, Today and Tomorrow for Young People with Co-morbidity: A Retrospective on the Richmond Fellowship NSW Young Peoples' Program

In 2008 the Social Justice Social Change Research Group (SJSC) at the University of Western Sydney (UWS) implemented a research project developed by the Richmond Fellowship of New South Wales (RFNSW) to explore the benefits and limitations of their Young People's Program (YPP). The clientele of the Program are young people with a dual diagnosis of mental disorder and drug use. The review of the YPP is part of the strategy of the RFNSW to achieve ongoing improvement of its services for young people with serious mental illness and drug issues.

Funding for the project was received from the Mental Health Coordinating Council under the NGO Mental Health and Drug & Alcohol Grants Program.

RESEARCH OBJECTIVES AND QUESTIONS

The purpose of the research project was to identify trends and specific interventions, contextual factors or other indicators that influence individual recovery and service outcomes for those young people with a mental disorder and co-occurring drug problems. The review was comprehensive, covering from the YPP's inception to the present-day. The findings were to be used to inform future service planning and staff recruitment, training and workforce development for RFNSW, related services and the sector more broadly.

RESEARCH DESIGN AND METHODS

The research project was developed as a mixed-method project comprising three aspects:

1. Document analysis: Examination of the complete set of case-files of the YPP (104)
2. Semi-structured interviews: Fifteen residents both past and present of the YPP
3. Focus Groups: Two in total – one with key family members of service users; the other with community-based case managers

The fieldwork commenced in December 2008, following ethics approval from the UWS Human Ethics Committee (Protocol Number **H5654**) and was completed in May 2010. The document analysis required the case-files be categorised according to data collection approaches. These categories came to reflect different time periods and as such, different phases of the YPP as follows: Phase 1, 1995-9; Phase 2, 2000-04; Phase 3 2005-9.

RESEARCH FINDINGS

Documentary Analysis - Examination of the 104 case-files revealed:

- Increase in numbers of clients entering the program with co-morbidity issues – Phase 1 68% to Phase 3 93%
- Increase in average time spent in the program - Phase 1 4 months to Phase 3 13 months
- Increase in percentage of residents completing the Program. That is, moving from high dependency living support to minimal support level - Phase 1 0% to Phase 3 30%

- Minimal decrease over the three phases of the Program in the perceived norm amongst clients around drug and alcohol use whilst in the Program - an average of 83% of residents using drugs whilst participating in the Program

- Increase in reports of consumption of alcohol by clients - Phase 1 46% to Phase 3 70%

- Increase in achievement of client-identified goals, with decrease in achievement of staff-identified goals

- Achievement of stability in employment of clients at exit (including both full and partial employment) over all phases of the Project

- Achievement of stability over all phases of the Project in clients exiting the program to live with their family

- Increase in clients moving from the program into private rental accommodation - Phase 1 7% to Phase 3 26%

- Increase in planned exits over all phases of the program - Phase 1 28% to Phase 3 48%

- Decrease in evictions over all phases of the program - Phase 1 57% to Phase 3 19%

Qualitative Interviews and Focus Groups - Analysis of this qualitative data indicated overwhelming support from clients, family members and case managers of former clients. The aspects of the Project identified as being most beneficial were:

- Staff - Being supportive, non-judgemental and respectful

- Programs – Experienced as particularly positive when designed around social activities

- Training – In life skills

- Learning – Goal-setting

The aspects of the Project identified as being problematic were:

- Supervision – Lacking at evenings and weekends

- Drug and alcohol use and violence - Associated with the problematic times of lacking supervision.

- Inconsistency and leniency in implementation of house rules – Particularly in reference to drug and alcohol use and unacceptable behaviours

RECOMMENDATIONS

On the basis of the above findings, it is recommended that the RFNSW implement the following:

Short-term strategies:

- Clear articulation of YPP's policy on rule-breaches (eg. cannabis use, drinking, aggressive/abusive behaviour)
- Clarification of sanctions associated with rule-breaches
- Staff training in implementation of rules and sanctions
- Client education workshops on adherence to rules and avoidance of sanctions
- Articulation of "indicators of success" (strengths) of the program. This articulation to be evidence-based resulting from the following sources of data, to be systematically recorded:
    - Medication management (including compliance or planned reduction in medication)
    - Management of drug and alcohol use
    - Development of life skills
    - Improvement in capacity for independent living, this may be reflected in movement between support levels, increasing independence and responsibility, or planned exits.
    - Monitoring and recording of goal establishment and achievement
    - Occupation during program and at exit (including employment, full or part time, education, volunteering)
    - Accommodation type at exit

Issues arising through the review which the RFNSW may wish to consider but which the review does not wish to posit as recommendations include:

- Review the night and weekend staffing of the Core House
- Review the degree to which the YPP wished to engage family members in the program

Long-term strategies:

- Seek further funding to expand the YPP so that young women with mental health issues could be accommodated in a women only environment.

ABBREVIATIONS

ABS	Australian Bureau of Statistics
DoH	Department of Housing
HASI	Housing and Accommodation Support Initiative
NGO	Non-government organisation
NMHS	National Mental Health Strategy
RF	Richmond Fellowship
RFNSW	Richmond Fellowship of New South Wales
SAAP	Supported Accommodation Assistance Programs
SJSC	Social Justice and Social Change Research Group
SMI	serious mental illness
SWAMHS	Sydney West Area Mental Health Service
TAFE	Tertiary and Further Education
UWS	University of Western Sydney
WHO	World Health Organization
YPP	Young Peoples' Program

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INTRODUCTION

Since the 1960's the mental health care system in most developed countries, including Australia, has undergone significant reform. Included in these changes are: a fundamental reformulation of the provision of mental health services; modifications to the roles and responsibilities of individuals and governments for mental health care; and a seismic shift in the nature and sites of mental health service delivery. As a result, changing concepts of mental health and mental disorder along with more sophisticated understanding of the factors contributing to mental health have challenged dominant forms of service delivery and practice. With the rise of the consumer or users' movement, 'consumer participation' has become enshrined as a central principle of policy and service reform in mental health (Bland & Epstein, 2008). All of which bodes well for those with mental health problems within the community.

The Richmond Fellowship of NSW (RFNSW) is a non-government organization (NGO) that provides mental health services for young people. As a key service provider the RFNSW recognises its responsibility to maintain quality care in this much-needed health sector. It is within this context that the RFNSW has undertaken a review of its services in the Young Peoples' Program (YPP).The Social Justice Social Change Research Group (SJSC) at the University of Western Sydney (UWS) was contracted to perform this review identifying the benefits and limitations of the YPP provided by the RFNSW. This document is the final report of that review.

The Richmond Fellowship of NSW

The RFNSW was established in 1975 as part of the International Organisation of Richmond Fellowship founded in 1957 in Richmond, England. The organisation offers various levels of accommodation and psychosocial programs to those with mental health problems with the purpose of assisting their integration into the wider community.

The ethos of the RFNSW is to maximise the well-being and potential of people living with a mental disorder (`Richmond Fellowship, Making Recovery Reality', http://www.richmondfellowship.org.uk/). From its initial operations in Glebe, the RFNSW has expanded its service provision beyond the Sydney metropolitan region to include rural areas of NSW.

A particular service of the RFNSW is the Young Peoples' Program (YPP). This program was first proposed in 1996 and came into being during a period of renewed focus on mental health at the national and state levels. The YPP was established in the Western Sydney region to provide accommodation and high-level support to young people aged 17-25 with co-occurring issues of mental health and substance use. Such co-morbidity is an increasing phenomenon within Australia (McLaren, Lemon, Robins & Mattick, 2008). As such, this review of the YPP is timely given the projection of its increased need in the area of community health and welfare.

Understanding Mental Disorder and Mental Health

The Politics of Terminology: It is important to note that the terms 'mental illness' and 'mental disorder' are frequently interchanged within literature and in the common vernacular. Though they both remain contested concepts (Read, Mosher & Bentall, 2004), the term 'mental disorder' is the more frequently used in both policy and academic literature and as such, it is this term that will be used in this report, occasionally interchanged with the term 'mental health problem(s)'.

A mental disorder has been defined as a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following: (a) delusions; (b) hallucinations; (c) serious disorder of thought form; (d) a severe disturbance of mood; and (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in points (a)-(d) (NSW Select Committee on Mental Health, 2002).

The Epidemiology of Mental Disorder

After cancer and cardiovascular disease, mental disorder is identified as the third leading health issue in Australia with 1 in 5 aged 16–85 (and 1 in 4 aged 16-24) receiving such a diagnosis over a 12-month period (AIHW, 2010).

Schizophrenia often manifests in the mid to late teens and depression is one of the most common health issues in young people and increases during adolescence (ABS, 2008; AIHW, 2010). As a result of these frequencies, one third of people admitted for mental health problems to public hospitals are under the age of 30 years.

Mental Disorder and Drug Use

Drug use can complicate diagnosis and exacerbate or trigger mental disorder in vulnerable young people (ABS, 2008; AIHW, 2010). Although use of illicit drugs has generally declined in Australia, including the use of methamphetamines and cannabis (AIHW, 2010; McLaren et. al 2008), cannabis remains the most widely used illicit drug in Australia and the world, particularly by young people from early teen years to late twenties (McLaren et al 2008). Cannabis use is most prevalent among those aged in their 20s, and is more commonly used by males than females (McLaren et. al, 2008). Adolescent cannabis use has been linked to a range of psychological and social problems including an increased risk of depression and suicide (ABS, 2008; AIHW, 2010).

According to Hall & Farrell (1997), there is a significant positive correlation between mental health problems and drug use. The common abuse of alcohol further complicates this social health issue. In this report, the presence of drug and alcohol issues in addition to the primary diagnosis of mental disorder is referred to as 'co-morbidity'. It is important to note that correlation does not necessarily mean causation, however, the previously common practice of separating mental health and drug and alcohol services in Australia has created a cultural divide such that co-morbidity can be misdiagnosed (Hall & Farrell, 1997), when interventions are needed that address both health issues simultaneously - especially given evidence suggests that people with co-morbidity have worse prognosis than those with only one type of disorder (McLaren et. al, 2008; MHCA, 2006).

The complexity of co-morbidity has significant implications for the emphasis and ordering of treatment regimes. As McLaren et. al (2008) show, the dynamic of co-morbidity may shift and change such that the focus of support and treatment may need to be both simultaneously, or the mental health issue at one stage and drug issue at another.

It is this consideration of the complexity of co-morbidity that is the foundation of the YPP of the RFNSW, and for which it is important in the performance of this review, to understand the social and political context which forms the back-drop for both the organization and the services it provides.

SITUATING THE STUDY

The Evolving Context of Mental Health: The National Mental Health Strategy

The *National Mental Health Strategy* (1992) was a significant commitment by the Federal and State governments of Australia to improve the lives of people with a mental disorder. As a framework to guide mental health reform, it identified four aims:

1. To promote the mental health of the Australian community
2. Where possible, prevent the development of mental disorder
3. Reduce the impact of mental disorders on individuals, families and their communities
4. Assure the rights of people with mental disorder (Department of Health & Ageing, 2010).

Subsequent National Mental Health Plans followed in 1997 and 2003. The most recent emerged in the context of the updated National Mental Health Policy influenced by the *Council of Australian Governments' (COAG) National Action Plan on Mental Health 2006-2011*.

From the outset, the National Mental Health Strategy emphasised the role of non-government organisations in providing support services to consumers and carers (`Overview of the Strategy', *National Mental Health Report 2007,* p.34).

National Mental Health Plans: Four Stages and Reports

The First National Mental Health Plan (1993-98): Attempted to coordinate mental health care reform in Australia via national activities. It focused on state/territory based, public sector, specialist clinical mental health services, and advocated major structural reform. A key emphasis was the growth of community-based services with less reliance on stand-alone psychiatric hospitals, and the 'mainstreaming' of acute beds into general hospitals (*Fourth National Mental Health Plan,* p.18).

The Second National Mental Health Plan (1998-2003): Expanded its areas of consideration to include more common disorders such as depression and anxiety and the promotion of mental health and de-stigmatisation of mental health problems. A key initiative was the establishment and funding of the national organisation *Beyondblue (Fourth National Mental Health Plan,* p.19).

The Third National Mental Health Plan (2003-2008): Stressed the importance of cross-sectoral partnerships and the need for more integrated and coordinated care.

The Fourth National Mental Health Plan (2009-2014): Emphasised a 'whole of government approach' to initiatives addressing mental health problems in response to the *COAG National Action Plan on Mental Health 2006-11*which identified areas of insufficient progress under the previous National Mental Health Plans *(Fourth National Mental Health Plan,* p.19).

This *Fourth* (and current) *National Mental Health Plan* (*2009-2014)* affirms the key aim of reorienting mental health care away from dependence on inpatient services towards community settings, prioritising:

1. Social inclusion and recovery
2. Prevention and early intervention
3. Service access, co-ordination and continuity of care
4. Quality improvements and innovation
5. Accountability - measuring and reporting progress

The NSW Community Mental Health Strategy 2007-2012

Since the commencement of the new millennium, the NSW government has strengthened its commitment to and investment in mental health services by developing the *Community Mental Health Strategy (2007-2012)* (the Strategy) to facilitate the delivery of community mental health programs by public mental health services and specialist Non-Government Organisations.

The focus of the Strategy is "recovery" and contains five elements:

1. Individualised care
2. Community participation
3. Promotion, prevention and early intervention
4. Service integration
5. Evidence-based practice

Although they are all important for the sector as a whole, the first three elements are the basis of the work of services concerned with providing supported accommodation services for people with mental health problems in the community.

Accommodation and residential services: Their pivotal role in mental health

Within the *National Mental Health Strategy*, a high priority has been accorded accommodation and community residential services in the recovery and quality of life of people who experience mental illness. Shortcomings in the area of accommodation options were linked to the failure of mental health initiatives overseas. By the *Fourth National Mental Health Plan 2009-2014*, an expansion in the number of 'living support services' provided by non-government organisations in the community was reported. A classic example of one such community residential service is the YPP of the RFNSW.

The Young People's Program: Supported Accommodation by the Richmond Fellowship of NSW

The YPP of the RFNSW is a transitional program providing supported accommodation for young adults between the ages of 18 and 35. All users of the service have lived with a severe mental disorder and over 80% present with co-morbidity.

The primary aim of the YPP is to provide a supportive environment, based on the principles of a therapeutic community, which can assist residents to reintegrate into the community. The strategy to achieve this aim is through the acquisition of social skills; behaviour self-management; psycho-education; assistance with vocational training and employment; medication compliance; advocacy; and physical health education which includes personal hygiene and sexual health (*Richmond Fellowship of NSW Annual Report 2001/2*).

The service model proposed is based on a three-team structure. Each team is responsible for a group of houses in a geographical area that comprises:

1. A *Core* House (intensive support)
2. A *Halfway* House (medium level support)
3. A cluster of Satellite/*Outreach* Houses (minimal support)

The teams support the different houses as follows:

1. Core Houses - in-house support - 10 hours per day, 7 days per week
2. Halfway Houses - drop-in support - 4 hours per day, 5 days per week
3. Outreach Houses – 'as needs basis' - 5 days per week

The model of the YPP is as follows:

1. Individual management plans are to ensure residents move between the three different levels of accommodation (from high need/intensive support to low need, near-independent/ minimum support)
2. Up to three months transitional support is provided to residents moving into independent accommodation
3. Residents relocate to independent accommodation within two years of entry into the program
4. Informal advice and emergency support services is provided to former users of the service
5. Regular reviews of each management plans is to ensure the optimum outcome for each individual

The objectives of the YPP are:

1. Assist each resident to make effective transition from their current circumstances to independent living and community integration
2. Assist each resident to work through present problems before progressing to independent living
3. Assist residents to develop and broaden their social networks and relationships
4. Foster in residents personal and social responsibility
5. Promote to residents attendance at rehabilitation and training programs offered through the Mental Health Services or other appropriate service providers

In accordance with the *NSW Community Mental Health Strategy (2007-2012)*, all service decisions of the YPP are undertaken via 'an active consultative process with consumers', and mechanisms put in place 'to seek representation from residents to participate in the ongoing administration of the organisation' (RFNSW Annual Report 2001/2, p.4).

This consultative, inclusive approach towards stakeholders has been maintained throughout this review of the YPP. But prior to reporting this method of review, it is necessary to establish the criteria by which to assess the effectiveness of the YPP as identified in the literature and policies on community-based mental health services.

THEMES IN MENTAL HEALTH POLICY AND LITERATURE

Policies and research on community-based mental health services consistently refer to the need for developing a coherent approach to the provision of services. Four individual themes predominate: models of consumer participation; recovery; social inclusion; and life skills. Each theme will be explicated to establish its relevance and role to this Review of the YPP of the RFNSW.

Consumer Participation

The need for active consumer involvement in the area of mental health has been recognised for some time (see for example the discussions in Browse & Courtney, 2006; Solomon et. al, 1998; Pilgrim & Waldron, 1997; Deegan, 1992; Chamberlin, 1990, 1984; Brown, 1981). Within this context 'consumers' refers to people with mental health problems who are clients of services; carers of clients; and families of clients. Advocates propose viable consumer participation in the following areas: decision-making about care; service planning; policy development; setting priorities; training and evaluation; and addressing quality issues in the delivery of mental health services (NSW Department of Health, 2008).

Client, family and carer participation in the planning, delivery and evaluation of mental health services is now enshrined in the *National Mental Health Strategy* and prioritised in the *NSW Community Mental Health Strategy*. This emphasis on consumer participation stems from a partnership (rather than biomedical) premise in which consumers are considered active agents in their own healing and achievement of wellbeing.

Though the benefits of consumer involvement in the provision of mental health services are extolled widely in the literature, the actualisation of such involvement presents challenges due to the following:

1. The need for tangible, user-friendly mechanisms for consumers to appropriately participate
2. The need for inclusive, non-stigmatising language which invites and encourages contributions and as such, is empowering
3. The need for avoidance of bureaucratic and/or professional jargon (including acronyms) that can hinder/marginalise the participation of even the most well-informed consumers and carers (Stacey & Herron, 2002; Solomon et. al, 1998).

Both concrete mechanisms to facilitate the contribution of consumers (and carers) and the less tangible realm of language are acknowledged as important in the *National Strategy on Mental Health* as well as relevant documents of the RFNSW.

Recovery

Recovery has emerged as a key paradigm in the field of mental health due to:

1. The consumer/survivor/ex-patient movement - a grass-roots, self-help and advocacy initiative based on the principles of social justice
2. Conceptions of psychiatric rehabilitation - an approach of professionals in the field to the provision of mental health services (Jacobson & Curtis, 2000).

The concept of 'recovery' in reference to mental health problems is founded upon the premise - 'that a person's disability is based on more than diagnosed pathology or the intensity of symptoms, [and] is the product of interactions between the individual and the environment' (Anthony, Cohen & Farkas 1990; cited in Jacobson & Curtis, 2000, p.2).

It was the consumer advocacy movement that shifted the meaning of recovery in reference to mental disorders, away from the traditional rehabilitation notion of functional ability to being the manifestation of empowerment. This distinction between rehabilitation and recovery is clear with regard to mental health problems:

> Persons are not passive recipients of rehabilitation services. Rather, they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of the disability... Rehabilitation refers to the services and technologies that are made available to disabled persons so that they may learn and adapt to their world. Recovery refers to the lived or real life experience of persons as they accept and overcome the challenge of the disability. (Deegan, 1988, p.11)

As with consumer participation, the challenges of translating and actualising recovery at a practical and experiential level are as formidable as they are ongoing. Because in the absence of parallel capacity building within service organisations, efforts to recruit and involve consumers in the process of their healing can easily become tokenistic.

Social Inclusion

If people are to attain and maintain emotional wellbeing, a sense of inclusion and participation within society are primary. For people living with mental health problems, social inclusion is integral to recovery in that:

1. Recovery from mental illness does occur
2. Social inclusion aids recovery
3. Social exclusion impedes recovery
4. Attitudes of other people strongly influence how well people recover (Merton and Bateman, 2007).

Social inclusion and participation refers to: engaging with friends and peers; maintaining employment and economic viability; education; physical exercise; and leisure and recreational activities. Being connected and engaged with others in society can result in:

1. Having a sense of purpose and agency
2. Feeling safe and secure
3. Being free from violence or the threat of violence
4. Having hope for the future (Merton and Bateman, 2007).

Those who experience serious mental disorder tend to have smaller social networks than members of the population who do not experience mental health problems. Increasing the inclusivity of people with a mental disorder can be addressed by:

1. Increasing access to information and decision-making
2. Improving standard of living, including opportunities to learn skills, earn a wage and live in safety
3. Encouraging relationships with others replacing dependence on the mental health system (Merton and Bateman, 2007)

While the attitudes of and inclusion with friends, family and the community are pivotal to recovery, it is axiomatic that professionals who are in regular contact with those who experience mental disorder should convey positive attitudes about the person's prospects of recovery. Pilgram, Rogers & Bentall, 2009) discuss the cultivation and maintenance of such attitudes towards those with mental health problems as needing to be a key tenet of staff training and development in the mental health field.

Life Skills

Acquisition and ongoing practice of life skills is not only a requirement of recovery, but of mental health per se. Since it is precisely this capacity that is disrupted by the advent or recurrence of mental disorder, it is rightly the focus of recuperative programs and efforts. The importance of a positive attitude, reduction of stigma, and belief that recovery is possible is now well established (Sheldon & King, 2001).

Studies have shown that people generally report satisfaction with their lives (Meyers, 2000). This finding has led to an emphasis on resilience as an innate human capacity (Masten, 2009). While mental disorder represents abnormal functioning (and that the capacity to mediate difficulty may thus be radically compromised or impaired), traditional psychiatric categories are based on a model of pathology that is 'problem-focused'. The emergence of an emphasis upon wellness represents a significant conceptual shift that can potentially complement and advance the process of recovery for those with mental health problems.

This conceptual shift emphasises the acquisition and maintenance of life skills and problem-solving capacities. According to Arns and Linney (1995), the functional skills of consumers of mental health services have a 'strong positive relationship with their level of residential and vocational independence'. Skill level is a better predictor of benefits to consumers and the broader society than are diagnostic categories (Arns & Linney, 1995), because life skills are important in the development of personal relationships which are crucial to recovery (Pilgrim, Rogers and Bentall, 2009).

The Practicalities of the Themes

The four major themes in policy and literature on community-based mental health services are consumer participation; recovery; social inclusion; and life skills. Though each theme is readily identifiable within policy and literature, their manifestation and implementation "on-the-ground" shows clear interdependency. Moreover, the practicalities of client-based services dictate that each and all of these themes need to be considered with reference to the exigencies of organisational capacity and the contingencies of influence such as policies, budgetary considerations and staff. It is the former and the latter which are particularly important to this review of the YPP of the RFNSW.

METHODOLOGY

The purpose of this study is to identify trends, specific interventions and contextual factors that impact upon the service outcomes of the YPP of the RFNSW. Given this review is from the YPP's inception through to the present, this study is examining the YPP from the perspectives of yesterday and today so that the YPP will continue with and improve upon its effective provision of services into tomorrow.

Project Design

So as to understand "what has worked in the past" for the YPP, a significant proportion of this study is a retrospective analysis of data. But it is also essential to understand "what is working now" for the YPP. As such, the perspectives of those who are current and past clients of and those who work for, the YPP are an essential source of data. In this way a triangulation of information is garnered through the following:

4. Document Analysis: of case-files
5. Interviews: with past and present service users
6. Focus Groups: with key family members of service users and case managers

The document analysis will provide quantitative data whilst the interviews and focus groups will provide qualitative data about the effectiveness of the YPP. Quantitative research represents the human experience through numerical categories while qualitative research is concerned with understanding and representing the human experience through detailed description and analysis of the quality, or substance, of the experience for the person (Marvasti, 2004). As this study relies upon both quantitative and qualitative data to establish the effectiveness of the YPP of the RFNSW, a mixed-method approach has been used (Tashakkori & Teddlie, 2003). This mixed-method approach consists of three parts as listed above, with each part described in order.

Document Analysis

Since its inception and across the three phases of the Program (1995-1999; 2000-2004; 2005-2009), the YPP has maintained case-files on users of the service.

The initial step in the analysis of the case-files required current staff members of RFNSW to de-identify the information within the files so as to maintain confidentiality. In consultation with the Steering Committee, a Case File Sheet (refer Appendix_) was developed which categorised the information within the files as follows:

1. Age at entry and exit
2. Gender
3. Mental health diagnosis and history
4. Drug use
5. Trends in medication management
6. Family involvement
7. Case-worker interventions
8. Service programs implemented
9. Exit strategies for reintegration

So as to maintain confidentiality, two staff of the YPP were seconded to examine the Case Files and record the relevant information.

Files Examined

In total, 104 files were examined. Of those 104 files twelve clients had two periods of time in the YPP or at Brumby House (the main residential facility attached to the YPP) and one client had three admissions. As such, the 104 files are referring to a total of 100 clients. Case Files were examined and the information collated over a 3 month period from December 2008 to February 2009.

Interviews

Recruitment Process

Of the Case Files examined, those with correct current information were contacted by a staff member of the RFNSW and invited to participate in the research. A $50 gift card incentive was offered for their participation.

Participant Profile

15 clients (current and previous) participated in the interviews and were equally distributed across each of the three phases of the YPP: 1995-99 (5 clients), 2000-04 (5 clients), 2005-09 (5 clients).

The gender distribution of the interview participants was skewed but mirrored both the gender bias always present in YPP and the implementation of policy in 2005 that made the YPP only available to males from a mixed-gendered program:
Male Participants - 13
Female Participants - 2

Age range of interview participants whilst clients in the YPP: 17-26.
Age range of interview participants at time of interview: 21-36.

Interview Process

Place of interview: Penrith office of the RFNSW
All interviews were performed by the principle researcher on the project.

Participants were provided with and requested to read an Information Sheet (refer Appendix_).
Participants were then requested to sign a Consent Form (refer Appendix_).

Refer to Appendix_ for the interview questions.
Interviews varied in time from between 30-60 minutes. This variation was due to the length of responses provided by the participants.

Interviews were electronically recorded with brief contextualising notes provided by the researcher. These interviews were then transcribed.

The interviews were conducted in two calendar periods: April-May 2009; August-September 2009.

Focus Groups

Two focus groups were conducted:
1. Family members
2. Case managers

Recruitment Process

Family members: The same recruitment process was adopted for the focus groups as for the interviews.

Case Managers: In accordance with a directive from the YPP, case managers external to but familiar with the YPP were approached by a member of the YPP staff. These case managers came from a broad spectrum of services.

Focus Groups' Profile

Family Members Focus Group:
- 6 participants
- 4 females; 2 males
- Representation across 4 families
- The females were mothers of former clients of the YPP
- The males were partners of 2 of the females and step-parents to the former clients

Case Managers Focus Group:
- 7 participants
- 5 females; 2 males
- Representation across a mixture of community-based mental health services; drug-and-alcohol services; and social workers

Focus Group Process

Place of focus groups: Penrith office of the RFNSW.
All focus groups were led by the principle researcher on the project.

Participants were provided with and requested to read an Information Sheet (refer Appendix 4). Participants were then requested to sign a Consent Form (refer Appendix 4a).

Refer to Appendix 5 for the focus group questions.
The focus groups varied in time from between 2-2.5 hours. This variation was due to the length of responses provided by the participants.

Focus groups were electronically recorded with brief contextualising notes provided by the researcher and notes on butcher's paper compiled by the participants at key points throughout the focus groups. These interviews were then transcribed.

The interviews were conducted in one calendar period: May 2010.

RESULTS

Analysis and Overview of Case-Files

A key element of the research project was the retrospective analysis of the case files. In line with ethical requirements, two staff members of the Richmond Fellowship of NSW who had access to the files as staff members were seconded from their regular positions to de-identify and collect data from the files. The case files were not linked to the interviews in any way and the information in the case files was not compared with the experiences of clients who were interviewed. A summary coding sheet was developed by the research team, in consultation with the Steering Committee, as a way of interrogating and summarising the material in the files. The summary coding sheet consisted of three basic areas: Demographics and history; Length of time and activity in/ experience of the Program; and Exit information (accommodation, employment, services).

Description of Case-File Data

The following findings refer to the data obtained from the case files only. One hundred and four case-files (104), the complete set of case files from the program were analysed for insight into who the program served; what it did; and what progress the residents made towards the goal of reintegration into the community.

The case files are clustered into three stages or phases of the Program, based on the reporting format used:

- Phase 1, from 1995-1999, reflects an absence of a formal reporting format with case files notes being very inconsistent.
- Phase 2, from 2000-2004, follows a set format but the reporting process was not standardised or consistent.
- Phase 3, from 2005-2009, contains files in a format which leads to information which is more comprehensive and standardised.

Demographics and History

The number of clients in the program were spread unevenly over the three phases (see Table 1), with Phase 2 (2000-2004) having the highest number (49; 47%) of the 104 case-files that were examined. Phase 1 (1995-1999) and Phase 3 (2005-2009) had roughly even numbers of residents (28/27% and 27/26% respectively).

	Phase 1 (1995 -99)	Phase 2 (2000-04)	Phase 3 (2005-09)
Number of clients	28	49	27
Percentage of total clients	27	47	26

Table 1: Numbers of clients all Phases

Referral to YPP

Over the three phases of the Program the referral pattern changed (see Table 2). In the first phase the majority of referrals came from Mental Health Teams (53%), whilst by Phase 3 this represented only 22% of referrals. Pialla, Outpatients Penrith provides Mental Health Services in the region of Sydney West Area Health Services and in Phase 3 is responsible for one third of all

referrals. These two services with the Early Psychosis Intervention and Hospital referral account for 85% of the clients coming into the YPP by the final Phase under review.

	Phase 1		Phase 2		Phase 3		Total	
	Number	%	Number	%	Number	%	Number	%
Mental Health Team	15	*53*	19	*39*	6	*22*	40	*38*
Pialla,	6	*21*	13	*27*	9	*33*	28	*27*
Early Psychosis Intervention	0	*0*	8	*16*	4	*15*	12	*12*
Community Based MHT	1	*3.5*	3	*6*	2	*7*	6	*6*
Hospital	1	*3.5*	2	*4*	4	*15*	7	*7*
Self	1	*3.5*	2	*4*	1	*3*	4	*4*
Correctional Facility	1	*4*	0	*0*	1	*3*	2	*2*
Richmond Fellowship	1	*3.5*	1	*2*	0	*0*	2	*2*
Drug and Alcohol Service	1	*3.5*	0	*0*	0	*0*	1	*1*
Living Skills centre	1	*3.5*	0	*0*	0	*0*	1	*1*
Foster Carer	0	*0*	1	*2*	0	*0*	1	*1*
Total	28	*99*	49	*100*	27	*98*	104	*101*

Table 2: Source of referral to YPP

Gender

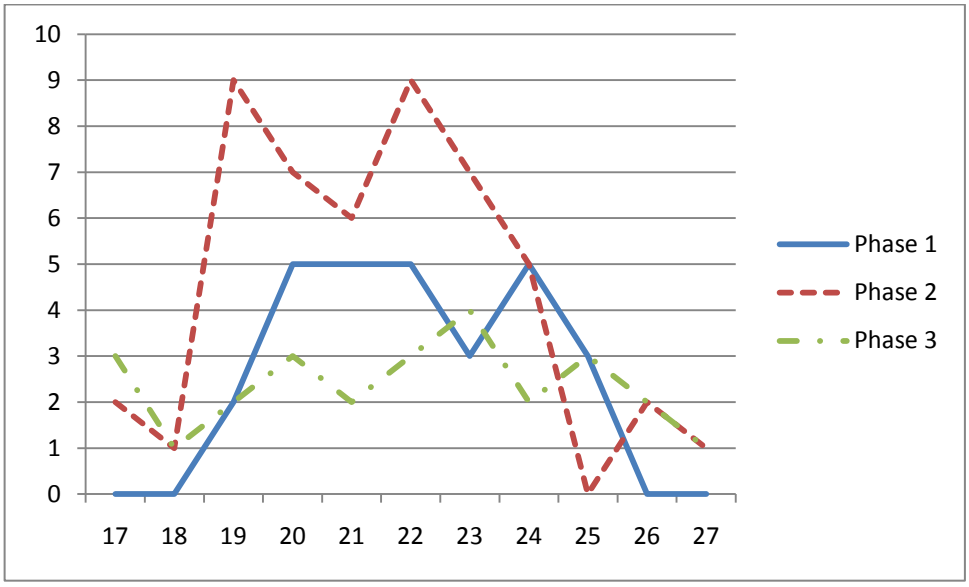
The program from 1995 to 2005 included males and females over the age of 16. From 2005 the program accepted only males, after an incident involving a female client being harassed by one of the male clients.

	Phase 1 (1995-1999)		Phase 2 (2000-2004)		Phase 3 (2005-2009)		Total	
	Number	%	Number	%	Number	%	Number	%
Male	24	*86*	35	*71*	27	*100*	86	*83*
Female	3	*11*	14	*29*	0	*0*	17	*16*
Not stated	1	*4*	0	*0*	0	*0*	1	*1*
Total	28	*101*	49	*100*	27	*100*	104	*100*

Table 3: Gender of clients all Phases

Age of Clients at Entry

The age of clients at entry to the program ranged from 17 to 27years, with some slightly different clustering of age in each phase
Phase 1 of the Program (1995-1999) tended to have clients clustered between 20-25.
Phase 2 (2000-2004) had a generally younger cohort under the age of 23.
Phase 3 (2004-2009) more clients were fairly evenly spread across the age range (17-27).



Graph 1: Age of clients at entry all Phases

Diagnosis Attributed to Clients in Case-Files at Entry

The majority of clients were identified as having a diagnosis of psychosis: 78 (75%) a diagnosis of schizophrenia; 10 an unspecified psychosis (11%); and 6 a drug induced psychosis (6%). Eight clients were admitted with a diagnosis of Bi-polar; and Personality Disorder was the diagnosis recorded for two clients.

The client group has complex problems and case notes referring to psychotic illness, depression, anxiety or bi-polar disorder in combination with drug use was not unusual.

Diagnosis	Schizophrenia	Psychosis	Drug induced Psychosis	Bipolar	Personality Disorder	Total
Number	78	10	6	8	2	104

Table 4: Diagnosis attributed to clients in case files at entry

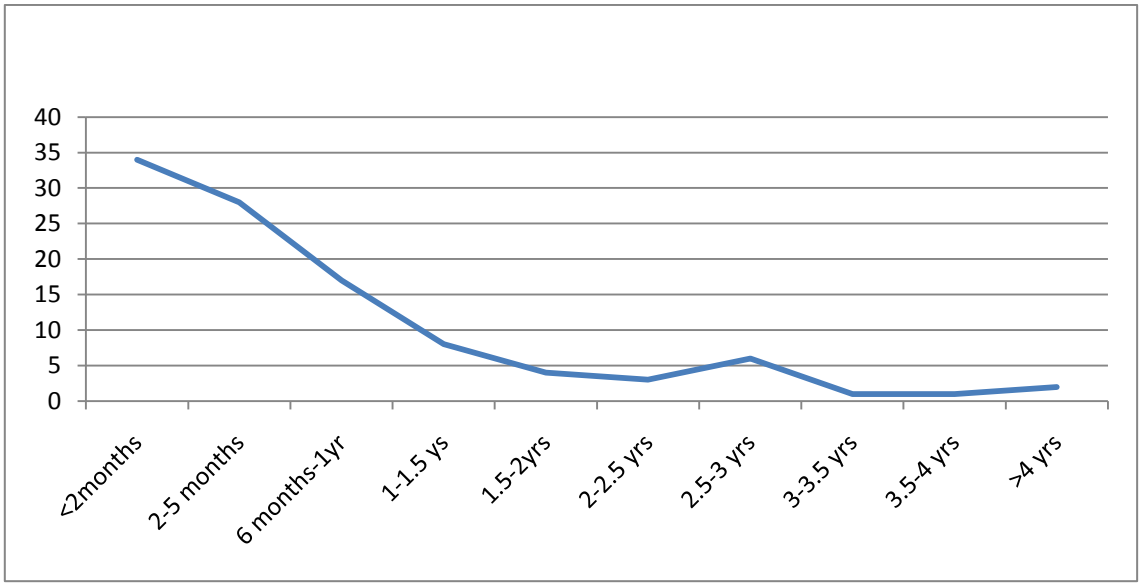
Drug and Alcohol Use at Entry to Program

The YPP accepts young people with mental health and drug and alcohol use. Its acceptance of young people with co-morbidity has steadily grown over the three phases of the data collection, such that , as can be seen from Table 5, by Phase 3 of the Program 93% of residents entered the program with a history of drug and alcohol use.

	Phase 1 (1995-1999)		Phase 2 (2000-2004)		Phase 3 (2005-2009)		Total	
	Number	%	Number	%	Number	%	Number	%
Drug and or alcohol use at admission	19	*68*	30	*61*	25	*93*	74	*71*
No Drug and or alcohol use at admission	9	*32*	18	*37*	2	*7*	29	*28*
Unknown usage	0	*0*	1	*2*	0	*0*	1	*1*
Total	28	*100*	49	*100*	27	*100*	104	*100*

Table 5: Drug and Alcohol use at entry to Program all Phases.

Experience in the Program



Graph 2: Length of time in Program all phases

Graph 2 shows a relatively broad spread of length of time spent in the Program from less than 2 months to over 4 years.

The average time in the Program increased over the three phases under review (see Table 6), from 4 months in Phase 1 to 13 months in Phase 3.

	Phase 1 (1995-1999)	Phase 2 (2000-2004)	Phase 3 (2005-2009)
Time in program	.5-15months	.25 -49 months	2 - 61 months
Average time in program	4month	9.4 months	13 months

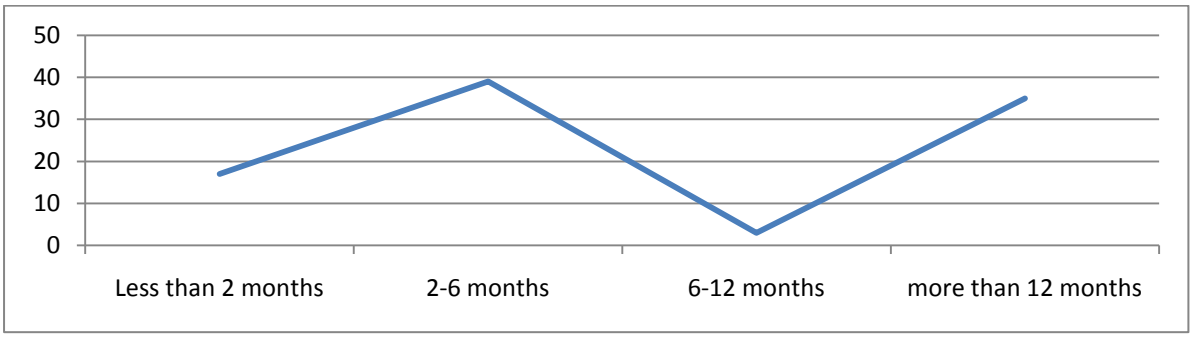
Table 6: Time spent in Program all Phases

The increased time spent in the program is possibly reflected in the increased numbers of residents who progress through the three levels of the program, from high support, to low support through to independent living (Table 7).

	Phase 1 (1995-1999)		Phase 2 (2000-2004)		Phase 3 (2005-2009)		Total	
	Number	*%*	Number	*%*	Number	*%*	Number	*%*
High Support	19	*68*	30	*61*	15	*56*	64	*62*
Low Support	9	*32*	8	*16*	4	*15*	21	*20*
Independent Living	0	*0*	11	*23*	8	*30*	19	*18*
Total	28	*100*	49	*100*	27	*101*	104	*100*

Table 7: Resident progress through the three support levels all Phases

A more detailed analysis of the information for Phase 2 (2000-2004)
(see Graph 3 below) the phase with the largest numbers of residents, shows a higher proportion of clients within the 2-6 month category (39%) and the over 12-month category (36%). This pattern suggests that there may be 'bottlenecks' in terms of the flow-through of clients from high-support, Core House, accommodation (Brumby House) to the low to minimum support house or satellite accommodation.



Graph 3: Length of time in Program Phase2

Substance use within the program

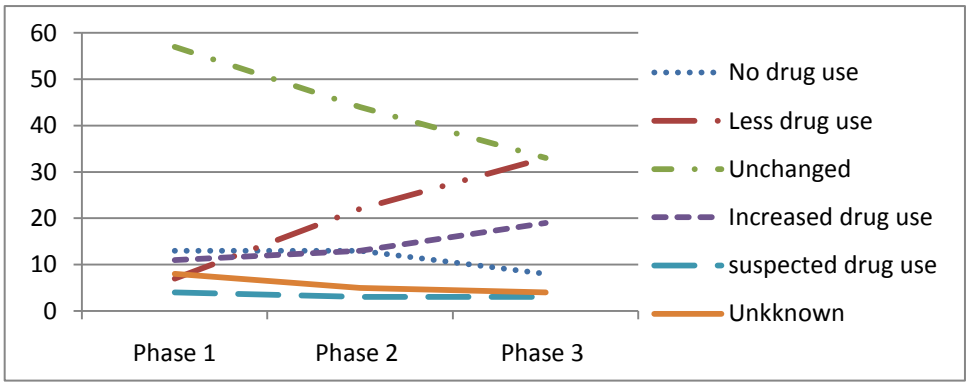
The use of alcohol, cannabis and other drugs for recreational purposes is stated in the case-files in a variety of ways and was often descriptive in tone. The overall picture is one of considerable substance use within the Program.

Over the life of the Program:
14% of clients appear to have increased their substance use during their stay at YPP
21% decreased their substance use.
45% appear to have had no change in their substance use.

	Phase 1 (1995-1999)	Phase 2 (2000-2004)	Phase 3 (2005-2009)	Total
	Number	Number	Number	Number
No drug use	13	13	8	11
Less drug use	7	22	33	21
Unchanged	57	44	33	45
Increased drug use	11	13	19	14
Suspected drug use	4	3	3	3
Unknown	8	5	4	6

Table 8: Drug use whilst in the Program (percentages)

There are differential trends, (see Graph 4 below) in drug use over the 3 Phases.



Graph 4: Drug use whilst in the Program

There is a noticeable increase in the number of clients for whom drug use is reported as decreasing over the three phases of the program from 2 clients (7%) in the first phase to 8 (31%) in the third phase.

There is also an increase in the number of clients who's reported drug use increased over the life of the program from 3 (10%) in Phase 1 to 5 (18%) in Phase 3.

Cannabis use within the program

The data from the case-files does not show how much or how regularly cannabis is used. This lack of information may be explained in two ways: first, some file entries suggest that cannabis use occurs when staff is not in attendance at night and on weekends and so can only be suspected; and second, cannabis use is banned within the Program and may result in exclusion - it is a covert activity of which staff may not be fully aware or willing to confidently assert in a case-file.

Reports of cannabis or suspected cannabis use were fewer in Phase 2 of the program at 57% than in either Phase 1 or Phase 3 where it was 64% and 67% respectively (Table 9).

	Phase 1 (1995-1999)		Phase 2 (2000-2004)		Phase 3 (2005-2009)	
	Numbers	%	Numbers	%	Numbers	%
Yes	15	*53*	24	*49*	15	*56*
Suspected	3	*11*	4	*8*	3	*11*
No	10	*36*	21	*43*	9	*33*
Total	28	*100*	49	*100*	27	*100*

Table 9: Cannabis use within Program all Phases

The files do not contain detailed information on degree of cannabis use nor the actions taken when such use is identified for that client.

Alcohol use within the program

Alcohol is referred to in the case-file data in the following ways: 'Minimal'; 'Some issues with alcohol'; 'Binge Drinking'; 'Intoxicated'; 'Abuse'; 'Combined with drug abuse'; 'No Use'; 'Unknown'. Table 10 displays the number of case-files referring to alcohol use whilst resident in the program.

	Phase 1 (1995-1999)		Phase 2 (2000-2004)		Phase 3 (2005-2009)	
	Numbers	%	Numbers	%	Numbers	*%*
Alcohol Use	1	*3*	1	*20*	0	*0*
Combined Drug and Alcohol	12	*43*	21	*43*	19	*70*
Unknown	0	*0*	2	*4*	1	*4*
No Use Reported	15	*54*	25	*51*	7	*26*
Total	28	*100*	49	*100*	27	*100*

Table 10: Alcohol use within Program all Phases

Over the three phases of the program reference to alcohol use increased. Whether this is an artefact of improved record keeping or reflective of a greater use of alcohol by clients is unclear.

In the first two phases of the program alcohol consumption was not reported in the majority of case-files, in the final phase nearly 70% of case-files have some reference to alcohol consumption.

Poly-drug use

The following Table indicates the number of case-files in which reference was made to the use of:

- Alcohol and cannabis together
- Cannabis without alcohol
- Alcohol without cannabis
- Neither

	Phase 1 (1995-1999)		Phase 2 (2000-2004)		Phase 3 (2005-2009)	
	Numbers	%	Numbers	%	Numbers	%
Alcohol and Cannabis	12	*43*	21	*44*	19	*70*
Cannabis no Alcohol	9	*32*	17	*36*	5	*18*
Alcohol no Cannabis	1	*4*	2	*4*	1	*4*
Neither Mentioned	6	*21*	8	*16*	2	*8*
Total	28	*100*	48	*100*	27	*100*

Table 11: Alcohol and Cannabis Use all Phases

In all three phases the combined use of cannabis and alcohol was greater than all other categories of: cannabis alone, alcohol alone; and neither alcohol nor cannabis.

Drug and alcohol use were fairly widespread over the three phases of the program. Reference is made in the case-files to clients being referred to drug and alcohol services in the community. There were few references to drug and alcohol services in-program other than sanctions used to address the use. These were warning and then exclusion from the program.

Medication Compliance

Table 12 is based on case-file notes concerning medication compliance which was either self-reported or noted from the referral. Medication compliance whilst in the program was not routinely recorded. The percentage of people compliant with medication at referral slightly rose over the life of the program as did the numbers who were non-compliant. This may be accounted for by an increase in the data collected at entry to the program.

	Phase 1 (1995-1999)		Phase 2 (2000-2004)		Phase 3 (2005-2009)	
	Numbers	%	Numbers	%	Numbers	%
Compliant	6	*21*	11	*22*	8	*30*
Compliant with prompts	7	*25*	18	*37*	5	*19*
Non-compliant	10	*36*	18	*37*	12	*44*
N/A	5	*18*	2	*4*	0	*0*
No information	0	*0*	0	*0*	2	*7*
Total	28	*100*	49	*100*	27	*100*

Table 12: Medication Compliance all Phases

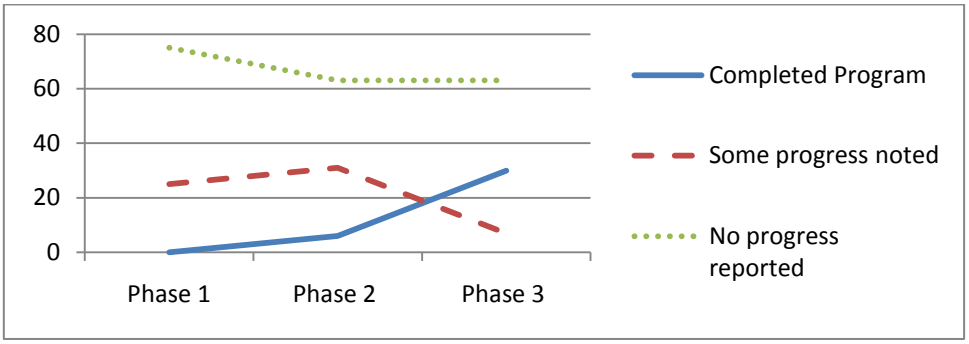
Progress Through the Support Levels

The YPP is designed to enable residents to progress through the support levels from intensive support group living (Brumby House) to medium level support group living (Circuit House) to minimal support, independent accommodation (individual or with others). Table 13 presents the progress of residents through these levels over the three Phases of the program.

	Phase 1 (1995-1999)		Phase 2 (2000-2004)		Phase 3 (2005-2009)	
	Numbers	%	Numbers	%	Numbers	%
Completed Program	*0*	*0*	*3*	*6*	*8*	*30*
Some progress noted	*7*	*25*	*15*	*31*	*2*	*7*
No progress reported	*21*	*75*	*31*	*63*	*17*	*63*
Total	*28*	*100*	*49*	*100*	*27*	*100*

Table 13: Progress through Accommodation levels all Phases

The following Graph shows the progression by clients through the Program in each of the three phases. Although the percentage of clients exhibiting no progress remained relatively constant over time (from 75% in Phase 1 to 63% in Phases 2 and 3), the number of completions increased from 0% (Phase 1) to 6% and 30% in Phases 2 and 3 respectively.



Graph 5: Progress through the support levels (percentage), all Phases

By the final phase under review, 30% of residents had progressed to independent living within the YPP Program. This is a substantial shift from Phase 1 in which no residents had moved through the three support levels.

The data in the case-files does not indicate how people are assessed for the purpose of progressing through the support levels or whether progress through the support levels or lack of progress indicates anything to do with their recovery from mental illness or drug use.

Achievement of Goals

Throughout all three phases of the YPP, two categories of goals developed by the staff of YPP in consultation with the client are recorded; one set were those described as clients goals, the other were those suggested by the staff as important goals in the recovery process for that client.

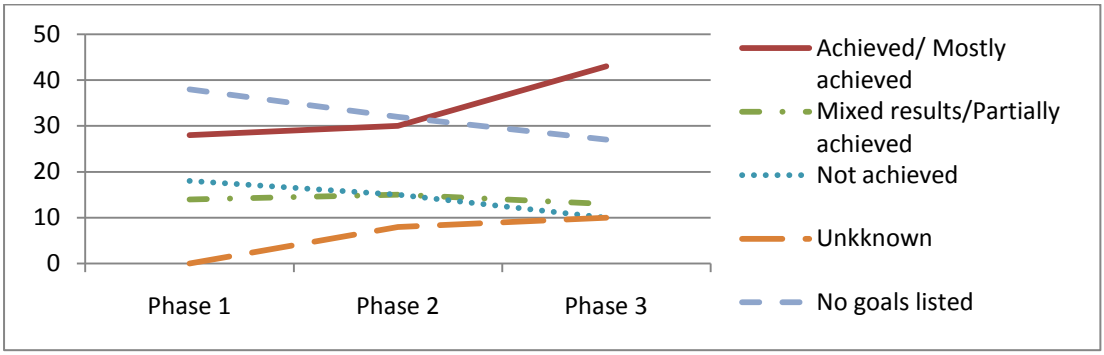
The following table presents the goal achievement for those goals set by the client.

	Phase 1 (1995-1999)	Phase 2 (2000-2004)	Phase 3 (2005-2009)
	%	*%*	*%*
Achieved	*21*	*16*	*24*
Mostly achieved	*7*	*14*	*19*
Partially achieved	*14*	*15*	*13*
Not achieved	*18*	*15*	*10*
Unknown	*0*	*8*	*10*
No goals listed	*38*	*32*	*27*
Totals	*100*	*100*	*100*

Table 14: Achievement of goals initiated by client

When the categories of 'Achieved' and 'Mostly Achieved' are collapsed, the results suggest that over one third of client-initiated goals were achieved and that the trend of goal achievement improved over the three phases of the Program.

The percentage of case files in which no goals were listed fell over the 3 Phases of the program.



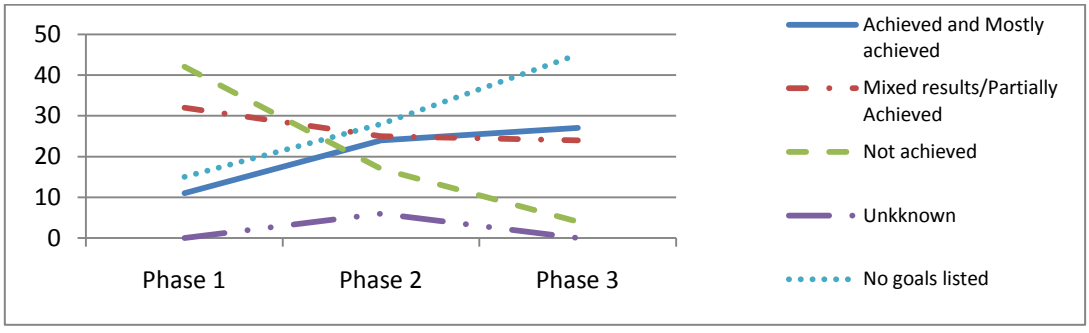
Graph 6: Achievement of Client focused goals (Percentage)

The following table presents the goal achievement for those goals set by the staff.

	Phase 1 (1995-1999)	Phase 2 (2000-2004)	Phase 3 (2005-2009)
	%	*%*	*%*
Achieved	*11*	*14*	*18*
Mostly achieved	*0*	*8*	*9*
Partially achieved	*32*	*28*	*37*
Not achieved	*42*	*16*	*4*
Unknown	*0*	*6*	*0*
No goals listed	*15*	*28*	*45*
Totals	*100*	*100*	*100*

Table 15: Achievement of goals initiated by client

When the categories of 'Achieved' and 'Mostly Achieved' are collapsed the results suggest a dramatic fall in goals 'not achieved' over the three phases of the Program and a rise in the number of goals 'Achieved' or 'Mostly Achieved'.



Graph 7: Achievement of service identified goals (Percentage)

The file entries indicate that clients were more successful in achieving the goals that they set for themselves rather than those initiated by YPP staff, but that over the three phases of the program there was an increase in all types of goals being achieved, or mostly achieved.

The above Tables indicate that staff did not routinely report the establishment, achievement or lack of achievement of goals (either client-focused or service-focused) in the case-files. In Phase 3 of the Program nearly 50% of case-files are missing goals identified by the service.

Exit

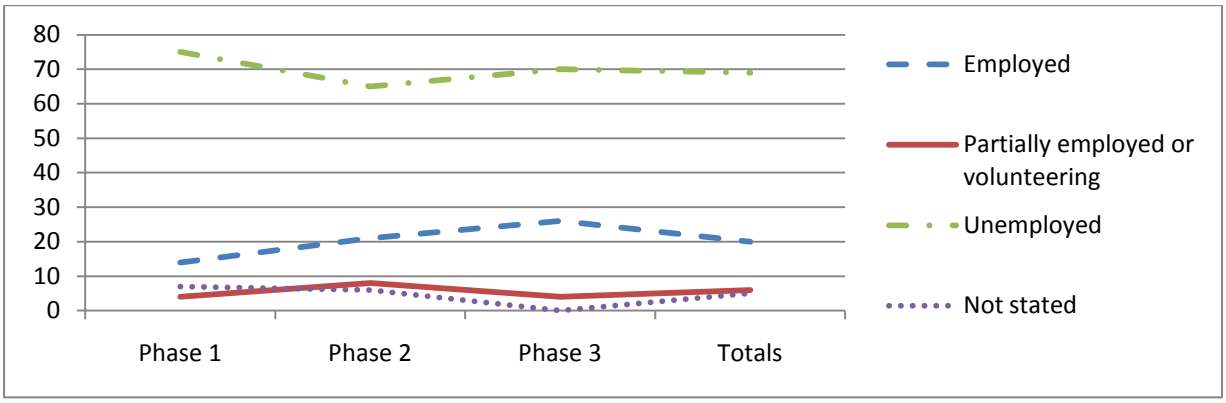
Client Employment Status at Exit

Over the three phases of the program the majority of clients (69%) are unemployed when they exit the Program. Twenty six percent of clients had some form of employment upon exiting the program (see Table 15).

	Phase 1 (1995-1999)		Phase 2 (2000-2004)		Phase 3 (2005-2009)		Total	
	Numbers	%	Numbers	%	Numbers	%	Numbers	%
Employed	4	*14*	*10*	*21*	*7*	*26*	*21*	*20*
Partially employed volt'ring	1	*4*	*4*	*8*	*1*	*4*	*6*	*6*
Unemployed	21	*75*	*32*	*65*	*19*	*70*	*72*	*69*
Not stated	2	*7*	*3*	*6*	*0*	*0*	*5*	*5*
Total	28	*100*	*49*	*100*	*27*	*100*	*104*	*100*

Table 16: Employment status at exit all phases

The following graph indicates that the number of clients who exit into full or partial employment over the life of the program has remained stable: 28% (Phase 1), 29% (Phase 2), 30% (Phase 3).



Graph 8: Employment status at exit all Phases (Percentage)

Client Accommodation on Exit

Analysis of the case-file entries point to family as the most popular exit accommodation (36 %) followed by private rental (16%) and supported accommodation (13%) (see Table 17). Exit accommodation was unknown in twelve percent of cases.

Table 13 revealed an increase in the number of residents who moved into the 3rd level, minimal support house of the program (30% by Phase 3). However a fuller picture emerges of the progress to independent living in the data on accommodation at exit. As can be seen from Table 17 if one were to combine the two types of accommodation at exit - private rental and friends - 32% of the residents exiting from the program in Phase 3 moved into some form of independent living

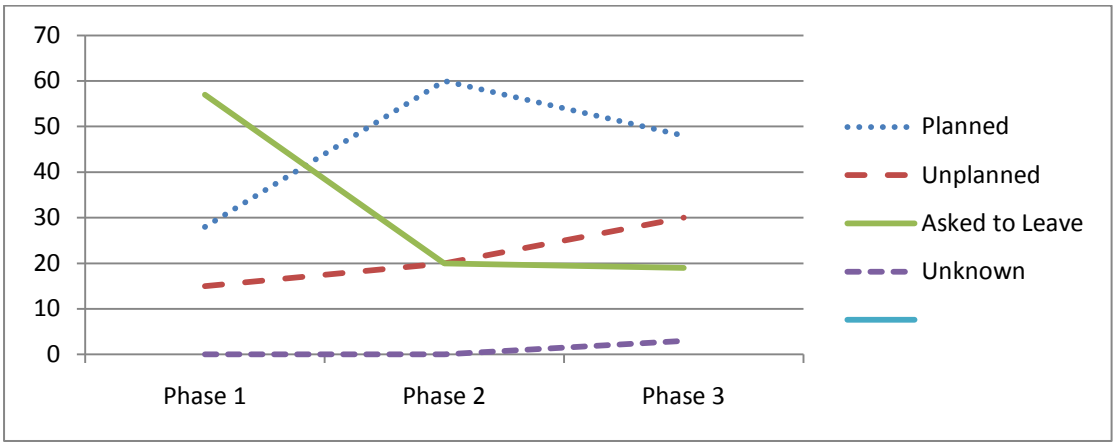
arrangement. This nearly equals the number of residents exiting to live with a family member. The rate at which residents find accommodation with family has remained stable over the three phases under review, but there has been a considerable increase in the number of residents exiting into private accommodation.

	Phase 1 (1995-1999)		Phase 2 (2000-2004)		Phase 3 (2005-2009)		Total	
	Number	%	Number	%	Number	%	Number	%
Family	10	35	18	37	9	33	37	36
Private	2	7	8	16	7	26	17	16
Supported Accommodation	4	14	6	12	4	15	14	13
Friends	2	7	5	10	2	7	9	9
D & A rehabb	2	7	3	6	1	4	6	6
Dept of Housing	3	11	3	6	0	0	6	6
Hospital	1	4	2	4	1	4	4	4
Gaol					1	4	1	1
Unknown	4	14	4	8	2	7	10	10
Totals	28	99	49	99	27	100	104	101

Table 17: Accommodation at exit all Phases

Circumstances of Exit

The case file entries also included reference to the circumstances of exit: specifically whether the exit was planned partially planned or unplanned. Planned accommodation involves the client finding accommodation with the assistance of YPP staff.



Graph 9: Circumstances around exit from the program (percentages)

Over the three phases of the program the number of planned exists from the program fluctuated (Table 18).

	Phase 1 (1995-1999)		Phase 2 (2000-2004)		Phase 3 (2005-2009)		Total	
	Number	%	Number	%	Number	%	Number	%
Planned	8	*28*	29	*60*	13	*48*	50	*48*
Unplanned	4	*15*	10	*20*	8	*30*	22	*21*
Asked to Leave	16	*57*	10	*20*	5	*19*	31	*30*
Unknown	0	*0*	0	*0*	1	*3*	1	*1*
Totals	28	*100*	*49*	*100*	27	*100*	104	*100*

Table 18: Circumstances of exit all phases.

The number of unplanned exits increased but it would appear that this was offset by the decrease in the number of people who were asked to leave the program. In Phase 1, 57% of residents were asked to leave the program. By Phase 3 this had reduced to 19% of residents being asked to leave, but more residents deciding to leave of their own accord. The comment most often made on the departure sheet for those who choose to leave the program was 'decided program was not for him'.

The reasons for exclusion from the program were, drug and alcohol use within the program, dealing drugs, violence towards staff or other residents and theft or sexually inappropriate behaviour (see table 18).

	Phase 1 (1995-1999)		Phase 2 (2000-2004)		Phase 3 (2005-2009)		Total	
	Number	%	Number	%	Number	%	Number	%
Continued drug/alcohol use including dealing	9	*57*	5	*50*	2	*40*	16	*52*
Aggression and threats of aggression	3	*19*	2	*20*	1	*20*	6	*19*
Aggression and drug/alcohol use	3	*19*	2	*20*	1	*20*	6	*19*
Breaking house rules	0	*0*	1	*10*	0	*0*	1	*3*
Theft	1	*6*	0	*0*	0	*0*	1	*3*
Sexually inappropriate behaviours	0	*0*	0	*0*	1	*20*	1	*3*
Totals	16	*101*	10	*100*	5	*100*	31	*99*

Table 19: Reasons for being asked to leave the program, all Phases.

Limitations of the Case-File Data

The limitations of the data set were extensive, especially those case-files from the first five years of the Young People's Program (1995-1999). Consequently, the analysis of the case-files could not reveal as much about the Young People's Program as was anticipated, especially in relation to the everyday program, interventions and outcomes.

A significant limitation in the case-file data is that it fails to clarify what programs and activities provided and therefore the relationship between the services provided and client outcomes. Another serious limitation of the case-files was the quality of case-file data concerning substance use, before and during time in the Program. The effectiveness of YPP strategies to manage substance use could not be identified through the case-file data.

Findings of Individual Interviews and Focus Groups

This section outlines the findings of:

- Individual interviews with current and past residents of the YPP
- Focus groups with family members of current and past residents of the YPP
- Interviews with case managers from community services who have worked with residents of the YPP.

The individual interviews and focus groups provided insight into the lived experience of the YPP by residents and their families. The staff and case managers provided insight from professionals about the impact and outcomes YPP program for residents.

Demographics

In response to invitations to all residents and ex-residents of the YPP with known addresses, 15 participants agreed to be interviewed between April 2009 and February 2010.

Thirteen were male and two were female. This gender division reflects the gender ratio of YPP over its existence.
Age range of interview participants whilst clients in the YPP: 17-26.
Age range of interview participants at time of interview: 21-36.

The interviewees were vague about their length of stay at Brumby House or their involvement with YPP and it ranged from 2-3 months to a maximum of 3 years.

Most (13 out of 15, 87%) reported having ongoing contact and support after they left Brumby House or the satellite (Circuit) House. Two interviewees reported little or no on-going contact.

Drug and Alcohol Use Whilst in YPP

Participants reported that drug and alcohol use was common prior and during their involvement with the YPP.

Ten of the fifteen interviewed (67%) reported having used cannabis along with other illicit drugs such as speed, heroin, LSD and ecstasy.

- "as much as I could get my hands on. Some days, you know, you can't get it and other days you can" (R 3)

- "Like cannabis, ecstasy, LSD, speed … I was going to parties and dropping in at parties" (R 5)

Three (20%) of those interviewed had never used cannabis. One stating he had never 'smoked dope in my life' but drank and smoked tobacco and had used other illicit drugs.

Four (27%) of the interviewees identified alcohol as a specific problem, two of them identified their drinking as alcoholic

- "I am an alcoholic, recovering alcoholic who drinks occasionally … I will always be an alcoholic, there is always a chance that I am going to relapse" (R 4)

Drug Use After YPP

Twelve (80%) of the fifteen participants acknowledged that they still drank alcohol regularly.

One (7%) participant identified no use of any recreational drugs. He specifically stated that he did not drink or use drugs of any kind at any stage of his life.

Participants identified two main reasons for stopping or reducing their use of alcohol, cannabis or other illicit drugs - having a stable life; and recognition of their mental health issues and the negative impact of drug use.

Stable Life

Having a stable life that included work, a girlfriend and close family that helped to motivate individuals to reduce use. 'R 1' pointed out how 'you don't drink the night before you go to work'. 'R 5' described how he 'stayed off drugs for years' because he was with the same girlfriend and working, 'doing all the right things'. He also spoke of his father being supportive.

Mental health issues and negative impacts of drug use

Being given a diagnosis of schizophrenia or other mental illness also facilitated the cessation of drugs for two interviewees.

- "I am a paranoid schizophrenic. I smoke pot I get paranoid. I am already paranoid" (R 4)

Drug and Alcohol Related Interventions

There was limited comment from the participants about specific YPP interventions around drug and alcohol use in the Program.

One (7%) participant mentioned visits of a drug and alcohol worker and oneother referred to a drug education program run at the House.

Several interviewees noted specific Program rules concerning alcohol, cannabis and other drug use. One participant described how the rules about drinking had impacted on the group when she was living in the house.

- "When I first came there they were always [drinking] and they cracked down on that. And um … so … if we wanted to drink we just went out to the park and have a drink down there because we weren't allowed to drink in the house. We could go out and drink but we weren't allowed to drink in the house." (R 7)

Two (13%) participants described the consequences of smoking cannabis while living at the house. After a few warnings, both were asked to leave because of smoking cannabis.
For one of these participants it was good that he was 'kicked out' because of his cannabis use "because no one wants drugs in the place". The other did not indicate being asked to leave helped him in either stopping cannabis or his recovery in general.

One interviewee pinpointed Brumby House as the main reason for 'getting off the drugs'.

- "… the main thing I think that Brumby did teach me was to get off the drugs and made me realise I could do stuff without being off my face …." (R 4)

Interviewees reported drug and alcohol use was common during residence in the YPP. Several reported they have now made a conscious decision to avoid drugs and to moderate their alcohol consumption.

Living in the YPP (Brumby House)

"Lots of positives"

The participants identified a number of 'good' things about their stay in the YPP or more specifically Brumby House to the positive experience. In one male participant's words there were "lots of positives" about his stay in the program. Fourteen (93%) residents discussed the role of staff, ten (67%) identified social events and social supports and six (40%) mentioned achieving goals as important for their recovery.

The staff

The staff were identified as pivotal, and one of the 'best parts' of the YPP. One interviewee stated Brumby House was "a very caring environment". He went onto say that the staff were "caring, respectful & empowering" in their approach to the residents. He identified particular staff as continuing to play a part in his ongoing recovery, despite not having been formally involved in the YPP for a number of years.

Another interviewee described particular staff as 'role models' for him.

Other interviewees reaffirmed this opinion of the staff. "Supportive" was a common word used when describing the RFNSW staff associated with Brumby and the Young People's Program more broadly. Other words used were "open", "approachable" and "flexible". It was generally reported that the staff gave 'heaps and heaps of support'.

According to one interviewee,

- "They just kind of knew who I was at that moment and helped me develop, you know." (R 1)
- "it's because of Brumby House and the staff and their approach to the whole thing. They turned my life around." (R 4)

Several aspects of the Brumby House experience were found helpful, respectful and therapeutic, and the importance of a structured 'family' environment where staff supported and respected the individual clients was emphasised.

- "So you are living in a family environment [at Brumby House]… you are learning how to take care of your family. … you can't learn unless you are [in] an environment like Brumby and Brumby teaches you how to live again." (R 4)
- "… the respect they showed me. I am very big on respect. They earned my respect by respecting me as an individual and who I was, what I was. Um … not many organizations do that." (R 4)
- "you find at drug and alcohol rehab, … because it's so structured and so demanding a lot of people don't stick it out and they don't try and stick it out. They just want to get out of there, they hate it so much. Where at Richmond Fellowship people, you just feel at home. You know what I mean? They feel at home, it's like a home." (R 5)

Social activities and events

Social events and outings were identified as essential parts of the program by all the interviewees. The outings included going to the shops (not shopping specifically), movies, going into the city (Sydney), and unique activities like riding on a jet boat, going fishing and as one participant discussed enthusiastically, going on a holiday. Barbecues at the Circuit pool were also mentioned in positive terms.

Interviewees identified the benefits of these as: socialising with others, and the activity itself. Life skills were developed (for example, catching trains) and, friendships were fostered through these social events. One interviewee reflected the outings really helped when he couldn't concentrate.

The social aspects of the YPP also included simply being in the house together, according to some interviewees. Being around other young people with mental health issues and at the same time having supportive staff was seen as very positive. As one interviewee described, it was "like a fellowship", almost a family. Most interviewees identified 'hanging out with the guys' in positive terms. Interviewees said that although there were 'structured things to do' they were also free to do what they wanted overall. Hanging out could mean playing pool and watching television or just sitting.

One interviewee described the importance of the combination of the events and activities with meeting people

- "I would imagine most people wouldn't be able … live with no activities, no outings, no friends… they provided all of that for you. Well you met people there and most of the time you become friends with them… their houses were great, their activities were good." (R 10)

Life skills

Comment was made on the basic life skills learnt like learning to cook, doing housework, cleaning, shopping (for essential items not simply luxury items) and budgeting. One interviewee stated it was through the structured activities that he learnt to live independently. Another said he learnt "how to take care" of himself through these structured activities. A further participant pointed out how when he lived with his parents he didn't learn things "like how to cook for myself or how to clean a bathroom and all that sort of thing". Living at Brumby House meant that he learnt these basic life skills.

- "they would just say it's your job to do the bathroom … but they would come and help you do your chores and teach you how to do them." (R 6)

As one interviewee described it, the program combined "what was needed" (to survive) with fun stuff like social events and outings. Another interviewee credited the programme with helping him 'to stabilize'.

Morning walks were identified as one activity that encouraged stability and structure to the day, despite the resentment about being pushed out of bed. Interviewees remembered doing yoga with one of the workers, which was seen as helpful for dealing with anxiety and "fun because none of us [could do it]… we were all like falling over and stuff" (R 7).

Achieving goals

Interviewees remembered the goals they set and described them as including learning to budget, getting a job, doing a course at TAFE or other educational institution, losing weight, reducing or changing medication, getting off drugs (recreational or medications), reducing alcohol consumption, getting their own place or developing hobbies (eg painting, sports), developing intimate relationships. The interviewees recalled that in meetings with individual staff, they discussed and developed personal goals or 'targets you wanted to achieve'. At the same time, these meetings were also opportunities for staff to make suggestions for goals and to develop goals that flowed from the staff understanding of residents' issues or problems. The interviewees, on the whole, remembered their personal goals rather than those suggested by staff.

- "so it could be things like I wanted to be employed by such and such a day or … I want a medication change. Anything you wanted to achieve um … while you were at the Richmond Fellowship, there were like short term and long term goals, that sort of thing… it was quite good to have those, just to set up what you wanted to do with yourself." (R 6)

Discussions about goals occurred 'as often as you needed'

- "Well as often as you needed to, like if you wanted to do a TAFE course or if wanted to organise accommodation or get work or … just organise a life strategy or a life goal or something like that you could go and talk about it and write it down. And just write down the appropriate steps and see what we could do about it" (R 5)

Several interviewees had losing weight as a goal

- "At one point we had a weight loss group. Because a lot of us were putting on weight … we just call it the Brumby belly … [because] you just sort of sit around all day and eat whatever you want …" (R 10)

Goal setting seemed to be a normal part of the routine at Brumby House but not all goals were achieved. Trying to achieve the goals was still beneficial as R 6 points out.

- "the other goal I set, which I was unsuccessful in getting, was to join the army. Which was something I was quite interested in. But um… Medical problems precluded me from military service. But even still I was supported in taking the fitness program, my fitness was an acceptable level and um… did a lot of tests before the testing day and yeah it was good to do the steps to achieving that goal even though I didn't know I was going to get it. It might have been a bit unrealistic but the staff [at Brumby House] were still supportive in achieving that goal. Yeah." (R 6)

One interviewee's goal was to get his own place and to 'get off meds'. Getting off meds was not easy and although not generally encouraged by the staff of the YPP, was none the less treated as a serious option by them. This interviewee discussed how his goal of 'getting off the meds' was motivated by his belief in the power and benefits of alternative medicine (eg Chinese therapies). He has now started a university course in this field:

- "they said do you know why you are in here? I said yeah, I understand I jumped off the meds too early and I stuffed up … We will release you then. And I said but I am not well. And they are like yeah but you understand why you are not well and that made me think, the knowledge, the wisdom that I had gained is worth more than the individual's health at the time… Um … three months later I am off meds, everything and I manage, I still see things, still hear things, still feel things. But I cope with it and that's what it's all about. And that's a direct, direct … to Brumby House and the Richmond Fellowship. I would never have been able to do it without them. I truly believe that" (R 4)

The general feedback from those interviewed was that the YPP had created s a therapeutic community in which residents felt respected and cared for and also in which they were expected to act and function as adults, taking responsibility for tasks in a shared house, experiencing full lives which included recreation and social events and setting goals for themselves.

Generally, the residents and ex-residents who were interviewed spoke in positive terms about their experience of YPP and criticisms were very general or minor or contextualised as necessary.

"I learnt nothing"

One (7%) interviewee described his experience as "frustrating" "restricting" and "not a lot to do" (R 3). He 'learnt nothing' and, said he didn't know why he stayed for so long (about 3 years). He reported the goals that were developed were not his and he did not find the experience or environment 'enriching' or 'empowering'. He stated that some of the guys were 'good' and the staff 'okay'.

The 'bit of freedom' that Brumby House offered in comparison with drug rehabilitation while at the same time, the daily routine of watching TV and hanging out with the guys was not fully satisfactory. It was 'very un-motivating … like no one did much there … hung around and just sat there all day' (R 1)

Other interviewees identified negative aspects of their experiences but even as they stated what they didn't like, they often expressed an appreciation of why these were necessary.

Being dragged out of bed at 8am

Several interviewees expressed resentment at being 'forced' to do things (around the house) and of 'being dragged out of bed at 8am' on a regular basis. Some interviewees resented being woken up to go for a walk. Interviewees also reported that they recognised these activities were part of living in a supported accommodation program and that getting up at any time could be a problem for them either because of their mental illness or as a result of medications for the illness.

Too lenient

Two interviewees were critical of staff responses to rule breaking. One interviewee thought that the staff were 'too lenient' with other residents when the rules were broken. Another described how difficult he found night times after the staff had gone for the evening. Some residents made

the most of this time by using/smoking dope and partying. This interviewee discussed the dilemma of 'dobbing in' other residents if they were partying or using.

Living with others

One interviewee stated, there was 'no choice about who you live with'. He found it very difficult to be living with other residents with schizophrenia, their influence was 'not that good', they were 'lacking motivation, isolating and doing nothing'. He felt he was watching them 'get sicker' and he didn't stay at Brumby for very long. He reported this to staff and they organised a transfer to an outreach house.

Another reflected on the difficulties for him of sharing with difficult people when he was unwell.

- "… he was just like a leach … an arsehole … and once you bring someone like that in that's not good [for others in house]. Especially, if they are struggling, because I was struggling at the time. It wasn't good for me because I was struggling." (R 5)

Living with other young people who used drugs and alcohol also created challenges.

- "it did cause its own problems… I lived for a while with someone who was an alcoholic and um… yeah for him… it wasn't good to be around alcohol." (R 6)

Living with others with mental health problems and who drank and/or smoked also raised issues of safety.

- "there was some violence at one stage between a couple of the house members who were drunk." (R 6)
- "there was one situation where this young guy … basically drank too much and became quite aggressive … [staff] had to sort of restrain him." (R 2)
- "one time this guy came to the house and … he was new, he was pretty big and he was … a bit scary, I don't know, a bit loco, you know, from drugs … we were drinking beers together upstairs and he went, he went absolutely crazy. And he tried to get into a fight with me." (R 8)
- "Oh there was one guy there I didn't get along, we almost came to blows a couple of times." (R 11)

House meetings

One interviewee discussed the weekly house meetings in negative terms.

- "Like the house meetings you have to attend, there is no way you could get away with not attending. But the house meetings were um … terrible." (R 9)

While interviewees reported acknowledging that to keep the house 'running properly' meant house meetings were probably necessary they suggested that staff could have used 'a different or better approach' and that 'the organisational skills of whoever is in charge at the time' impacted on the running of these meetings.

The difficulties the interviewees identified with the YPP in many ways mirror the difficulties associated with independent, shared accommodation and hence are not specifically criticisms of the YPP program per se.

The difficulty of recovery for people living with a mental illness can be captured in the words of one of the interviewees. Having a job was one of his goals and the staff of the YPP was able to support him to a degree, but his illness and travelling by public transport interfered with maintaining jobs, even when he liked the work.

- "I had a job. I had heaps of jobs when I was there, but I would get unwell or something, you know I would quit or leave. … the best one I had was a ball person [inaudible on electronic recording] … yeah it was real good … And they [staff at BH] would drive me there and back. They drive you to work and then pick you up. Then I started to get, to catch the train and stuff. And [started to feel] paranoid [on the train] … And I think what made me quit was … it was actually taking so long [to get there by train]." (R 10)

Recommendations for Improving the YPP: The Residents' Point of View

Interviewees suggested the YPP experience could be improved with more outings and group activities; exploring alternative approaches to eviction for rule breaking; and more support after moving out.

More outings and group activities

Social outings were seen as core group activities but two residents discussed the need for more activities within the house. It was suggested that more outings especially day outings, but even smaller ones, like going for coffee, ten-pin bowling, playing tennis, going to a basketball game or to the movies would be good.

One issue that arose in relation to the request for more outings was the cost. As one interviewee pointed out, living on Centrelink meant residents didn't have a lot of money to pay for activities so a strategy was needed to fund extra activities. One system a resident remembered related to the 'holding back of some money' [pension] to be used for big or costly outings (not only rent and bills).

Barbecues were identified as an enjoyable, low cost activity especially when they were at 'the house around the corner' ('Circuit' the medium support house) that had a swimming pool.

These social outings were seen as core group activities but two residents discussed the need for more activities within the house. The 'bit of freedom' that Brumby House offered in comparison with drug rehabilitation while at the same time, the daily routine of watching TV and hanging out with the guys was not fully satisfactory. It was "very un-motivating … like no one did much there … hung around and just sat there all day." (R 1)

Alternative approaches to eviction for rule breaking

One interviewee suggested that there should be alternative ways of handling rule breaking like drug use.

- "that's one place I think they could improve … It's hard because what do you do? … You can't really tolerate drug use because it's quite bad for mental health … it's sort of counterproductive. But there has got to be a better way than evicting them although having said that … you would get a couple of warnings [before being evicted] … but there has to be a better way." (R 6)

Not all interviewees sympathized with leniency in dealing with those who broke the rules.

- "They could have just kicked him out and told him go to hell. If I was them, that's exactly what I would have done" (R 5)

One interviewee discussed the need for more staff over night because of the 'partying' at night, the potential for aggressive behaviour and the lack of respect for rules and for others in the house. His sleep was disrupted on occasion because of the noise and suggested that, if funding was not available for staff to stay overnight, a random check be conducted at night to make sure that there were 'no parties going on'.

More support after moving out

Two residents suggested that more support after moving out would have helped them.

- "from what I remember after I moved out I didn't get a lot of contact with the house … Just staying in touch or occasionally meeting up after I moved out would have been good." (R 6)

One interviewee suggested there should be 'some kind of stepping stone' between houses but did not specify what that might look like.

- "Oh it's kind of like being in two houses you have got all these people around, you have got workers [in one house] … [you] move over to the other house, you see workers like once, maybe twice a week. Yeah, it's just a fair bit of difference …" (R 11)

One interviewee identified the need to relocate Brumby House as it is currently distant from main centres and public transport. The distance made it difficult to develop independence and keep in contact after exiting the Program.

One interviewee pointed out that although she still maintained connections with the RFNSW and saw that as valuable the friendships she made with other residents while living in Brumby did not continue after leaving.

The interviewees were suggesting improvements could be made which were in essence about them developing greater independence, self-reliance and social competence, such as more outings and greater structure within the house, whilst also maintaining a certain standard of behaviour should be expected of the residents.

Family Focus Group

Six parents from four different families (4 mothers and two step-fathers of current or past residents of the program) attended the focus group. All were extremely supportive of the programme.

- "Overall I think Richmond fellowship is a great program, they do a wonderful job. There needs to be more programs like it." (P 1)
- "Excellent support service. [it] should continue in similar fashion and hopefully be strengthened." (P 2).
- "Should be more places [like this]." (P 3)
- "Incredibly supportive to families, we would be lost without [this] service." (P 4)

Attitudes of staff

There was strong support for the attitudes and behaviours of staff. One mother described how much she appreciated the way staff treated her son "as a respectful, decent, worthwhile person" and were non-judgmental towards the residents. The staff, in her opinion, had "non-punitive, non-paternalistic attitudes".

The program as a whole was seen as 'normalising' with the focus of staff on "what they [the clients] can do rather than on what they can't do". A mother of a former client described the staff as 'respectful' and able to set "firm boundaries, which he [her son] grew to respect".

Life skills

The focus on life skills was seen to be very beneficial and contributed to the quality of life of their children encouraging them to become more independent, gain insight into mental illness and learning how to manage it.

- "My experience was very positive. My son entered very unwell with no living skills at all and he came out to live independently and able to work small amounts. He gained insight into his illness and takes responsibility for its management. This was a direct result of Richmond Fellowship." (P 4)

- "Brumby gave my son the necessary life skills and support required to take control of his life and direction." (P 3)

Areas of Possible Improvement of the YPP

Unsupervised time

Although parents felt that the YPP was a safe environment, one participant expressed her concern about fire danger as a result of smoking [tobacco]. This seemed to be a general concern because of the heavy medications that the participant's sons were on and the possibility of falling asleep at night while smoking.

The lack of supervision at night was also a concern of the parent's although they recognised the problems in 24 hours-a-day supervision.

Another concern was that the parents believed staff gave warnings [about unacceptable behaviour] without consistent follow-through, such as eviction.

Group work

Suggestions were made to "have more group work around managing and expressing emotions" for the residents such as around anger management.

Parents who had participated in the 'family group sessions' spoke of these as helpful and felt it assisted them 'to support each other in coming to grips with the issues for their children and their own grief and worry. They felt it was a useful service and one which should be offered again.

General concerns

Participants believed family members asked that they be listened to more as they could offer support to their sons in living with their mental disorder. Much of the discussion around concerns was about the lack of resources for young people with mental health problems. All participants in the focus group identified the lack of places (including supportive outreach programmes) as a "huge problem", which needed to be remedied as quickly as possible. This was seen as a responsibility of government and not a criticism of the YPP or RFNSW.

Case Managers' Focus Group

A focus group of seven case managers, comprised of mental health nurses, social workers and a drug and alcohol counsellor from community based services used by residents of the YPP was conducted.

The participants were generally very supportive of the program:

- "a very essential service that does a really good job." (CM 1)
- "this service must continue." (CM 2)

Staff

Case workers pointed to the attitudes of staff as one of the strengths of the YPP. They described staff as "supportive", "approachable" and "quite knowledgeable".

At the same time, one respondent pointed out that "Brumby staff knows their limitations" and worked well with other services. "They are aware of client deterioration and will act on that knowledge to contact appropriate other services." (CM 3)

Caring community

Case Managers identified the YPP as a "caring environment" clients were "made to feel at home". Staff were seen as willing to advocate for their clients. It was described as safe, stable housing with routines, peer connectedness and 'contact with stable adults' who assisted the residents to develop 'adult life skills'.

The staff were seen as communicating well with mental health staff and were described as "aware of other services or if not they check appropriate services with others". There is "good liaison with other services, both government and non-government". A "culture of communication" existed within the YPP and the RFNSW more broadly. No "them" (caseworkers and clinicians) and "us" (RFNSW staff) attitude existed within the RFNSW. They identified this as a real strength of the service and an indication of the embedded-ness of the YPP in the overall provision of services to young people with mental disorders.

Case managers also identified the willingness of the YPP to accept 'challenging clients' and to address 'difficult behaviours' as a major strength. Their preparedness to accept clients with issues of substance usage' was seen as a real strength. The entry criteria were not seen as rigid and 'lots of excluding criteria' did not exist.

Life skills

The support offered by the YPP was described in a variety of ways: social; psychological; occupational; drug and alcohol and life skills.

Case managers reported that the YPP ensured 'continuity of care' for their clients. YPP workers were seen to encourage residents to comply with medication regimes and to address physical and mental health issues.

The Case Managers' Recommendations

Better exit strategies

Case managers expressed the need for better exit strategies, specifically in relation to the 'bottleneck' that is created when residents remain in the house/houses for long periods of time. One case manager reported that the challenges of moving the residents onto other appropriate options were both external (lack of other appropriate options) and internal (unclear exit strategies on the part of YPP).

Strategies for challenging behaviours and unacceptable behaviours

The case managers spoke about what they saw as the lack of specific strategies for challenging and unacceptable behaviours. These included both drug and alcohol use and abusive, aggressive or violent behaviour (towards residents and staff). While they appreciated the demanding nature of working in the YPP, they thought that RFNSW needed to develop and/or strengthen specific strategies for challenging and unacceptable behaviours. One case manager discussed the need for 'therapy in place' strategies.

The YPP approach to inappropriate or unacceptable behaviours was seen as confusing for both residents and case managers. They understood that YPP staff in the case of inappropriate or unacceptable behaviours gave warnings to residents but there was the feeling that the ultimate consequence (of being asked to leave) was applied inconsistently or at very difficult times. For example, being asked to leave just before Christmas was difficult both for the young people and the case managers in terms of finding options and managing the situation. The consequences of inappropriate or unacceptable behaviours needed to be clearer for all concerned although it was understood that there were varied circumstances and the needs of all residents should be considered at all times.

Lack of activities during the day and location of the houses

The lack of activities during the day was identified as a crucial issue. Individuals referred to how their clients had claimed they were bored and spending too much time hanging around the house, doing nothing.

One case manager singled out the location of Brumby House as problematic. She felt that the lack of public transport and distance from key centres (eg. shops) created dependency of the young people on the YPP staff and fostered hanging around the house, doing nothing. The residents relied on staff driving them to places (such as shops, health centres and workplaces) rather than walking or catching public transport.

Staffing

All the case managers felt there was a need for more staff supervision, especially at night and on weekends. One participant expressed concern about illicit drug use and access to unmonitored websites. She expressed concern that a culture of viewing 'pornography as a group' was being fostered and that in her opinion, this had the potential to be a major issue especially given that some residents are likely to have been sexually abused. But this issue was not pursued by the case manager.

An equivalent service for young women

Since 2005 YPP has been a males-only service and the case managers identified this as a major problem. They all thought the 'males-only' policy created a serious service gap and that there was a need for an equivalent young people's program for young women with a mental disorder and problem substance use. Given the reasons for the current 'males-only' policy, they understood that a separate house might be the best option. In their opinion, there would be enough referrals to support a 'females-only' house in the Penrith region.

DISCUSSION AND CONCLUSION: THE YPP YESTERDAY AND TODAY – A STORY OF INCREASING SUCCESS

Since 1975 the RFNSW has assisted those with mental health problems to reintegrate into the community. Through the provision of accommodation and psychosocial programs the RFNSW has aimed to maximise the well-being and potential of people living with a mental disorder. The YPP was established by the RFNSW with the purpose of providing much-needed support to an often forgotten population – young people (17-25) with mental health problems. This review of the YPP tells the story of a community-based organisation that has found its client-group increasing in complexity. This complexity has brought forth various management and service-provision issues. The retrospective analysis of case-file data; interviews with past and present clients; and focus groups of family members and case managers, indicates that the YPP has addressed many of those issues such that the program has successfully survived. It is the purpose of this review that the YPP will identify and reflect upon its successes so as to continue with such, but also, be able to identify and reflect upon points for improvement in their service-delivery so as to ensure the YPP will not just continue to survive, but also thrive.

Entering the YPP

The referral base of the YPP has increased over the three phases of the program (1995-1999; 2000-2004; 2005-2009). Initially Mental Health Teams provided the majority of referrals (53%). Today the clients of the YYP continue to be sourced in that way but they predominantly come to the YPP from outpatient services of the Sydney West Area Health Service, the Early Psychosis Intervention and Hospital Service – totalling 85% of the client-base.

This finding suggests an increased readiness on the part of the regional health services to acknowledge the important role of community-based service providers in the effective reintegration of people with mental-health problems. The finding also suggests an increased demand for such services with no indication that demand will decrease in the foreseeable future, which establishes both the importance of the YPP and the need for its continuation.

Profile of the Client-Base

Over the years of its operation, the YPP has seen some significant changes in the profile of its client-base. The age of clients has seen some interesting fluctuations. Initially, clients were predominantly from within the 20-25 age-bracket. During the second phase of the YPP a younger cohort began to access the program (<23). But today the YPP has clients generally spread across the age spectrum (17-27). What these changes would mean for the YPP is that the client-base would have differing needs, expectations and capacities – due to their particular life stages - and as such, would require modes of management appropriate for that stage.

The gender differentiation of the YPP has seen sudden change. Though the client-base has always been predominantly male, an incident between a male and female client produced a change in program policy resulting in the YPP having exclusively male clients since 2005. This decision may be understandable given the significant gender bias in the first two stages of the program. However, it does mean that an equally important cohort of the community – young females with mental health problems – no longer have access to a service the provision of which as has already been established, is only going to increase in demand.

The mental disorders experienced by the clients, and the very reason for their entry into the YPP, were varied. The majority fell on the spectrum of psychosis (92%) with the usual diagnosis being

schizophrenia with the remainder being categorised as displaying either mood disorder, conduct disorder, adjustment disorder or personality disorder. This variety of mental health problems indicates the clients' needs as having a focus on the management of medication and/or behaviour management.

Another diagnosis presented by 15% of the clients was drug-induced psychosis. This mental health problem is an indicator of what has become an added complexity to the demands placed upon the services provided by the YPP. That complexity being clients with mental disorders presenting with drug use and/or dependency – or what is referred to as co-morbidity.

An Added Complexity – Co-morbidity

Though the intention of the YPP has always been to service young people with mental health diagnoses, the issue of drug use and/or abuse has been a co-occurrence since the program's inception. In every phase of the YPP's existence the majority of clients have displayed co-morbidity upon admission, with 2005-2009 being the most significant at 93%.

It is well established in the literature that people displaying co-morbidity is a difficult client group to work with and one for which a multi-level approach is required (Graham, 2008). The YPP as part of the overall health service provision to this group offers: stable accommodation; assistance in developing life skills necessary to independent living; and referral to appropriate services. However, the results indicate that within the YPP there were no regular programs run specifically on drug and alcohol education.

The interview and focus group data revealed a norm of drug and alcohol consumption existed amongst the client group. This behaviour specifically pertained to the consumption of drugs and alcohol either on the RFNSW premises, during the unsupervised times (night and weekend) or offsite use whilst resident in the program. The most common reported use was of residents consuming both alcohol and cannabis. Though there were sanctions against drug and alcohol use with the ultimate being exclusion from the program, participants in the focus groups reported these sanctions were either applied inconsistently or reduced to the level of a warning.

Despite no evidence of a specific focus in the YPP upon drug and alcohol cessation, the case files indicated that throughout the YPP's existence, 21% of clients reported as having reduced their drug and alcohol use, while 44% reported no change. Interventions around drug and alcohol use may have been informal, client specific, or part of the milieu created within the YPP program. Data from the case files, interviews and focus groups do not establish the existence of a specific 'YPP approach' to drug and alcohol use. However, by articulating what does occur in the program, the YPP may be able to explain why the use of drugs and alcohol did not increase for the majority of residents, despite being in an environment where there were clear norms around their use.

"Every Day in Every Way..." – The Lived Experience of Clients of the YPP

We know from the literature that active consumer involvement is important for recovery (see for example Deegan, 1992; Browse et al., 1998). The process of goal-setting and the finding that between 30% - 45% of the goals clients set for themselves were achieved suggests that something in the program, consistent with a philosophy of consumer involvement, is enabling clients to work towards and achieve goals they set. However it is not clear what this 'something' might be. In the interviews with current and past resident's and with the focus groups with family members, mention was made of the importance of staff attitude and the respect the staff showed to their sons

and daughters. Goals set by clients were respected by staff even if the staff felt they were not in line with their goals for that client.

Attitude is discussed in the literature as important in relationships concerned with the amelioration of mental health problems (Pilgrim et al., 2009). The evidence strongly supports the idea that relationships in general and the quality of relationships, specifically, are more important for the mental health of people than any specific therapeutic techniques or interventions (including medication) (Pilgrim et al., 2009). It would appear from the results that the staff and their attitudes to the residents of the YPP both past and present is a significant factor in the experience of the YPP, and is highly regarded by those involved with the program.

A general strengths-based perspective was identified by the focus group participants and some of the residents which if articulated, could provide some very clear guidance around how the YPP could describe and evaluate its program. Such a perspective would appear to underpin much of the YPP and sits well with the recovery paradigm in mental health (Jacobson and Curtis, 2000). Whilst rules and limits were set in the YPP, they were consistent with the sorts of expectations of any adult living in shared accommodation. The findings suggest this was offered in a 'home-like' respectful environment.

The support offered by staff did not extend to nights and weekends and this raised some anxieties for parents around safety and for a slippage of behaviour from the residents. The parents acknowledged that supervision 24/7 brings with it its own problems. In such an arrangement there is an assumption of incompetence and the possibility of infantilising the clients which would be counter to the aims of the program.

The tension between risk management and a degree of autonomy for the clients is a tension faced in many facilities dealing with young adults. However a program designed to act as a transition to independent living has a greater need than most to afford its residents the opportunity to savour independence in a measured but authentic manner. The staffing of the service on weekdays may "strike the right balance" in doing that, but this is a decision the RFNSW needs to make about the continued structure of the YPP.

Another arena in which the tension between intervention and client autonomy is experienced pertains to daytime activities. The interviews with current and past residents and the parent focus groups were very positive about the structured activities offered by the YPP, and the importance of life and skills for consumers of mental health services has long been acknowledged (Arn and Linney, 1995). However residents also spoke about a lot of unstructured time and expressing an interest in having more structured activities. As such, the YPP could explore developing a range of short programs that run over a specified time period. Such programs may appeal to external funders willing to support the work of the YPP and eager to see their contribution attached to a specific activity.

Behaviour management can be a significant issue for clients with co-morbidity. The YPP has always adopted the approach of providing enough space and opportunity for people to take responsibility for themselves. But the need for specific strategies for dealing with clients when their behaviour is inappropriate was identified. Consistent, clearly articulated rules with stated sanctions, which are implemented creates a clear structure in which known consequences will flow from decisions clients make. This includes some clarity around the use of alcohol and cannabis. The need for policies and practices around unacceptable behaviour is consistent with an approach which takes seriously the clients' capacities for taking responsibility for their lives.

Moving On and Moving Out – Successful Exit Strategies of the YPP

The main purpose of any program review is to measure the success or otherwise of that program. As regards the YPP, there are no specific indicators by which to measure the success of the YPP. This difficulty occurs because 'completion rates' a statistic often referred to as an indicator of "success" may, in the case of the YPP, present a misleading picture.

Over the life of the YPP the completion rates rose steadily to 30%, but this may not provide a complete story of client success. For example, a client may have need for a short stay in Brumby House and then proceed into independent living outside of the program, but this would appear as a non-completion and hence quite incorrectly not judged as a success.

Achievement of goals is a possible indicator of success, but clients may have been recorded as only partially achieving their goals, despite having achieved the most significant and important goal to them; and then moving into independent accommodation.

Other possible indicators of the success of the YPP include: employment at exit rising to 30% in the last phase under review; and known accommodation at exit accounting for 88% of the clients. However the service offered by the YPP to young people with mental disorders, and accepting those with co-morbidity issues, is an uncommon provision for which there are no available comparative best-practice benchmarks to measure against.

Possibly the clearest indicator of the success of the YPP is the data pertaining to planned exits. A 'planned exit' implies a conscious and deliberated decision to move on. It suggests opportunity for assisting the clients to establish themselves in the community and set strategies in place to support them. Whether this is the case is unclear from the case files and therefore makes this a somewhat weak indicator. None the less, over the three phases of the program there was an increase in the percentage of clients who did plan for their exit moving from 28% in the first phase to 48% in the last phase of the review period suggesting that the YPP has become increasingly successful in assisting people into community-based living which is in accordance with the Program's stated objective.

Given that 36% of all clients of the YPP exit into the family home, the role of the family deserves attention. Family members provide a very important part of the service mix available to support young people with mental disorder. The families participating in this research were very aware of the service provided by the YPP and applauded what it afforded their sons and daughters. They were also very aware of a general paucity of services for this group and wanted the YPP to provide more structured programs both for the resident but also for the family members having to deal with issues of mental disorder in their family. The ability of the YPP to offer more structured programs to the residents as well as support or education for families is clearly an important issue which the RFNSW needs to consider in light of its resources and focus on assisting young people towards reintegration.

The four themes evident in the literature around best practice in community-based mental health services; consumer participation, recovery, social inclusion and the development of life skills, are all in evidence in the YPP. It is now incumbent on the YPP to articulate how these themes are executed in the daily running of the program and for the benefit of the clients.

Limitations Experienced Throughout the Research

The retrospective, mixed method nature of this project was innovative. At the same time, the limitations of the case-file data set were extensive, especially those case files from the first five

years of the YPP (1995-1999). The case-files could not reveal how the program was implemented, interventions applied or the breadth of outcomes of many of the residents, past and present in the YPP. Though the data reported in the files improved over time, on the whole it did not facilitate the development of a comprehensive picture of the YPP program, its inputs and outcomes.

The qualitative data collected in the interviews and focus groups indicated a great deal of support for the YPP program and a belief that it was a most successful and valuable component of the mental health services necessary for young people with mental health issues. However, like the case-files, there were also limitations in relation to the interviews (individual and focus groups). The process of recruiting residents (especially past residents) for individual interviews was challenging and fewer interviews were conducted than expected. This challenge extended to the participation of family members and case managers. It was not possible to locate family members or case managers involved with the YPP from Phase 1 of the program. The retrospective nature of the project required all participants to reflect on past experiences and while that is a useful strategy for gaining insight into how participants remember the program, it is an unreliable method for establishing what interventions occurred and their impact at the time. The case-files were not of sufficient quality to fill this void because the quantitative data collected from the case-files was not of sufficient depth or consistency to enable a clear articulation of what elements contributed to what outcomes for the client group. From the case-files it was not possible to describe the success of the YPP or how or why it succeeded.

A clearer method by which to record client information and consistency around what information is routinely collected, may enable the accumulation of 'evidence' of the success of the YPP and provide the RFNSW with the type of data that would assist in future applications for funds.

In Conclusion

The YPP came into being at the beginning of a period of immense change in the mental health field and it offered an emerging model of community-based mental health provision. The case-files from the earliest period reflect a very informal approach to file-keeping. This approach changes over the life of the program to the final stage in which the information is more consistently and systematically recorded. This change reflects the evolution of the program and changes in expectations of non-government organisations around reporting and accountability. As the focus on evidence-based practice increases, the imperative for the YPP to be able to provide evidence of its success in terms of the outcomes for residents will grow.

Service provision in the field of mental health can be complex and success is dependent upon factors outside the arena of any one service. This complexity increases for those services involved with clients with co-morbidity. Despite these complexities, it is incumbent upon those organisations to identify the contribution they make to the overall provision of mental health services. This report and review of the YPP goes some way towards identifying those dimensions and outcomes which may well inform the anecdotal evidence which already exists about the value of the YPP and can assist the RFNSW to identify those aspects which require more consistent data collection for reporting on its activities; and in applying for further funding, such that the RFNSW ensures the successful continuation of the YPP into tomorrow and beyond.

RECOMMENDATIONS:
TAKING THE YPP INTO TOMORROW –
ENSURING CONTINUING SUCCESS

This research has demonstrated the complexity of a multi-layered recovery focused community program with young people with an identified mental disorder and problem substance use. While cannabis is a drug of choice of young people, alcohol is also problematic and both need to be addressed within the context of supported accommodation programs like the YPP. The research findings indicate aspects of the Program that are seen by the residents, families and case managers to be working well. There are also areas of the Program that are in need of revision and review. In both cases the RFNSW has an opportunity to reframe and revitalise its existing program in light of the following recommendations.

RECOMMENDATIONS

On the basis of the above findings, it is recommended that the RFNSW implement the following:

Short-term strategies:

- Clear articulation of YPP's policy on rule-breaches (eg. cannabis use, drinking, aggressive/abusive behaviour)
- Clarification of sanctions associated with rule-breaches
- Staff training in implementation of rules and sanctions
- Client education workshops on adherence to rules and avoidance of sanctions
- Articulation of "indicators of success" (strengths) of the program. This articulation to be evidence-based resulting from the following sources of data, to be systematically recorded:
    - Medication management (including compliance or planned reduction in medication)
    - Management of drug and alcohol use
    - Development of life skills
    - Improvement in capacity for independent living, this may be reflected in movement between support levels, increasing independence and responsibility, or planned exits.
    - Monitoring and recording of goal establishment and achievement
    - Occupation during program and at exit (including employment, full or part time, education, volunteering)
    - Accommodation type at exit

Issues arising through the review which the RFNSW may wish to consider but which the review does not wish to posit as recommendations include:

- Review the night and weekend staffing of the Core House
- Review the degree to which the YPP wishes to engage family members in the program.

Long-term strategies:

- Seek further funding to expand the YPP so that young women with mental health issues could be accommodated in a women only environment.

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Appendix 1: Coding Case File Sheet, Young People's Program

Demographics and History

Age	**Referral Source**
Gender	**Age at Onset of Illness**
Diagnosis	**Homelessness**
D & A use	
	Number and duration of inpatient Psychiatric admission
Medication Compliance	
	Educational/vocational history
Contact with Family	
	Criminal history
Physical health issues	

Time in the Program	Exit
Date of Entry **Duration of Stay**	**Date of exit**
Progress through support levels	**Services connected to**
Services accessed whilst in the program	**Vocational Status**
	Relationship with family
Income Source	
Drug and Alcohol use whilst in the program	
	Exit accommodation (parents, independent, supported, crisis)
Goals set at entry (or later) and achievement of goals	
	Mediation compliance
	Circumstances of exit (Completion, asked to leave, left voluntarily)
Hospital admissions No. Duration (bed days)	

Appendix 2

Information Sheet (Residents)

Project Title: A study of the presenting issues and outcomes for young people with a mental illness and co-occurring substance abuse

Young people who are or have been clients of the Richmond Fellowship Young People's Program (YPP) are invited to participate in a study about services for Young People with co-occurring mental health and drug/alcohol issues. You need to be over the age of 18 and currently well.

The project is being conducted by:

- The Richmond Fellowship NSW and
- The Social Justice and Social Change Research Centre, University of Western Sydney.

We have a steering committee consisting of the parties above and other mental health services for young people to advise us about the way we carry out this study.

We want to find out what services and interventions 'work' for young people with co-occurring mental health and drug/alcohol issues. We want to identify the successful and not-so-successful elements of the YPP to inform best practice models and we want to find out what it offers for young people. You may know the program better as Brumby House.

We know that a lot of clients, ex-clients and workers from other services that work with young people with co-occurring mental health and drug/alcohol issues believe that the Richmond Fellowship offers an effective service through the YPP or Brumby House. We would like to find out what elements of the program are effective to feed into the YPP and other programs working with this group.

As a current or past client of the YPP you can help to give us some insight into what works (or worked) for you at the YPP.

If you are interested in participating in this study please contact:

- Associate Professor Natalie Bolzan
- Social Justice and Social Change Centre at the University of Western Sydney
- Phone: (02) 9772 6531 email: n.bolzan@uws.edu.au

We invite you to participate via an interview and/or participation in a focus group with other people who are, or have been clients, of the Richmond Fellowship Young People's Program (YPP). If you decide to participate in this study we will ask you some questions about the following: your mental illness, what you know about your diagnosis, whether or not you have ever used drugs (legal and illicit) on a regular basis, what your prescribed medication is at present, your age, the supports and services you are currently getting and what services you have found helpful to live with your mental health issues. Although anonymity cannot be ensured during the process of focus groups the information provided will be de-identified and your anonymity will be preserved in the research as a whole and in any outcomes from the research (publications etc).

If you are using cannabis or other substances, we will ask you NOT to not to talk aboutpeople or events in the group that may require a researcher to report information to police as the researchers have an obligation to report knowledge of illegal activities and knowledge of how illegal drugs are obtained to the police.

The project is being carried out over two years. The interviews will be happening in the next few weeks in a venue near to you. We will be carrying out the focus groups in Sydney at a later date at the Richmond Fellowship (either the Homebush or Penrith office, depending on the needs of participants) or if preferred, at the Parramatta or Penrith campus of the University of Western Sydney.

We will use the information we find out from you to inform social policy and practice in relation to young people with a mental illness and to improve services, program and outcomes for young people in general. We will also tell community mental health service workers and drug and alcohol counselors about the study and what they can do to better help people living with mental illness.

Travel costs: We know that you may find it difficult to travel to us. We can organize transport for you or we will reimburse you for costs of travel to come to the interviews or focus group (no more than $20). We will also try to have the interviews or groups close to where you live. If you feel uncomfortable after being interviewed or being in the focus group you can ask to see a counselor who is outside the study and we will arrange this at no cost to you.

Refreshments will be offered at the time of interviews and meals (finger food) will be provided before or after the focus group depending on the time of the group.

Outside of the actual process of conducting focus groups, your privacy, confidentiality and anonymity will be preserved at all times. We will not put your name or anything that will identify you on any of the information you give us. We will not contact any of your current mental health workers or family members about your participation in the study. All of the information we collect will be retained in locked storage, only available to members of the research team for the life of the project and destroyed after the end of the project.

We will give you a copy of our report at the end of the project before we release it so you can check that you will not be identified in any way. We will also invite you to come to a seminar when we tell other consumers and workers about the study.

You are free to withdraw from participation in the study at any time – you do not have to give us any explanation about this. If you wish, we will give you a copy of the report at the end of the study. You can choose to be interviewed and not participate in the focus group.

Please contact us at any time if you would like further explanation or information about the project and how you would like to be involved.

Contacts:

Associate Professor Natalie Bolzan, Social Justice Social Change Centre at the University of Western Sydney. Ph 9772 6531 email n.bolzan@uws.edu.au

Scott Turner, Assistant Area Manager Sydney Area - (Penrith), The Richmond Fellowship of NSW, Ph 02 4720 4500 Mob 0411 349 592 Fax 02 4720 4589 sturner@frfnsw.org.au

NOTE: This study has been approved by the University of Western Sydney Human Research Ethics Committee or the University of Western Sydney Human Research Ethics Panel. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the following: by telephone: 02 47 360 883 or by email humanethics@uws.edu.au . Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

College of Arts
Social Justice and Social Change
Research Centre

Appendix 2a - Consent Form (Residents)

Project Title: A study of the presenting issues and outcomes for young people with a mental illness and co-occurring substance abuse

Young people who are or have been clients of the Richmond Fellowship Young People's Program (YPP) are invited to participate in a study about services for Young People with co-occurring mental health and drug/alcohol issues. You need to be over the age of 18 and currently well.

The project is being conducted by:

- The Richmond Fellowship NSW and
- Social Justice Social Change Centre, University of Western Sydney.

We have a steering committee consisting of the parties above and other young people's mental health services to advise us about the way we carry out this study.

We want to find out what services and interventions 'work' for with co-occurring mental health and drug/alcohol issues. We want to identify the successful and not-so-successful elements of the YPP to inform best practice models and we want to find out what it offers for young people. You may know the program better as Brumby House.

A. I have read the Information Sheet about the project. YES / NO

B. I understand what my involvement will be in the project:

- I know that I will be asked questions about: my mental illness, what my life was like at the time I entered the program (Brumby House), my experience of Brumby House, and how my life is now YES / NO

- I understand that participation in this research study will involve an interview and/or participation in a focus group with other people who are, or have been clients, of the Richmond Fellowship Young People's Program (YPP) also known as Brumby House. YES / NO

C. I am willing to participate in this research study. YES / NO

D. I have had all my queries/questions answered by the researcher YES / NO

E I understand that I can withdraw from the research at any time, and that I do not have to provide any explanation about this. YES / NO

F. I understand that I will not be identified in any way during and after the project and that all information I give will be completely confidential YES / NO

G. I understand that all information I give to the project will be completely anonymous and will be destroyed after the project ends. YES / NO

Signed …… Date…….

Appendix 3 (Residents)
Interview Schedule and example questions

Project Title: A study of the presenting issues and outcomes for young people with a mental illness and co-occurring substance abuse

The information you give us will be completely anonymous. Thank you for participating in this study

Topics to be covered:

1. Demographics: E.g., age, area of residence, gender

2. Mental Health History: E.g., Diagnosis & time of diagnosis, last episode of mental ill health, number of episodes of mental ill health, medication & dosage (if any), other forms of treatment including therapy &/or self help activities (in the past).

3. Current Mental Health Status: E.g., What mental health issues do you have at present? Are you receiving mental health care at present? What kind (if receiving mental health care at present)? Medication & dosage (if any), other forms of treatment including therapy &/or self help activities (in the present).

4. Current circumstances: E.g., Social supports, family relationships, employment, education.

   Example of questions: What other supports and help do you get? What supports and help would you like to get?

5. Drug use (other than medication): Use of recreational drugs (including alcohol & tobacco)? E.g., Have you ever used recreational drugs? How often and for how long? Do you currently use recreational drugs (including alcohol & tobacco)? If so, what drug(s)? How often and how much of each drug would you use in a week?

6. Knowledge of mental health issues and recreational drug use: E.g., What do you know about your mental health issue or illness? What do you know about the effects of recreational drugs on your mental health?

7. Young People's Program, Richmond Fellowship - This topic area will be focused on eliciting their experience of the YPP and will cover the following areas in broad terms: E.g., Time of entry into, departure from the program & & reasons for both; What did the program provide in terms of strategies/interventions or activities that helped them with their mental health and/or their recreational drug use? What was missing in terms of strategies/interventions or other activities? In their opinion, did the Program help them in their recovery?

8. Other: Are there any other ideas or things you would like to tell us about your experiences of the YPP and/or RFNSW?

9. Thank you for talking to me. Are there any questions you would like to ask me?

Appendix 4
Information Sheet
(Key Stakeholders)

Project Title: A study of the presenting issues and outcomes for young people with a mental illness and co-occurring substance abuse

Service providers and involved family and friends who have been associated with the Richmond Fellowship Young People's Program (YPP) are invited to participate in a study about services for Young People with co-occurring mental health and drug/alcohol issues. You need to have knowledge of the YPP and/or have been/ are currently associated with the program.

The project is being conducted by:

- The Richmond Fellowship NSW and
- The Social Justice and Social Change Research Centre, University of Western Sydney.

We have a steering committee consisting of the parties above and other mental health services for young people to advise us about the way we carry out this study.

We want to find out what services and interventions 'work' for young people with co-occurring mental health and drug/alcohol issues. We want to identify the successful and not-so-successful elements of the YPP to inform best practice models and to find out what it offers for young people. You may know the program better as Brumby House.

We know that a lot of clients, ex-clients and workers from other services that work with young people with co-occurring mental health and drug/alcohol issues believe that the Richmond Fellowship offers an effective service through the YPP. We would like to find out what elements of the program are effective to feed into the YPP and other programs working with this group.

As a service provider or involved family member or friend associated with the YPP you can help to give us some insight into what you believe works (or worked) at the YPP.

If you are interested in participating in this study please contact:

- Associate Professor Natalie Bolzan
- Social Justice and Social Change Centre at the University of Western Sydney
- Phone: (02) 9772 6531 email: n.bolzan@uws.edu.au

We invite you to participate via participation in a focus group with other people who are, or have been service providers or involved family & friends, of the Richmond Fellowship Young People's Program (YPP). If you decide to participate in this study we will ask you some questions about the following: your experience of YPP, what you know about the experience of clients of the service, the generic supports and services you think are useful for young people with co-occurring mental health and drug/alcohol issues and what you think work or doesn't work in relation to the Young People's Program at RF. Although anonymity cannot be ensured during the process of focus groups the information provided will be de-identified and your anonymity will be preserved in the research as a whole and in any outcomes from the research (publications etc).

If you are using or know about the use, production or sale of cannabis or other illicit substances, we will ask you NOT to talk about people or events that may require a researcher to report information to police as the researchers have an obligation to report knowledge of illegal activities and knowledge of how illegal drugs are obtained to the police.

The project is being carried out over two years. The focus groups will happen within the next few months and will be carried out in Sydney at the Richmond Fellowship (Penrith or Homebush) and/or at

a campus of the University of Western Sydney (Penrith or Parramatta), depending on participants. The specific details of place and time will be identified at the initial contact. If you wish to participate in the study but don't want to be involved in a focus group, we can arrange for an individual interview.

We will use the information we find out from you to inform social policy and practice in relation to young people with a mental illness and to improve services, program and outcomes for young people in general. We will also inform community mental health service workers, drug and alcohol counselors and the wider community about the study and what they can do to better help people living with mental illness.

Travel costs: If you find it difficult to travel to us, we can arrange transport or we will reimburse you for costs of travel to come to the focus group (no more than $20). We will also try to have the groups in a venue closer to you. If you feel uncomfortable after being in the focus group you can ask to see a counselor who is outside the study and we will arrange this at no cost to you.

Refreshments will be offered during the focus group (tea/coffee and biscuits etc) and meals (finger food) will be provided before or after the focus group depending on the time of the group.

Outside of the actual process of conducting interviews or focus groups, your privacy, confidentiality and anonymity will be preserved at all times. We will not put your name or anything that will identify you on any of the information you give us. We will not contact any of your current mental health workers or family members about your participation in the study. All of the information we collect will be retained in locked storage, only available to members of the research team for the life of the project and destroyed after the end of the project.

We will give you a copy of our report at the end of the project before we release it so you can check that you will not be identified in any way. We will also invite you to come to a seminar when we tell other consumers and workers about the study.

You are free to withdraw from participation in the study at any time – you do not have to give us any explanation about this. If you wish, we will give you a copy of the report at the end of the study.

Please contact us at any time if you would like further explanation or information about the project and how you would like to be involved.

Contacts:

Associate Professor Natalie Bolzan, Social Justice Social Change Centre at the University of Western Sydney. Ph 9772 6531 email n.bolzan@uws.edu.au

Scott Turner, Assistant Area Manager Sydney Area - (Penrith), The Richmond Fellowship of NSW, Ph 02 4720 4500 Mob 0411 349 592 Fax 02 4720 4589 sturner@frfnsw.org.au

NOTE: This study has been approved by the University of Western Sydney Human Research Ethics Committee or the University of Western Sydney Human Research Ethics Panel. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the following: by email humanethics@uws.edu.au or by telephone: 02 47 360 883. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

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Appendix 4a (Key Stakeholders)

Consent Form (Key Stakeholders) Project Title: A study of the presenting issues and outcomes for young people with a mental illness and co-occurring substance abuse

Service providers and involved family and friends who have been associated with the Richmond Fellowship Young People's Program (YPP) are invited to participate in a study about services for Young People with co-occurring mental health and drug/alcohol issues. You need to have knowledge of the YPP and/or have been/ are currently associated with the program.

The project is being conducted by:

- The Richmond Fellowship NSW and
- Social Justice Social Change Centre, University of Western Sydney.

We have a steering committee consisting of the parties above and other young people's mental health services to advise us about the way we carry out this study. We want to find out what services and interventions 'work' for young people with co-occurring mental health and drug/alcohol issues. We want to identify the successful and not-so-successful elements of the YPP to inform best practice models and we want to find out what it offers for young people. You may know the program better as Brumby House.

1. I have read the Information Sheet about the project. YES / NO

2. I understand what my involvement will be in the project:

   a. I know that I will be asked questions about: my experience of YPP as a family member, what services the YPP provides that I believe to be helpful (or not) for young people with mental health issues and cannabis, alcohol or other drug use, thoughts on improving YPP or other services for young people.
   YES / NO

   b. I understand that participation in this research study will involve participation in a focus group with other people who are, or have been, involved family and friends of a person who has been a client of the Richmond Fellowship Young People's Program (YPP).
   Y ES / NO

3. I am willing to participate in this research study. YES / NO

4. I have had all my queries/questions answered by the researcher YES / NO

E I understand that I can withdraw from the research at any time, and that I do not have to provide any explanation about this. YES / NO

5. I understand that I will not be identified in any way during and after the project and that all information I give will be completely confidential YES / NO

6. I understand that all information I give to the project will be completely anonymous and will be destroyed after the project ends. YES / NO

Signed …… Date……

Appendix 5

Focus Group Schedule (Key Stakeholders)

Project Title: A study of the presenting issues and outcomes for young people with a mental illness and co-occurring substance abuse

The information you give us will be completely anonymous. Thank you for participating in this study

Topics to be covered:

10. Demographics: E.g., age range, gender, current employment, education Age range,

11. Role in relation to YPP: within YPP or other OR Family member: parent/sibling/other OR Friend

12. Length of time with/connected to YPP

13. Knowledge of program: Extensive or through feedback from clients only

14. What does the program provide in terms of strategies/interventions or activities that helps or helped young people with their mental health and/or their recreational drug use?

a. Living skills
b. Supportive people – staff
c. Social activities
d. Developing networks (friends or other)
e. Developing strategies for managing mental illness
f. Educational support (formal or informal)
g. Education on drugs & mental illness
h. Employment support
i. Other therapeutic engagement

15. What was missing in terms of strategies/interventions or other activities?

16. In your opinion, does (or did) the Program help young people in their recovery from mental health and cannabis/alcohol and other drug problems? How?

17. Other: Are there any other ideas or things you would like to tell us about your experiences of the YPP and/or RFNSW?

18. Thank you for talking to me.