Evaluating the Hawthorn House Residential Rehabilitation Service

Geoff Smith
Theresa Williams
Linley Lefay
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1. EXECUTIVE SUMMARY

“Instead of relatively short and sharp encounters with the health service, more people are embarking upon journeys of years or decades, requiring assistance and support..... [The question is] what kind of services and care best fit the needs of people who are on a patient journey? It is better to spend time working out what provisions the patient needs for their journey than rushing to complete and document the plan and plug every hole ....... nothing beats actually hearing what the patient has to say and finding out what they think they want and need.”

[Professor Stephen Leeder, 2007]

This report describes the evaluation of Hawthorn House, a residential rehabilitation service situated in the Perth inner city suburb of Mount Hawthorn, which commenced operation in December 2006. As part of the development approval process it was agreed with the Town of Vincent that Hawthorn House would only operate for 3 years and that during that time the service would be evaluated. The Western Australian Centre for Mental health Policy Research was approached to conduct the evaluation.

The evaluation considered four key questions:

- Has Hawthorn House achieved its objectives?
- Are the clients and family caregivers satisfied with the service?
- What impact has Hawthorn House had on the local community?
- How can the evaluation findings shape future services and policy development?

Over the 22 months to September 2008, Hawthorn House had accepted 39 clients [44 admissions] out of a total of 163 referrals or 1 in 4 referrals. The majority of their residents had a serious mental disorder [71% schizophrenia or schizo-affective disorder] and almost half of them have been in contact with mental health services for over 10 years.

Given the inability to access the hospital utilisation data and the significant gaps in the NOCC data, it has not been possible to objectively demonstrate the extent to which clients have functionally improved, but there has been universally positive feedback on client outcomes from the clients themselves and their family caregivers and from the public and non-government service providers who have been involved in their follow-up.

An important element of the success of Hawthorn House has been the involvement of individual clients and their families in the assessment of their needs and the development of self-organised care plans. The concept of the Individual Care Plan is currently being adopted across the whole of NMAMHS.

In the first year of the service’s operation, a great deal of the staffs’ time and energy had to be put into clarifying the model, establishing the operational policies and procedures and setting up the clinical program while, at the same time, working with the clients and trying to manage the relationship with the local community. This has inevitably impacted on a number of key areas of Hawthorn House’s activities such as the development of its relationships with the public mental health services, both community and inpatient.
On the other hand, Hawthorn House has gradually built and strengthened its relationships with the non-government and community service sectors and has developed good relationships with a number of local businesses and organisations. It has generally been well accepted into the local community and the Community Advisory Group, which was formed to monitor incidents following the opening of Hawthorn House, was suspended during 2008 because there have been insufficient issues to require regular meetings. It appears the initial fears of the community have not been realised.

A number of referral agencies, particularly inpatient services, expressed their frustration at not being able to get their clients admitted to Hawthorn House, despite the fact that there has been significant underutilised capacity. On the other hand, staff from the Community Mental Health Teams were generally more positive, with many finding that the assessments by Hawthorn House had been very useful in shaping up their management plans, even when the referred client was not accepted.

Difficulty in accessing housing, a lack of any comprehensive, integrated system of community rehabilitation and the inability of the Community Mental Health Teams to provide the levels of community supports required by clients following discharge has led Hawthorn House to develop a community follow-up service to support its clients in their transition back into the community.

As Hawthorn House represented a new model of service provision, unfamiliar to many of the staff, there needed to be a significant investment in staff training, particularly in the principles of recovery-based rehabilitation and in the development of evidence-based interventions.

Overall, the evaluation found that Hawthorn House has been an innovative service with high levels of satisfaction amongst clients and family caregivers. The critical components of the Hawthorn House program that were considered by the clients and family care-givers as being most important for them in the recovery process were:

- The skills, values, beliefs and attitudes of the staff of Hawthorn House. They particularly valued the sense that staff were genuine and actually cared about them, encouraged them to take responsibility for their lives, listened to their opinions and respected their choices, believed in their potential and worked to instil self worth and hope and gave them the time to build their confidence to the point where they felt that they could manage back in the community.

- The involvement of individual clients and their family care-givers in the thorough assessment of their needs and the development of self-organised individual care plans. The MANCAS, the individual needs assessment tool, and the Individual Care Plan is in the process of being adopted and implemented across NMAHS. This is seen by Hawthorn House staff as one of the most important and enduring legacies of Hawthorn House.

- The size of Hawthorn House and its location in the inner city suburb of Mount Hawthorn, with its ready access to retail and community services. Many spoke of the importance of the 'small group setting' not associated with any other psychiatric institution.

- Recognition that families, friends and neighbours and other factors such as housing, education, training, employment and community involvement, could have just as profound an impact on their recovery as any intervention delivered by mental health services.
The evaluation identified four important lessons that can be learned from the experience of Hawthorn House that need to be addressed and each of them has been made the subject of a recommendation:

**Need for a Comprehensive Range of Rehabilitation Services**

Despite the demand for rehabilitation services in the North Metropolitan area, current rehabilitation services are fragmented and do not provide the range of programs or services necessary to meet the diverse rehabilitation needs of the population.

**Need for Skills Development**

Rehabilitation needs to be recognised as a specialised area of practice with its own competencies. There are already pockets of expertise in evidence-based psychosocial interventions in WA that could be harnessed to develop and deliver a training program for staff in NMAMHS.

**Need for Adequate Preparation for New Services**

The planning and development of operational policies need to be completed and the key leadership team appointed well in advance of the opening of any new service. Furthermore, planning needs to focus not only on the ‘internal environment’ but on the broader ‘external context’ in which the service will be operating. This has important implications for the imminent start-up of the new Joondalup Intermediate Care Service.

**Need for an Evaluation Framework for New Services**

When developing a new service, consideration needs to be given to putting in place an evaluation framework, which reflects the specific purpose and objectives of the service.
2. THE DEVELOPMENT OF HAWTHORN HOUSE

‘The Journey’

“Hawthorn House is still a baby ..... still learning ..... people have never done this work before and it has taken time to get clarity about programs and staff roles. We have not had anything like this anywhere else in Western Australia.”

“We are still growing the service.”

[Hawthorn House Staff, October 2008]

2.1 Introduction

Hawthorn House is located in the Perth inner city suburb of Mount Hawthorn, very close to good public transport, shops and other community amenities. It was originally a community hospital, then aged care facility, built in the 1930’s. Most recently it was converted into a 16 bed, permanently staffed, medium term rehabilitation unit for people experiencing a serious mental illness. It opened in December 2006.

The initial expectation was for Hawthorn House to accept people between 18 and 65 years for a maximum of 16 weeks of active structured psychiatric rehabilitation in well staffed community accommodation. A full description of the Hawthorn House service is provided in Appendix 1.

At the time Hawthorn House was established the Department of Health agreed that the service would be evaluated. The Western Australian Centre for Mental Health Policy Research was approached to conduct the evaluation, which commenced in August 2008.

2.2 Development Stages

This section aims to place the evaluation in a context and briefly outlines the key developments of Hawthorn House from 2004 to 2008. Many of the evaluation findings need to be considered against the backdrop of these evolving policy and service developments.

Hawthorn House has gone through a number of stages from its initial inception to the current time.

Original Model: A Clinically Staffed Long Stay Hostel with Inreach

In July 2004, the Office of Mental Health introduced a discussion paper entitled, Enhancing the Capacity of Mental Health Services that set, as a priority, the need for the development of alternatives to inpatient care. In August 2004, a Working Party was established in the North Metropolitan Area Mental Health Service (NMAHS) to progress the development of such alternatives and this culminated in September 2004 in a Proposal for the Establishment of a High Tolerance Accommodation Unit.

The initial proposal was for the establishment of a 14 to 16 bed, clinically-staffed hostel in Hawthorn House for “the most behaviourally challenging long-term clients. Approximately 50% should be expected to move on to less supported accommodation within 2 years”.

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In December 2004, a submission was made by the North Metro Area Mental Health Service (NMAMHS) to the Department of Health, Mental Health Division through the Mental Health Strategy Project Control Group, requesting approval for the establishment of an Intermediate Care Service. The main objective was to increase access to acute inpatient beds by providing “longer term, high support, high tolerance hostel accommodation” for those patients that have no other accommodation options because of their challenging behaviours. These patients were primarily located at Graylands Hospital.

It was proposed that the hostel would be staffed by nursing staff “experienced in managing individuals with challenging behaviour” and Occupational Therapy Assistants. The operation of the hostel was to be overseen by Inner City Community Mental Health Services (ICCMHS), which would control access and provide “inreach” services several times per week from medical and allied health staff. After hours crisis response was to be provided by the ICCMHS and the Psychiatric Emergency Team.

Within the submission, it was recognised that Hawthorn House was an interim solution and that “longer term, smaller and closer-to-home step down facilities are more desirable.”

The project was approved by the Mental Health Division in March 2005 and a Hawthorn House Project Working Group was set up to progress it.

**Changing Models: From Hostel to Intermediate Care to Rehabilitation**

Between May and July 2005, the model for Hawthorn House began to shift. By October 2005, Hawthorn House was being described as “a clinically staffed, 20-bed intermediate care, step down unit in the community [aimed at providing] interim supported accommodation for individuals who are no longer acutely unwell but are not yet ready to live unsupported in the community [but who] are ready to commit to a short term, 6 to 16 weeks rehabilitative, residential program in a community setting”.

Within this new model, Hawthorn House would be a stand alone facility with its own full time medical and allied health staff and no longer linked to the ICCMHS other than for the on-call consultant roster.

To establish Hawthorn House, development approval from the Town of Vincent was required. Following its approval of the project on 23 November 2005, the Town of Vincent considered revoking its decision and a lengthy period of negotiation followed. During this time there was considerable attention from the media and community concern was expressed about opening a mental health facility in what is primarily a residential locality. As a result of negotiations with the Town of Vincent agreement was reached with the Department of Health that:

- The number of residential places would be reduced from 20 to 16;
- Hawthorn House would only operate for 3 years;
- Minimum staffing levels would be established;
- Clients with a history of violence, drug and alcohol abuse or criminal record would not be admitted; and
- A Community Advisory Group would be established.

Hawthorn House opened in December 2006 as a 16 bed, fully staffed, residential rehabilitation unit for clients “currently occupying a bed in the North Metropolitan Area” who were “rehabilitation ready” and could “actively participate” in a short to medium term rehabilitation program of 6 to 16 weeks.
Initially considered a ‘hospital’ under the Hospital Act, its status was altered to a ‘community based facility’ after a few weeks when it was realised more flexible governance and operational approaches were required to be an effective community based rehabilitation facility. However, this confusion over whether Hawthorn House was a ‘hospital ward’ or a community facility was detrimental to the creation of a less institutional culture.

**Community Follow-up: Care Coordination Trial**

When Hawthorn House residents were discharged to the community, staff at Hawthorn House often found it difficult to arrange the level of support from community services the ex-residents needed. When the opportunity arose for Hawthorn House to participate in the WA COAG Care Co-ordination trials the Hawthorn House Executive Group agreed to take part to improve post-discharge support for former residents.

The trial helped formalize a closer collaboration between staff at Hawthorn House and the non-government services providing support to people who had been discharged from Hawthorn House. As a result, Hawthorn House now operates a residential service plus an outreach service into the community.

### 2.3 Wider Service and Policy Context

Hawthorn House was always meant to be an interim arrangement. It was intended that the ‘model’ would be transferred, at the end of 2009, to a new 22 bed Intermediate Care facility at Joondalup. It was originally anticipated that the Joondalup Intermediate Care facility would be run and staffed by the public mental health service, most likely with staff from Hawthorn House. The Department of Health subsequently decided that this service will be operated by a NGO with clinical inreach from the public mental health services. The new facility is likely to open in mid 2010.

It is now clear that the Hawthorn House rehabilitation model will not transition to the Joondalup Intermediate Care service, as this is to be a sub-acute facility.

Hawthorn House was developed as part of a wider process of expanding options to inpatient care. In addition to the Intermediate Care units being constructed at Joondalup and Rockingham, a number of community based accommodation facilities have been built or are in progress. These include Community Options (30 places) and Community Supported Residential Units (147 places in Perth; 50 places in rural areas).

On the broader policy and planning front Hawthorn House, as a rehabilitation service, should sit within a wider rehabilitation system. However, rehabilitation services in Western Australia are fragmented and there is currently no well developed, rehabilitation service system.

Over recent years there has been a concerted effort by a broad range of stakeholders to develop the mental health rehabilitation system. In 2004 the Department of Health released *A Recovery Vision for Rehabilitation: Psychiatric Rehabilitation Policy and Strategic Framework*. This advocated a needs driven client centred focus of care, with the concept of recovery to be incorporated into care planning and the development of stronger partnerships with the non-government organisations.

In 2008 the Mental Health Division, Department of Health sponsored a two day event *Discover Recovery – Mental Health Rehabilitation Symposium* to foster debate on what a recovery oriented mental health rehabilitation system would like look like for Western Australia. A rehabilitation advisory committee was subsequently formed to further consider this question. More recently, NMAMHS has initiated a project called *Pathways to Care*, to develop a framework for rehabilitation services across northern metropolitan areas.
The development of mental health services will be significantly progressed during 2009 with the recent Ministerial announcement to deliver:

- A Comprehensive Review into the Adequacy of Current Mental Health Services in WA;
- State Mental Health Policy; and
- State Mental Health Strategic Plan 2010 to 2020.

Hawthorn House will continue to operate during 2009 within this dynamic environment. These broader policy and service developments have had an impact on Hawthorn House, and this has been taken into consideration when forming the evaluation findings.
3. THE EVALUATION PROCESS

3.1 Evaluation Questions
The evaluation considered four key questions:

1. Has Hawthorn House achieved its objectives?
   - What factors (positive and negative) have affected implementing the service?
   - Has Hawthorn House targeted appropriate clients, and what are the characteristics of those who were admitted and those who were not?
   - What is the support for the program among key stakeholders?
   - What have been the most effective and least effective elements of the model of care/service model in achieving outcomes?
   - What are the major outcomes that have been achieved by Hawthorn House?
   - What unanticipated positive and negative outcomes have arisen from the establishment of Hawthorn House?

2. Are the clients and their family caregivers satisfied with the service?
   - Which aspects of the service were the most useful and least useful and why?
   - What changes would clients and family caregivers make to the service to improve it?

3. What impact has Hawthorn House had on the local community?
   - What adverse incidents have occurred which might have had an impact on the local residents?
   - What level of community engagement has developed around Hawthorn House?

4. How can the evaluation findings shape future service and policy development?
   - Will the type of clients currently provided a service by Hawthorn House be able to be managed within the existing mental health service system when Hawthorn House closes? If not, what services should be developed to meet the needs of this particular client group?
   - What has been learned from establishing and implementing the service at Hawthorn House and can this generalise to the wider mental health service system?

The scope of the evaluation, including the objectives, key questions, methodology, data sources and management of the project, is outlined in Appendix 2. This document was presented to the Hawthorn House Executive Group on August 6th 2008. Following feedback from this group the scope and methodology was modified and endorsed by the Hawthorn House Reference Group at their first meeting on August 27th 2008.
3.2  Hawthorn House Evaluation Reference Group
The Hawthorn House Evaluation Reference Group was established to guide the evaluation. The terms of reference are outlined in Appendix 3. Membership comprised the following:
- Ms Raighne Jordan, Director of Nursing (Chairperson);
- Dr Arianne Cullen, Carer representative;
- Ms Gloria Butts, Carer representative;
- Ms Rebecca Daniels, Consumer representative;
- Dr Elizabeth Fisher, Staff representative;
- Ms Carey Harris, Clinical Nurse Manager Hawthorn House (project contact person);
- Dr Sandy Tait, Head of Service, Hawthorn House;
- Ms Linley Lefay, Project Officer, WA Centre for Mental Health Policy Research;
- Smith Dr Geoff, Medical Director, WA Centre for Mental Health Policy Research; and
- Ms Theresa Williams, Director, WA Centre for Mental Health Policy Research.

The project reported to Ms Leanne Sultan, A/Director of Operations, Adult Mental Health Service, North Metropolitan Area Mental Health Service (NMAMHS).

3.3  Evaluation Methodology
The evaluation was undertaken in the following broad stages.

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**Figure 1: Hawthorn House Evaluation Stages**

One consequence of these challenging deadlines is that it was not possible to undertake a full literature review. Difficulties in obtaining the data also resulted in limiting the original scope of the data collection and analysis.
4. CLIENT AND FAMILY CAREGIVER VIEWS

4.1 Office of the Chief Psychiatrist Review

In 2008 the Office of the Chief Psychiatrist undertook a Clinical Governance Review of Hawthorn House as part of the Chief Psychiatrist’s responsibilities, under the Mental Health Act 1996, to monitor standards of care. The review was undertaken shortly before this evaluation and included consultation with clients and family caregivers. Consequently, it was decided not to burden clients and their families by repeating this exercise, but rather to rely on these findings as the primary source of input on their views of the Hawthorn House service.

Four carers completed questionnaires. A total of eight clients were interviewed including five female and three male. Their length of stay at Hawthorn House ranged from 3 weeks to 14 months.

The questions covered four areas including the admission process, information provision, involvement in treatment and service planning and complaints. Overall the comments were very positive and can be summarized as follows:

- The majority of those interviewed indicated that they felt included in the decision to refer and admit to Hawthorn House and all reported receiving an orientation to the service on admission.
- Most received information about service provision, their condition, the medication they were prescribed and associated side effects and the majority had received as much information as they wanted.
- The majority of clients reported that the staff were very good at involving them and their family members in treatment decisions.
- Of the eight clients interviewed all could identify their case manager and five reported having an Individual Management Plan (IMP), being involved in its development, agreeing with what was in the IMP and having been provided with a copy of the plan. The two clients who reported not having an IMP were new to the service and the plans were in the process of being developed.
- All of the clients reported that they had the opportunity to tell staff what they thought about the way the Hawthorn House is run and most said some change had occurred and that the complaints system was easy to use.

When asked about examples of what has been good about the treatment and support they had received at Hawthorn House, responses included:

I have been under Mental Health for over 20 years with over 500 admissions. At the time I went into Hawthorn House I was locked in Graylands Hutchison ward for 1 year – within 8 months of being in Hawthorn House I have my own place and handle my own finances.

They include me in my management plan 100% and everything is open for negotiation.

The idea of the place is excellent. There should be more places like it. It gave me a place to go to get my life back together before going home after hospital. Explaining about illness and treatment. Respite before going into deep end of life at home but not hospital.
4.2 Client Feedback: Current Evaluation

A total of four current clients of Hawthorn House were interviewed by the evaluation team including three female and one male. The interviews were conducted with the clients as a group during their weekly resident meeting but without the Hawthorn House staff being present. The feedback from these clients was overwhelmingly positive. Selected highlights from clients give the flavour of the feedback.

Question: How did you get to Hawthorn House and what is it like being here?

I was stuck in hospital for six months. My parents wouldn’t have me back if I didn’t do a program first. Heard good reports of Hawthorn House but I didn’t push to ask to come. Once I got here I got very excited about coming to Hawthorn House. I hope I can go back to society and live as a normal person. All the things of being in a hospital are here but without being a hospital. It’s different to being in a hospital. More respect at Hawthorn House.

I was not happy where I was living. My doctor suggested I come to Hawthorn House. There aren’t many places you get the respect of staff as you get at Hawthorn House. Many places you are treated as a lower person, you are just a mental health issue.

Question: What has helped most while you’ve been here?

Staff here are genuine and actually care.
Lots of support here to achieve your goals.
Hawthorn House gets you out of the hospital environment and into the community.
Learn a lot in groups.
There’s a lot of independence in Hawthorn House and now I feel more independent and ready to go home.
I find here sending someone back to hospital is a last resort. In other places they don’t think or try and keep you out.

Question: What could be improved?

There could be more group therapy and talking to a psychologist is very important, in groups and one to one.

Question: What about the buildings, are they OK?

Felt like a hospital at first but after a few weeks it doesn’t feel like a hospital.
Mt Hawthorn is a good area. It’s quiet but has Scarborough Beach Road, shops and buses.
You walk outside and you are in the community, not hospital grounds.
The only thing that should go is the Hawthorn House sign out front.

Question: What about supposed to be here for 15 weeks at the most?

Too short!
Too stressful to know that you can only be here for 15 weeks. Some people need a longer time.
Question: Anything else you would like to say?

I just want to say that there are a lot of people in the community who would be good here but they haven’t heard of Hawthorn House. It takes years to get here.

It’s a shame its closing, but we can learn from it.

4.3 Family Caregiver Feedback

The results of the four carer questionnaires completed for the Office of the Chief Psychiatrist Clinical Governance Review of Hawthorn House indicate that family caregivers were involved in service planning and monitoring, there were processes for advising them of treatments and providing information about available treatments and options.

One family caregiver carer provided the evaluation team with a written statement of her perspectives on Hawthorn House. With her permission, some excerpts follow:

A Family Point of View

My daughter has been in and out of large hospitals…..Much in wide thick binders had been written about her. There was not much time in these large places for any one-on-one with any individual person. They would give her more drugs to quieten her down, and when we, as her family visited with her couldn’t have a decent visit. They probably tried their best with so many, many patients who were there.

There is much to Hawthorn House that large hospitals don’t have…..The residents learn to move forward. They are taught self worth and given hope. The professionalism in this place is perfect for the future. They have hope, those in residence.

There is a management plan for each person. Those in residence get to know each other and even learn to have support for each other. No dull moment, but hope. There is a professional respect on both sides. Doctors, Nurses, Family Carers. They have patience for patients. Those in residence know they can speak anytime to those that are trusted to care for those who have been through so much.

My daughter is now in her own place in another community and thriving, yet she has been known to ring to talk, and now and then those that have been in residence can go back to Hawthorn House for more strength to carry on, even encouragement. I am thankful for Hawthorn House. The place has not just helped my daughter, but me as well, as knowing much had gone down the line within my family.
5. HAWTHORN HOUSE STAFF VIEWS

5.1 The Process
Semi structured face-to-face individual interviews were conducted with 12 current staff from Hawthorn House, along with 1 former staff member who had been part of the Executive Management Group and had recently moved to another service. The interview questions are in Appendix 4. These questions were not rigidly adhered to in the interviews, but rather guided the topics to be covered by the evaluators. In sampling the staff for interview, the evaluators attempted to obtain a balanced mix of professional disciplines and lengths of employment at Hawthorn House. The following key themes emerged from our consultations.

5.2 Establishing the Service
What staff said…….

On opening, Hawthorn House had no policies, no documentation, no structure and no programs.

There was no staff preparation prior to opening and many staff had never worked in rehabilitation before.

There was no process in place for assessing needs and bringing in care plans. The whole program was based on WRAP (Wellness Recovery Action Plan), a personal tool for clients to use and not a clinical intervention.

What was very apparent from the consultation with staff was that the underlying framework for Hawthorn House and the operational policies and procedures necessary for its proper functioning were not well developed at the time of its start up. A great deal of staff time and energy has subsequently gone into trying to redress this problem, a task made more difficult by the complexity of coexisting service demands. Furthermore, as the first residential rehabilitation program to be set up in WA, there has been no existing framework on which its operational policies and the clinical program could be modelled.

5.3 The Staffing
What staff said…….

Taking nurses from hospital settings has not worked well. It would have been better if they had been from the community. Some staff want to control clients with rules, regulations and schedules. A lot find client autonomy difficult to handle.

Couldn’t understand how the staff mix had been derived. There were too many OTAs and they were working shifts as glorified nursing assistants. They were being used for base staffing rather than for the day programs.

We could have done with staff with a lot more rehabilitation experience. Staff have found it difficult to understand the recovery-based rehabilitation model.

Staff education has been a major problem. Hawthorn House staff have not been able to access educational opportunities like other North Metro services. It needs to be linked into the system.
The role and reporting-lines of the Occupational Therapy Assistants (OTAs) has been a source of tension and dissatisfaction within Hawthorn House since its inception. The prevailing view was that they did not have the training and experience necessary to be assigned to the after hours roster as ‘virtual nursing assistants’ and their role should be restricted to working with clients in the day program. There was also a perception that the lack of community experience amongst nursing staff and rehabilitation experience amongst all staff had not been helpful in the development of the service. Staff education, particularly in the ‘recovery-based rehabilitation model’, was seen as a priority.

5.4 Internal Management

What staff said……..

_Hawthorn House has been a good place to work, much more co-operative and less hostile, not perfect, but easier to resolve problems in a smaller unit._

_There has been a power struggle as to who is in charge and whether staff should report to the senior of their discipline or the senior staff member on duty. We needed a clear management structure and reporting lines from the start._

_The strength, ability and mix of the executive team drove forward the development of the assessment process._

Staff satisfaction with working in Hawthorn House was generally high although there was a perception that communication between the management team and other staff had not been as well developed as it could be. There was an impression amongst staff that there had been a “power struggle” within the management team and that what was needed was a clear management structure and reporting lines.

5.5 The Clients

What staff said……..

_Hawthorn House is treating the clients with the most potential to benefit from the rehabilitation program. Clients being ‘rehabilitation ready’ is very important._

_Generally feel that we are taking the right clients. The strict admission criteria were important in helping Hawthorn House clients fit into the community._

_The strict admission criteria have prevented many people coming into the unit that could have benefitted from the program._

There was general support for the admission criteria that had been set, including the restriction on people with substance abuse problems, a history of violence or a criminal history, with most staff believing that this had been important in settling community concern. ‘Rehabilitation readiness’ was seen as a crucial ingredient for successful client outcomes, although staff recognised that this precluded many people with persistent illness and disability from accessing their service. There was also awareness that this had created the impression of ‘cherry-picking’ amongst some referral agents.
5.6 The Program

What staff said…….

Barriers between the staff and clients are broken down, care de-mystified. Residents are invited to examine their case notes and care plans and these can be modified as a result.

Extensive use of carer/family meetings has also been very useful.

There is no structured, regular program that goes for 12 to 16 weeks. The program is developed each Friday for the next week.

Not all the program needs to be delivered in the actual building. There could also be rehabilitation in the community.

I think that people should not be staying so long, just a quick month or so and then discharged to the community for follow-up.

Hawthorn House was not meant to be long-stay, but we can’t do what clients need in 16 weeks.

The area of least agreement amongst staff was the Hawthorn House program, with almost as many different views as interviewees. Suggestions included:

- More structured, regular program for 12 to 16 weeks;
- Short stay and discharge for community follow-up;
- Longer period of rehabilitation;
- More of the program community-based;
- Less unstructured time;
- Shouldn’t be transporting clients around; and
- Clients should be doing their own cleaning and cooking

This is an area that clearly requires considerably more working through amongst the staff to reach a consensus view about what is actually required to meet the needs of their client group.

5.7 Individual Care Planning

What staff said…….

The assessment tools and package of care offered by Hawthorn House is the best offered by all services. It looks at all aspects of a person’s life holistically.

Things that have worked very well include having a clear assessment tool to identify client’s needs, having a Care Team and a Care Coordinator, putting plans on PSOLIS and regularly reviewing them.

Care planning with a thorough psychosocial assessment has been a very good outcome. Active involvement of, and ownership by, the client has been a very important element.

Staff sometimes don’t follow the Care Plans and you can be the only one doing it.

There was virtually complete agreement amongst staff that the assessment tools and care plans developed by Hawthorn House had been highly successful. The active involvement of,
and ownership by, the client was seen as an essential ingredient. This was seen as potentially one of the most important and enduring legacies of Hawthorn House.

5.8 Discharge to the Community

What staff said……..

We discharge people with a comprehensive discharge plan and get other agencies involved to support clients. Support from Community Mental Health Services alone is not enough.

We try to use NGOs and community resources to normalise clients’ experiences. We make use of ILP housing as well. Many of our clients don’t have a discharge address. Housing is a huge problem. Nearly all our clients, though, have gone to independent housing.

Our ambulatory arm works well. It’s been a big success. We need to get support services involved early once clients leave. With the Community Mental Health Services, they don’t get much. A once a week visit is not enough.

Hawthorn House has found that the services provided by the Community Mental Health Services have generally not been sufficient for the needs of its clients following discharge and has been gradually building up its outreach services to assist in the transition back into the community. It has also been strengthening its relationship with non-government psychosocial rehabilitation services, Independent Living Program service providers, local community services, employment support services and education providers. The lack of access to supported housing is seen as a major problem.

5.9 External Relationships

What staff said……..

Hawthorn House is seen as a boutique service. It’s so different from existing services that it has not had any other option but to function independently. Community mental health staff say that Hawthorn House staff have time to do their job properly and that clients are not going to get that service there.

Hawthorn House has had a major problem with occupancy since it opened. We should have had people banging on the door. We should have had small teams go and do assessments and undertake education of staff in the hospitals about what Hawthorn House actually does.

Over time, Hawthorn House has been building up its use of services in the community. In the last 6 months in particular, we have been linking more into organisations like TAFE and Ruah Workright.

There has been a change in attitude of people in the local community; no hostility now from the neighbours.

Some people think that the place has already been shut down.

Hawthorn House staff feel that their service is not well understood in the public mental health sector despite the efforts have been made by individuals to educate staff in the hospitals and community mental health services. Some people felt that more could have been done to promote Hawthorn House and its work. Overall there is a view that the links to the local community and a range of community organisations has been a strong feature of the service.
5.10 Future Directions

What staff said…….

There is a need for a residential rehabilitation service. It should be able to take people in from the community who are failing, rather than sending them to hospital.

A place like Hawthorn House should not just be residential. Some clients can have their deficits addressed without overnight stays. I would like to see a continuum of services; residential, day patient, outpatient and community.

Hawthorn House is not enough by itself. We need more facilities like this in 2 or 3 different geographic areas. Location is an important consideration.

The proposed unit at Joondalup is too big and it will be difficult to individualise care plans. It will also present a problem with group work because it is difficult to work with large groups.

The proposal for the NGOs to run the new services at Joondalup is good. It will need to be properly linked into the community and into the mental health system.

There was a general agreement that a service such as Hawthorn House was not enough to meet the rehabilitation needs of people with mental illness and disability. There needs to be a range of services in different geographic areas. The views of staff on the new Joondalup service were mixed.

5.11 The Transition

What staff said…….

I found it depressing that Hawthorn House was going to close and there was to be no place for the staff in the new system. I thought that they would be part of the new Joondalup unit initially. I don’t want to hang about to see Hawthorn House fall apart.

Currently, Hawthorn House is capped at 12 clients. The capacity will gradually be wound down as it approaches its closure date.

There is considerable uncertainty amongst staff about their work future and about how the service will be transitioned to close at the end of 2009. Early clarification of both these issues is imperative both for the sake of the staff and for the stability of the service.
6. EXTERNAL STAKEHOLDER VIEWS

6.1 Process
Between October and December 2008 a total of 19 external stakeholder organisation interviews were conducted, either in person or by phone. These were semi-structured individual interviews which sought to find out:

- the extent and nature of their contact with Hawthorn House;
- their perspectives on which aspects of the service provided by Hawthorn House had worked well and which had not; and
- their views on what future services are needed when Hawthorn House closes.

The key external stakeholders interviewed were staff from:

- Psychiatric inpatient units (Graylands, Joondalup, Swan Districts, SCGH);
- Community mental health services (Inner City, Osborne, Mirrabooka, Swan);
- The non-government sector (Perth Home Care Services, Richmond Fellowship, Ruah Community Services, Lorikeet Club House); and
- Local organisations (Town of Vincent, Baptist Church Mount Hawthorn, Chemmart Pharmacy Mt Hawthorn).

In addition, information from the Community Advisory Committee Minutes provided insights into community concerns and complaints about the operation of Hawthorn House.

6.2 Psychiatric Inpatient Units
The main themes which emerged during the interviews related to the role and purpose of Hawthorn House, gaining entry to the service, the assessment process including obtaining feedback, and the direction of future service developments when Hawthorn House closes.

Role and Purpose
What people said…….

- It was going to be a step-down unit, and then became rehab.
- Original expectation was a hostel where patients could get a bed; take the tough substance using clients.....more a push model.
- Goal posts kept on being changed.

Entry to Hawthorn House
What people said…….

- Don’t want to take them…they're too restricted in who they can take.
- Want research type patients not ‘real world’ patients.
- Concept of rehab ready is not clear…everyone needs to be given a shot.
- Different rules for different services.
- Did good advertising of their service to get clients but resistance because people thought it was a boutique service.
**Assessment process and feedback**

What people said……..

- Constant refusals and minimal feedback.
- Do good assessments….have a ‘can do’ attitude.
- Staff who refer don’t always get to see the feedback letters.
- Try out for HH is a cumbersome process for an inpatient unit.

**Future Services**

What people said……..

- Need both rehab and step-down.
- Need a variety of services…geographic location an issue…not sure if can access Joondalup from Midland.
- Need a range of accommodation options.
- Need a drug and alcohol rehab service.

The inpatient units had varying expectations for Hawthorn House, from providing step-down sub acute care, to patients in short stay inpatient units, to accommodation for long term Graylands patients with challenging behaviours. Clearly these diverse expectations were incompatible and could not be met in the one service.

The genesis for this lack of clarity about the purpose of Hawthorn House originated during the project development stage, where the service model evolved from a clinically staffed hostel primarily for long-stay Graylands patients to a rehabilitation service for the wider NMAMHS. This change was not well communicated to the inpatient units who were key referrers to the service. Many of the negative comments and dissatisfaction with Hawthorn House arose as a result of the diverse perceptions of the Hawthorn House role.

While most people understood the Hawthorn House executive had not determined the strict entry criteria, nonetheless, it restricted their capacity to refer clients who required residential rehabilitation and was frustrating. In the early days of the establishment of Hawthorn House their staff visited the inpatient units to publicise the service. However, as inpatient staff often change, this communication strategy needed to be maintained.

The overwhelming sense was that it was very difficult to get a client into Hawthorn House. While the formal entry criteria were understood, the concept of ‘rehabilitation ready’ seemed too vague and difficult to understand. The comment was made at one inpatient unit that it proved so difficult to have a client accepted that “some clinicians just gave up.” Perceptions varied across hospitals, with the comment from one that the inpatient assessments were not seriously considered by the Hawthorn House staff, whereas another felt that the Hawthorn House assessments were very thorough. There was a general comment from all of the units that when a client was rejected for admission into Hawthorn House, the letter back to the hospital was not always seen by the referring clinician. More feedback, perhaps face to face, on the reasons for not accepting a referral would have been helpful.

The “try out process” of transitioning to Hawthorn House, where a client would spend time at the unit over several days before being admitted, was not considered to be manageable for an inpatient unit as they don’t have the available staff to transport patients.

In terms of the future, there was an overwhelming view that there are significant gaps in the range of services currently offered and that the mental health system faces continued issues
with finding suitable accommodation for clients to be discharged to. There was agreement that the mental health service system needs both sub acute/step down services which includes providing those services into people’s homes, with a full range of rehabilitation services across geographic locations so that an “integrated model” which is district based can be developed in each locality.

6.3 Community Mental Health Services

What people said…….

- Hawthorn House is empowering and promotes recovery.
- Have clients’ best interests at heart.
- Comprehensive assessments generated a lot of good ideas.
- Have been hamstrung with having to be a ‘good neighbour’ …..the criteria restrictions were unrealistic.

Overall the comments from the Community Mental Health Teams on Hawthorn House were positive. They recognised the entry criteria restrictions that Hawthorn House operated under and consequent difficulty in having clients accepted into the service, but noted that those clients who were discharged from the program appeared to have done well.

The assessments were considered to be comprehensive and the feedback to the clinic was useful even if the clients were not accepted. One clinic mentioned difficulties in the transitioning of discharged clients in the early days of Hawthorn House where it was not clear who had clinical responsibility for the client. This seems to have been sorted out now.

The Joondalup Intermediate Care service is not believed to be a substitute for Hawthorn House and will probably be used mainly by clients from the Joondalup/Clarkson catchment.

6.4 Non-Government Agencies

What people said…….

- Can’t speak highly enough of them… the staff are very dedicated.
- Staff seem to be really passionate about what they’re doing.
- They teach our support workers skills.
- They provide hands on support.
- As an example of a mental health service, I'd like to see heaps more of them around.

There was overwhelming support and positive comments from the non-government agencies about Hawthorn House. These non-government services are mainly receiving clients who have been discharged from Hawthorn House.

They particularly appreciate the way Hawthorn House works with their agencies in the lead up to discharge and the level of support their workers receive once the person has left Hawthorn House. This includes being involved in the development of the management plan, the gradual transfer of the client and the continued contact after discharge. If the non-government staff need support or advice, Hawthorn House staff are very available and willing to assist.

The Community Mental Health Teams continue to manage the clients medication post-discharge but the comment was made that these teams are “overworked and underfunded” and not able to provide the level of assistance that Hawthorn House provides. The Hawthorn
House responsiveness and support to the non-government organisations was important but so too was the approach taken by the Hawthorn House staff who have a “personal, human relationship with the clients.”

There was strong support for Hawthorn House to continue or at least be replaced by a similar service(s) with the comment that we “could do with another twenty such units”. The planned Joondalup facility was seen to be too far away for many clients.

6.5 Local Community Organisations

What people said…….

Would love it to stay in the area.
Demystifies the unknown and some of the negative connotations of mental illness.
The concerns of the community did not turn out as was originally thought.

Overall the comments were positive and Hawthorn House staff have put in a lot of time and effort connecting with the local community. The local Baptist Church have supported Hawthorn House in having an Annual Open Day and Fair and this has been a great success with positive feedback from local residents.

6.6 Community Advisory Committee

One of the conditions set by the Town of Vincent for the development application approval of Hawthorn House was that a Community Advisory Committee be established. This was to include local community residents and representatives from the Department of Health and the Town of Vincent. The purpose of the committee was to manage and deal with any community concerns or complaints.

The committee was operational from 4th December 2006 and met on a monthly basis for the first six months and afterwards on a quarterly basis. By early 2008 it was proving difficult to obtain a quorum for the meetings. In March 2008 the Town of Vincent agreed that the Community Advisory Committee only meet on an as needs basis because there had been insufficient issues to require regular meetings. To that point in time most complaints had been relatively minor including a parking infringement, a distressed resident in the Hawthorn House grounds, residents smoking in public places and leaving cigarette butts and a safety concern regarding rear access to the premises. All issues have been addressed by the Department of Health and the Town of Vincent in a timely, co-operative manner. It appears the initial fears of the community have not been realised.
7. DATA ANALYSIS

7.1 Data Objectives and Limitations
The original intention was to obtain data to understand:

- Hawthorn House activity (Source: Mental Health Information System (MHIS) and case notes);
- Outcomes for clients (Source: National Outcomes and Casemix Collection (NOCC); and
- The impact on hospital use (Source: Hospital Morbidity database).

The following figure provides a schematic outline of the original data requirements for the evaluation. The areas highlighted in red indicate that the data was to be provided by Hawthorn House, while that in black was to be sourced from the Information and Reporting Unit, Department of Health.

DATA REQUIREMENTS

Legend: Data to be sourced from Hawthorn House (red): Data to be sourced from DoH MHIS and Hospital Morbidity (black)

Figure 2: Data Requested for Hawthorn House Evaluation
The evaluators and the Reference Group believed it would be important to understand the patient journey through the mental health service system, both prior to being admitted to Hawthorn House and after their discharge. This history of service use required de-identified individual data to be provided. This, of course, would not have been reported in any way which would have enabled individual clients to be identified.

Unfortunately, a number of issues restricted access to the data within the timeframe of the evaluation. When the data request was submitted to the Department of Health, Information Management and Reporting section, they advised that unit level record data which would link the MHIS with Hospital Morbidity would require approval from the WA Human Research Ethics Committee. Unfortunately, the tight deadlines to complete the evaluation meant that there was insufficient time to complete this process. Hence, de-identified data was provided only from the MHIS, not the Hospital Morbidity System, and was limited to activity within Hawthorn House and not prior and subsequent hospital episodes. Furthermore, while the NOCC data was available, it had significant gaps and consequently it was unable to be used in the evaluation.

As a result, the data analysis is restricted to Hawthorn House service activity, together with limited aggregated information about the clients of the service. It does not include:

- Inpatient episodes and ambulatory occasions of service prior to or after discharge from Hawthorn House,
- NOCC data on client outcomes at the point of admission and then discharge from Hawthorn House; nor
- Information about individual client mental health service use or ‘journey’ prior to or after discharge.

All of the following data relates to the period from December 2006 when Hawthorn House opened through to the end of September 2008.

### 7.2 Hawthorn House Admissions

There have been 39 people admitted to Hawthorn House, comprising a total of 44 admissions. Four people had repeat admissions.

#### Length of Stay

Figure 3 shows the length of stay for clients who have been discharged from Hawthorn House, and highlights the 16 week maximum length of stay cut off point. The average length of stay for the 34 completed episodes was 127 days (18 weeks), ranging from 6 days to 414 days (59 weeks). This does not take into account the current residents.

While the operational guidelines for Hawthorn House set a length of stay ranging from 6 to 16 weeks, a total of 5 (15%) episodes were less than the minimum of 6 weeks length of stay and 17 (50%) exceeded the 16 week maximum stay limit.
Length of Stay for Current Residents

Figure 4 shows that by the end of September 2008 Hawthorn House had 10 residents in the 16 bed facility, giving a bed occupancy of 62.5%. The maximum length of stay of 16 weeks had been exceeded by 7 of the 10 residents, with the longest having been at Hawthorn House for over 18 months.

Figure 4: Length of Stay in Weeks for Current Residents of Hawthorn House at 30.9.08
Referral Source Admitted Residents

Figure 5 shows that of the 39 people admitted to Hawthorn House the largest number came from Graylands Hospital ((n=14, 36%), followed by SCGH (18%, n=7).

![Referral Source Graph]

Source: Hawthorn House
Note: To avoid double counting only the referral source for the first admission was counted.

Figure 5:    Referral Source for Hawthorn House First Admissions from December 2006 to September 2008

Discharge Destination for Hawthorn House Residents

Figure 6 shows that most residents went to their own home on being discharged from Hawthorn House (n=11, 28%), with the next largest group going to the ILP (n=6, 15%), followed equally by Richmond Fellowship and Hostels (n=3, 8%).

![Discharge Destination Graph]

Source: Hawthorn House
Note: Only the discharge destination for the first admission was counted.

Figure 6:    Discharge Destinations for Hawthorn House Residents from December 2006 to September 2008
7.3 Hawthorn House Resident Characteristics

Age
There have been 20 females and 19 males admitted to Hawthorn House. The average age of the females was 38 years (median 40) and for the males it was 28 years (median 31.5). Overall the average age was 33 years, with a median of 38.5.

Diagnosis
Figure 7 shows that of the 39 people admitted to Hawthorn House, the overwhelming majority had a diagnosis of schizophrenia (n=23, 60%), with the next largest category being schizoaffective disorder (n=4, 11%) and personality disorder (n=4, 11%).

![Resident Diagnosis Diagram]

Source: Mental Health Information System

**Figure 7:** Diagnosis for Persons Admitted to Hawthorn House between December 2006 and September 2008

Time Since First Contact with MHS
Figure 8 shows that of the 39 people admitted to Hawthorn House, 38% (n=15) have been in contact with mental health services for over 15 years. However, an equal number were within their first five years of contact with mental health services, with 15% (n=6) being in their first year.
Figure 8: Years Since First Contact with Mental Health Services for Persons Admitted to Hawthorn House between December 2006 and September 2008

7.4 Hawthorn House Non-Admitted Referrals

Figure 9 shows that of the 124 referrals to Hawthorn House who were not accepted into the service between December 2006 and September 2008, there were 65 females (52%) and 59 males (48%). Graylands Hospital referred the most (n=48, 39%), followed by SCGH (n=23, 19%) and Joondalup Health Campus (n=19, 15%).

Figure 9: Source of Referrals to Hawthorn House for Persons Not Admitted between December 2006 and September 2008
7.5 Summary

Admitted Clients

- Over a 20 month period Hawthorn House had a total of 44 admissions, comprising 39 people. Of the 44 admissions, there have been 34 discharges.
- The average length of stay for the 34 completed episodes was 18 weeks, with 50% exceeding the 16 weeks maximum stay.
- At the end of September 2008 there were 10 residents (bed occupancy 63%) of whom 7 exceeded the 16 week length of stay. The longest stay was 18 months.
- Most of the admissions were people referred from Graylands, followed by SCGH.
- People were mainly discharged to their own home or the ILP, followed by Richmond Fellowship or hostels.
- The average age of admitted clients was 38 years for females and 28 years for males.
- 60% of clients had a diagnosis of schizophrenia, followed by 11% with a schizo-affective disorder and 11% with a personality disorder.
- Of the 39 people admitted to Hawthorn House, 15 have been in contact with mental health services for over 15 years, however an equal number are recent clients within their first 5 years of contact.

Non-Admitted Referrals

- Hawthorn House received 124 referrals of clients whom they did not admit to the service. There were almost equal numbers of males and females. They were mainly referred by Graylands Hospital (39%), followed by SCGH (19%), then Joondalup Health Campus (15%).
8. KEY FINDINGS

8.1 Hawthorn House

Client Outcomes

Has Hawthorn House achieved its objectives? In terms of client outcomes, the answer would have to be an unequivocal 'yes'. Given the inability to access the hospital utilisation data and the significant gaps in the NOCC data, it is not possible to objectively demonstrate the extent to which clients have functionally improved or reduced their use of hospital services. But there has been universally positive feedback on client outcomes from the clients themselves and their family caregivers and from the public and non-government service providers who have been involved in their follow-up.

Here is what one parent had to say about her daughter’s care at Hawthorn House.

“Our daughter has been resident at Hawthorn House for some months now, having come from …… Hospital where she had been for nearly a year. Since the onset of her illness 3 years before that, she had been in and out of various acute psychiatric hospitals, both public and private. Her life during this time had been miserable: she was in effect, incarcerated for months in physically extremely unhealthy environments, with virtually no meaningful counselling or constructive goal-setting. Day after day she merely subsisted, fearful of the ‘outside’ world, extremely anxious and depressed about a future which she could not see extending beyond the locked-in walls of her hospital ‘prison’.

She was extremely overweight, virtually completely indolent both physically and mentally, and had no structured exercise or rehabilitation program other than occasional art lessons which she was not compelled to attend. She consumed large amounts of Coca Cola and confectionary, as vending machines were the main snack food available. There was minimal continuity between staff members assigned to her, no case manager and very little communication from the staff to us about her condition unless we asked. There was no plan for the future. She had lost hope and had tried on more than one occasion to take her own life.

She was largely estranged from her family and friends and had been unemployed and unable to study or function in any way for 3 years. During this time our family had been grieving the loss of our daughter and sister as we knew her: this grief has had profound and damaging effects on our whole family as we had to watch her, aged from 16 to 20, suffer so terribly and for so long. Needless to say, we too had lost hope.

At Hawthorn courtesy, respect and kindness were shown from the start, even though the program was very new and a prototype in the state. Here the residents were treated as human beings and expected to take responsibility for themselves. Furthermore the physical set-up, with a smallish building in the middle of a cosmopolitan inner suburban area, close to amenities and a typical cross-section of people, has made her feel much more in touch with the ‘real’ world and undoubtedly will prepare her better to re-integrate into the community at large. The healthy physical environment with openable windows, nutritious food and encouraging attitude to exercise, has helped her become, and remain relatively well physically.
From her admissions to Hawthorn my daughter was assessed thoroughly with regard to her specific problems. She was encouraged to set achievable goals and to set time targets for these. The issues limiting her return to normal function were identified and have been worked on logically and with self-organized plans. My husband and I have been kept abreast of developments so that we can help wherever we can and aim to re-integrate her back within the family and our community as soon as possible.

Since her initial assessment there have been frequent structured counselling sessions, including CBT. She has felt secure and safe with the staff, in particular her case managers: this has greatly facilitated her progress, to the point where she is beginning to break down her paralysing social phobias and to deal with her severe post-traumatic stress syndrome in a meaningful way. She has developed a greater insight into her own problems and how to approach them.

Previously terribly isolated and trapped in her awful thought patterns and behaviour, she has managed to again use public transport and has successfully looked after friends’ children. She has, most importantly, begun to re-connect with her peers and our dreams of her walking down her home town streets again like an “ordinary” girl, of forming healthy relationships, perhaps finding a partner, and of contributing to society by using her talents in work, have now become realizable. Above all, she is happier, has regained her sense of humour and is usually fun to be around. She continues to work on developing initiative and is greatly helped here by the staff at Hawthorn.

Chapters could be written about the factors involved in the success of the Hawthorn program. Of paramount importance is the fact that this work is carried out in a community setting, far from any hospitals. In fact it is my belief that this truly “integrative” rehabilitation can only be successful in a community-based, small group settings such as the one which Hawthorn provides and which is not associated, either administratively or geographically, with other psychiatric institutions.

The extremely skilled and consistent care provided by the staff at Hawthorn is crucial to the program’s success. The staff clearly believe in the residents’ potential: they expect them to work on themselves, they treat them with respect and they do not give up on them. They have given my daughter back her dignity and restored her long-vanished hope of living a “normal” life.

My daughter’s situation is but one of many which illustrates the dramatic change which can occur in even the most chronically traumatized patients given the above type of care. I am profoundly grateful that my beloved child has been given this chance. I am also hopeful that such an intelligent and humane way of helping this long-suffering, extraordinary brave group of people, will become the accepted standard on our much-anticipated overhaul of the mental health system in Western Australia.”

So what are the critical ingredients of Hawthorn House from the client and family caregiver perspective?

In the words of clients……..

There aren’t many places you get the respect of staff as you do at Hawthorn House. Staff are genuine and actually care. Lots of support here to achieve your goals.
And their family caregivers……

*The residents learn to move forward, they are taught self worth and given hope.*

*Respect and kindness were shown from the start ....here the residents were treated as human beings and expected to take responsibility for themselves....The staff clearly believe in the residents’ potential....They treat them with respect and they do not give up.*

The critical components of the Hawthorn House program that were considered by the clients and family care-givers as being most important for them in the recovery process were:

1. The skills, values, beliefs and attitudes of the staff of Hawthorn House. They particularly valued the sense that staff were genuine and actually cared about them, encouraged them to take responsibility for their lives, listened to their opinions and respected their choices, believed in their potential and worked to instil self worth and hope and gave them the time to build their confidence to the point where they felt that they could manage back in the community.

2. The involvement of individual clients and their family care-givers in the thorough assessment of their needs and the development of self-organised individual care plans. The MANCAS, the individual needs assessment tool, and the Individual Care Plan is in the process of being adopted and implemented across NMAHS. This is seen by all staff as one of the most important and enduring legacies of Hawthorn House.

3. The size of Hawthorn House and its location in the inner city suburb of Mount Hawthorn, with its ready access to retail and community services. Many spoke of the importance of the ‘small group setting’ not associated administratively or geographically with any other psychiatric institution.

4. Recognition that families, friends and neighbours and other factors such as housing, education, training, employment and community involvement, could have just as profound an impact on their recovery as any intervention delivered by mental health services.

**External Relationships**

Hawthorn House has developed good relationships with a number of local businesses and organisations. It has generally been well accepted into the local community and the staff have made an effort to reach out to local residents through their Hawthorn House Fair and Open Day. The Community Advisory Group, which was formed when Hawthorn House opened, was placed on hold during 2008 as there had been no ongoing issues to deal with.

As Hawthorn House has developed, it has gradually built and strengthened its relationships with the non-government and community service sectors. What it hasn’t managed to do is to develop the same strength of relationship with the public community and inpatient mental health services. While it is clear that staff have tried to develop these links, what is required is significant investment of time and resources, both of which have all too often been in short supply because of the effort required to establish the service. Inpatient services, where there is often a high staff turnover, can present a particular challenge.

**Referral, Admission and Discharge**

One of the most contentious issues for referral agencies has been the difficulty in getting their clients admitted to Hawthorn House, despite the fact that there has been significant underutilised capacity with an average occupancy rate of 60% or less. In the 22 months to September 2008, Hawthorn House accepted 39 clients out of 163 referrals or roughly 1 out of every 4 referrals.
This raises the question of whether Hawthorn House has been targeting the right clients or has been too restrictive in the application of their selection criteria. The data, however, shows that the majority of their residents have a serious mental disorder [60% schizophrenia] and that almost half of them have been in contact with mental health services for over 10 years.

The main reasons for non-acceptance were that clients were still acutely unwell, did not wish to be admitted to Hawthorn House or could not, even with assistance, identify any issues that they needed to work on. These were the elements that were used in assessing ‘rehabilitation readiness’, a concept that was not well understood by the referral agencies, but which was considered important by Hawthorn House staff in terms of clients being able to benefit from their program.

Some of the hospital-based referring clinicians commented that little credibility had been given to the extensive assessments that had already been undertaken within their agencies, while others could not recall having ‘personally received’ the assessment reports. By contrast, staff from the Community Mental Health Teams were generally more positive about the Hawthorn House assessments, many finding that they had been very useful in shaping up their management plans, even when the client was not accepted. Consideration needs to be given to providing, in addition to its detailed assessment report, face-to-face feedback to the referring clinician to improve communication and give an opportunity for both parties to understand and learn from each other.

The original project brief envisaged a length of stay of up to 16 weeks, during which clients could be assessed, their rehabilitation program commenced and then discharged to the community for continued support and care. In practice this has proved difficult to achieve and the average length of stay for completed separations has been around 18 weeks.

The major contributors to the extended length of stay have been the difficulty in accessing housing, the lack of any comprehensive, integrated system of community rehabilitation and the inability of the Community Mental Health Teams to provide the level of community support required by clients leaving Hawthorn House. Furthermore, the setting of these limits was somewhat arbitrary and never recognised the levels of disability of the client population and the time needed for them to make the transition to community living.

This lack of adequate services following discharge has led Hawthorn House to develop its community follow-up service to support its clients in their transition back into the community. It also proved a stimulus for Hawthorn House to strengthen its relationship with the non-government sector, engaging them in the Individual Care Plans and being responsive and supportive to their requests for assistance.

**Staffing and Staff Training**

There have been questions about whether Hawthorn House has had the right mix of staff, particularly focused on the use of Occupational Therapy Assistants as ‘virtual nursing assistants’ on the night roster and about the lack of community experience amongst many of the nursing staff. These issues, however, serve more to highlight the fact that there has not been any formal, organised investment in staff development.

While the staff of Hawthorn House were supposed to get some training prior to the opening, this did not happen. As this was a new model of service provision, unfamiliar to many of the staff, there needed to be a significant investment in staff training, not only in the areas of needs assessment and individual care planning as has happened, but in the principles of recovery-based rehabilitation and in the development of evidence-based interventions which are such integral parts of best practice in rehabilitation.
Operational Issues for Consideration

Overall, Hawthorn House has been an innovative service with high levels of satisfaction amongst clients and family caregivers and, furthermore, staff satisfaction has been generally high. In view of this and the fact that Hawthorn House will be closing in approximately 7 months, the evaluators decided not to make any recommendations aimed specifically at the operational and organisational aspects of the service. However, the Hawthorn House Executive Group could consider addressing the following:

- Review its assessment process to facilitate entry from inpatient units; and
- Provide face-to-face or telephone feedback to the referring clinician, in addition to the written detailed assessment report.

8.2 System Learning

We have identified four important lessons that can be learned from the experience of Hawthorn House.

Need for a Comprehensive Range of Rehabilitation Services

There is obviously a significant demand for rehabilitation services in the North Metropolitan area. However, a 16 bed residential rehabilitation service like Hawthorn House was never going to be able to satisfy the diverse needs of all the different services in the NMAHS; nor was it going to find it easy to operate in the absence of a properly functioning community rehabilitation system. Current rehabilitation services are fragmented, primarily clinic-based, skills training programs that do not provide the range of programs or services necessary to meet the diverse rehabilitation needs of the population.

Need for Skills Development

Rehabilitation needs to be recognised as a specialised area of practice with its own competencies. The Hawthorn House experience highlighted not only the lack of rehabilitation services, but also the restriction in the skills base of staff across mental health services and the lack of any formal specialised skills development program in WA. There are already pockets of expertise in evidence-based psychosocial interventions in WA that could be harnessed to develop and deliver a training program for NMAMHS.

Need for Adequate Preparation for New Services

The planning and development of operational policies need to be completed and the key leadership team appointed well in advance of the opening of any new service. As demonstrated in the case of Hawthorn House, it is very difficult to do this development work while at the same time establishing relationships with outside agencies, building up the program and managing the day-to-day care of clients. Furthermore, planning needs to focus not only on the ‘internal environment’ but on the broader ‘external context’ in which the service will be operating. Although this has implications for the start-up of all new services, it is particularly pertinent for Joondalup and Rockingham Intermediate Care Services, which are the first of their kind in WA.

Need for an Evaluation Framework for New Services

When developing a new service, consideration needs to be given to putting in place an evaluation framework, which reflects the specific purpose and objectives of the service. Furthermore, while large amounts of mandatory data are collected by mental health services, little of this is used routinely by management to continually improve the service and evaluate whether it is achieving its major objectives.
9. RECOMMENDATIONS

It is recommended that:

Recommendation 1

The NMAMHS:

- Develop a comprehensive range of rehabilitation and recovery support services.
- Coordinate these services around ‘district’ populations of between 150,000 and 250,000; and
- Ensure that the clinical rehabilitation services should not be separate from community mental health services but be part of the comprehensive suite of recovery orientated services.

Recommendation 2

The factors identified by clients and their family care-givers in the ‘Key Findings’ section [page 34] as being critical for the recovery process, should be incorporated into all community-based rehabilitation services. Specifically:

- Emphasis on the development of positive therapeutic relationships;
- Thorough assessment of needs and the development of individual care plans in partnership with clients and family care-givers;
- The importance of size and location of community rehabilitation facilities;
- The maintenance of social relationships and the importance of other community services such as education, training and employment.

Recommendation 3

The NMAMHS expand the uptake of client-centred, standardized Needs Assessments and Individual Care Plans across the adult community mental health program.

Recommendation 4

The NMAMHS develop a rehabilitation training program that incorporates training in the principles of recovery-based rehabilitation, needs assessment, individual care planning and evidence-based interventions by:

- In the short-term, engaging with the existing in-house training programs such as the Centre for Clinical Interventions, the Psychosocial Interventions for Psychosis Program [SMAMHS] to further develop and expand access to specialised clinical rehabilitation and psychosocial recovery training programs; and
- Longer term, working with SMAHS, WACHS and the Mental Health Division to consider options for a whole of system approach to ongoing education and training for mental health staff, particularly for evidence-based psychosocial interventions.
Recommendation 5

The Mental Health Division, in collaboration with NMAMHS:

- Select and fund the non-government and the clinical ‘in-reach’ service for the Joondalup Intermediate Care Service at least 6 months prior to opening to allow for the earliest possible appointment of their leadership groups to enable them to jointly develop:
  - operational policies;
  - roles and responsibilities;
  - protocols for sharing of information;
  - a process for on-going engagement with key stakeholders;
  - program structure;
  - skills-based staff development programs; and
  - an evaluation framework to enable continuous quality improvement and service evaluation to be implemented.

Recommendation 6

A detailed study of Hawthorn House client outcomes, with an accompanying cost benefit analysis, should be undertaken.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>CMHS</td>
<td>Community Mental Health Services</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>HH</td>
<td>Hawthorn House</td>
</tr>
<tr>
<td>HoNOS</td>
<td>Health of the Nation Outcome Scales</td>
</tr>
<tr>
<td>ICCMHS</td>
<td>Inner City Community Mental Health Service</td>
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<tr>
<td>IMP</td>
<td>Individual Management Plan</td>
</tr>
<tr>
<td>MANCAS</td>
<td>Manchester Care Assessment Schedule</td>
</tr>
<tr>
<td>MHS</td>
<td>Mental Health Service</td>
</tr>
<tr>
<td>MHIS</td>
<td>Mental Health Information System</td>
</tr>
<tr>
<td>MH-ORC</td>
<td>Mental Health Operations Review Committee</td>
</tr>
<tr>
<td>NMAHS</td>
<td>North Metropolitan Area Health Service</td>
</tr>
<tr>
<td>NMAMHS</td>
<td>North Metropolitan Area Mental Health Service</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Government Organisation</td>
</tr>
<tr>
<td>NOCC</td>
<td>National Outcomes and Casemix Collection</td>
</tr>
<tr>
<td>OTA</td>
<td>Occupational Therapy Assistant</td>
</tr>
<tr>
<td>PSOLIS</td>
<td>Psychiatric Services On-line Information System</td>
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<tr>
<td>RPH</td>
<td>Royal Perth Hospital</td>
</tr>
<tr>
<td>SCGH</td>
<td>Sir Charles Gairdner Hospital</td>
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<tr>
<td>SMAHS</td>
<td>South Metro Area Health Service</td>
</tr>
<tr>
<td>SMAMHS</td>
<td>South Metro Area Mental Health Service</td>
</tr>
<tr>
<td>WACHS</td>
<td>WA Country Health Service</td>
</tr>
<tr>
<td>WRAP</td>
<td>Wellness Recovery Action Plan</td>
</tr>
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</table>
Hawthorn House was originally a community hospital, then aged care facility, built in the 1930’s. It was converted into a 16 bedded, permanently staffed, medium term rehabilitation unit for people experiencing a serious mental illness and opened in December 2006. It is located in the Perth inner city suburb of Mount Hawthorn.

Hawthorn House provides active structured Psychiatric Rehabilitation in well staffed community accommodation. The service accepts people between 18 and 65 years for a maximum of 16 weeks.

Psychiatric Rehabilitation is a set of targeted interventions intended to reduce, or prevent further deterioration of, disabilities associated with serious mental illness. It is a clinically driven process of assisting people to acquire and to use their strengths and skills, supports, and resources necessary for successful and satisfying living in the environment of their choice. It is an active treatment program and Hawthorn House accepts people ready and able to engage with activities that can lead to functional improvement emphasising psycho-social domains.

Rehabilitation takes place within the framework of a commitment to recovery, a biopsychosocial approach and evidence based practice. Psychosocial rehabilitation helps clients progress towards self management of the mental illness and their health, meaningful daily occupation, improving their social interaction and community inclusion, coming to terms with the impact of their illness and achieving better living conditions.


Staff are multi disciplinary with professional backgrounds of Occupational Therapy, Nursing, Social Work, Art Therapy and Medicine and a wide variety of working experiences. Staff all share similar values including a belief in the resident’s capacity to recover and progress towards their goals. The service uses formal assessment instruments including the Manchester Care Assessment Schedule (MANCAS) and outcome tools such as HoNOS, the Life Skills Profile and the Kessler 10. Great importance is placed on regularly reviewed negotiated Care Plans, which are re-negotiated regularly with the residents.

The service aims to create a safe inclusive encouraging environment with a major emphasis on social interaction based on healthy, balanced relationships with staff and other residents. It encourages the involvement of family as appropriate and community mental health and NGO Services.

Staff comprise the following:

- Clinical Nurse Manager (SRN 3) - 1.0 FTE
- Level 2 Nursing Staff – 4.5 FTE
- Level 1 Nursing Staff – 4.5 FTE
- Enrolled Nurse – 3.5 FTE
- Senior Occupational Therapist - 1.0 FTE
- Occupational Therapy Aids – 8.8 FTE
- Senior Social Worker - 1.0 FTE
- Welfare Officer – 1.0 FTE
- Staff Development Nurse (SRN 2) – 1.0 FTE
- Consultant Psychiatrist (Head of Service) 1.0 FTE
- Medical Officer – level 12 – 1 FTE
- Clerical Assistant - 1 FTE
- Patient Care Assistants/domestics – 3 FTE
- Chef/cook – 1 FTE

Hawthorn House has one sedan car and a people mover.

**People Must Be ‘Rehabilitation Ready’ - What Does That Mean?**

What the clinical team at Hawthorn House is looking for in the referral information, and subsequent assessment, is evidence to support the individual’s capacity to address issues highlighted as impacting on the quality of their lives. This can be reflected in the level of insight they have into the illness process, their preparedness to change, their capacity to identify issues and goals for themselves as well as their commitment to a course of action.

The staff use the Stages of Change model and the Rehabilitation Readiness framework to gauge where an individual is as this impacts on their behaviour. If the individual is considered to be at the Contemplation, Decision or Action phases this is the ideal time to offer focussed structured rehabilitation programmes. The stages of change are:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td>Not thinking about changing their behaviour in the next 6 months and may be unaware of their problem</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Aware of problem, thinking about changing in the next 6 months but not committed to action</td>
</tr>
<tr>
<td>Preparation (Decision)</td>
<td>May have unsuccessfully tried change, still thinking about change, planning action in next 1 month</td>
</tr>
<tr>
<td>Action</td>
<td>Changes behaviour for 1 day to 6 months</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Maintains behaviour change for over 6 months</td>
</tr>
<tr>
<td>Relapse</td>
<td>Regresses to earlier stage of change</td>
</tr>
</tbody>
</table>

This approach is often used for substance use. The style of ‘motivational interviewing’ is similar but takes into account the neuro-cognitive issues in severe mental illness.

To be ELIGIBLE individuals need to:
- Be aged between 18 and 65 years;
- Have a primary diagnosis of a major mental illness;
- Be rehabilitation ready;
- Have medium term rehabilitation needs;
- Live in the North Metropolitan catchment area;
- Actively participate in their rehabilitation;
- Currently occupy an acute hospital bed;
- Have a community based case manager; and
- Have somewhere to live on completion of the programme.

Individuals will be EXCLUDED in the following circumstances:
- In acute phase of illness or relapse and still requiring close monitoring;
- Primary diagnosis of substance abuse or ongoing risky drug abuse;
- Requiring intensive treatment and support within a hospital environment;
- Requiring intensive and long-term rehabilitation needs;
- Requiring respite from financial, accommodation or social crises;
- History of violence towards people or animals or serious crime; and
- Recent history is self-harm or concerning suicidal thoughts.
1. INTRODUCTION
This paper outlines the scope of the evaluation of Hawthorn House, including the evaluation objectives, key questions, methodology, data sources and the management of the project.

This draft document will be presented and discussed with the Hawthorn House Executive Group on August 6th 2008. Following feedback from this group the scope and methodology will be modified and finalised.

2. EVALUATION OBJECTIVES
The evaluation aims to consider four key questions:

1. Has Hawthorn House achieved its objectives?
   - What factors (positive and negative) have affected implementing the service?
   - Has Hawthorn House targeted appropriate consumers, and what are the characteristics of those who were admitted and those who were not?
   - What is the support for the program among key stakeholders?
   - What have been the most effective and least effective elements of the model of care/service model in achieving outcomes?
   - What are the major outcomes that have been achieved by Hawthorn House?
   - What unanticipated positive and negative outcomes have arisen from the establishment of Hawthorn House?

2. Are the consumers and their carers satisfied with the service?
   - Which aspects of the service were the most useful and least useful and why?
   - What changes would consumers and carers make to the service to improve it?

3. What impact has Hawthorn House had on the local community?
   - What adverse incidents have occurred which might have had an impact on the local residents?
   - What level of community engagement has developed around Hawthorn House?

4. How can the evaluation findings shape future service and policy development?
   - Will the type of consumers currently provided a service by Hawthorn House be able to be managed within the existing mental health service system when Hawthorn House closes? If not, what services should be developed to meet the needs of this particular client group.
   - What has been learned from establishing and implementing the service at Hawthorn House and can this generalise to the wider mental health service system?
3. EVALUATION FRAMEWORK

The approach which underpins the evaluation derives from program approach which recognises that there are four linked stages in the process of human service delivery, namely, inputs, process, outputs and outcomes. It is an approach which is particularly useful in understanding the complex interactions between key stakeholders and recognises that the way in which program is planned, resourced and implemented impacts on service delivery and outcomes.

![Evaluation Framework Diagram]

### Needs
- What are the socio-demographic and clinical characteristics of the target population?

### Process
- How is the program implemented?
- Fidelity of implementation?
- How is the operation of the program impacting on achievement of the program objectives?
- What are participant reactions?

### Outcomes
- To what extent are desired changes occurring? For whom?
- What seems to work? Not work?
- What are the unintended outcomes

### Impact
- How does this program impact on hospital use?

Source: Based on the Kellogg Foundation Logic Model [http://www.uwex.edu/ces/pdande/evaluation/pdf/nutritionconf05.pdf](http://www.uwex.edu/ces/pdande/evaluation/pdf/nutritionconf05.pdf)

A participatory approach will underpin the evaluation. Ownership of the process and learning from the results of the evaluation are key aspects of this approach. Major stakeholders will be involved throughout and will play a significant part, not only through the consultation process, but also through membership of the Steering Committee. Another feature of this participatory approach is that early feedback on results will be made available to the Steering Committee.

4. EVALUATION METHODOLOGY

The evaluation will involve the following stages:

1. **Project Initiation:** Face to face meetings with key stakeholders including the Hawthorn House Executive Group, the Mental Health Division and the Executive Director Mental Health NMAHS. This stage will involve developing the evaluation scope and methodology.

2. **Reference Group:** Determine membership and develop terms of reference. Initiate meetings and decide on meeting frequency.

3. **Environmental Analysis:** Gathering and reviewing documentation relevant to the development and implementation of Hawthorn House and other key policy and service initiatives in Western Australia will provide the policy context.
4. **Literature Review:** A review of the academic literature and policy documents from other jurisdictions will be conducted to develop an understanding of models of residential rehabilitation facilities and the outcomes they have achieved.

5. **Data Collection:** A range of data sources will be used including interviews with stakeholders, data extractions from the Mental Health Information System including PSOLIS and NOCC and case studies of individual clients (de-identified).

6. **Data Analysis:** A variety of data analysis approaches be used depending on the data type.

7. **Reports:** A draft report which outlines the findings of the evaluation will be provided to the Steering Committee for feedback prior to developing the final report. The draft final report will be submitted to MH-ORC seeking their approval for public release.

The key project stages and approximate timelines are shown below.

<table>
<thead>
<tr>
<th>Stage/Time</th>
<th>Aug 08</th>
<th>Sept 08</th>
<th>Oct 08</th>
<th>Nov 08</th>
<th>Dec 08</th>
<th>Jan 09</th>
</tr>
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<tbody>
<tr>
<td>Project Initiation</td>
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<tr>
<td>Establish Steering Committee</td>
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<tr>
<td>Environmental Analysis</td>
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<tr>
<td>Literature Review</td>
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<tr>
<td>Data Collection</td>
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<tr>
<td>Data Analysis</td>
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<tr>
<td>Draft Report &amp; Committee Feedback</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Final Report</td>
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</table>

5. **DATA SOURCES**

To address these evaluation questions both quantitative and qualitative data will be required. A number of approaches will be used to obtain this data including:

- A review of the literature and policy/operational documents and relevant reports.
- Data from the mental health information system.
- NOCC outcomes data.
- Data from the MANCAS assessments.
- Interviews with key stakeholders including Hawthorn House staff, clients, family caregivers, the Mental Health Division, Graylands Hospital etc.
- Case studies to highlight the consumer and carer outcomes.

6. **EVALUATION GOVERNANCE**

The evaluation will be advised by a Reference Group. Membership will be discussed with the Hawthorn House Executive Group, but should include representation from the Mental Health Division, the Head of Department Hawthorn House, a staff representative from Hawthorn House, a consumer, a carer. Terms of reference for the Steering Committee will also need to be developed.
APPENDIX 3: Hawthorn House Reference Group: Terms of Reference

INTRODUCTION
The Hawthorn House project provides intermediate rehabilitation services to individuals with serious mental illness (SMI) returning to the community post discharge from hospital. Hawthorn House is a 16-bed community based facility and situated in an inner city suburb near Perth. An evaluation of Hawthorn House’s outputs and outcomes are required to inform the Office of Mental Health of the efficacy of this approach to care and to inform future rehabilitation strategies. The Western Australian Centre for Mental Health Policy Research will undertake this evaluation.

EVALUATION OBJECTIVES
The following evaluation objectives and framework were proposed and endorsed by the Hawthorn House Executive Committee on 06/08/2008 (see Appendix 2).

1. Has Hawthorn House achieved its objectives?
2. Are the consumers and their carers satisfied with the service?
3. What impact has Hawthorn House had on the local community?
4. How can the evaluation findings shape future service and policy development?

It was hoped a report could be completed, at least in draft form, by December 2008.

REFERENCE GROUP PURPOSE
To support and advise the Western Australian Centre for Mental Health Policy Research personnel in their task of evaluating Hawthorn House.

OBJECTIVES
1. To ensure the key stakeholders including the Mental Health Division, Town of Vincent and Executive Director Mental Health NMAHS are involved in this process.
2. To guide adherence to the agreed methodology, process and timetable.
3. To support access of the researchers to documentation, data and key stakeholders including the executive group, residents and family caregivers where ever possible
4. To provide feedback and guidance as requested by the researchers
5. To endorse the final report prior to its release to the Executive Director Mental Health, NMAHS and the Division of Mental Health.

PROCESS
1. Invite a representative sample of stakeholders to form the group.
2. Meet regularly with the researchers to monitor the progress of the project.
3. To provide feedback and information as requested to the researchers.
4. To work closely with the researchers on the evaluation process.
5. To sign off on the report before it is provided to the project owner - The Division of Mental Health.
PROPOSED MEMBERSHIP
Chair, Ms Raighne Jordan, Director of Nursing

Members
Dr Arianne Cullen, Carer representative
Ms Rebecca Daniels, Consumer representative plus one TBA
Dr Elizabeth Fisher, Staff representative
Ms Carey Harris, Clinical Nurse Manager Hawthorn House (project contact person)
Dr Sandy Tait, Head of Service, Hawthorn House
Ms Linley Lefay, Project Officer, WA Centre for Mental Health Policy Research
Dr Geoff Smith, Medical Director, WA Centre for Mental Health Policy Research
Ms Theresa Williams, Director, WA Centre for Mental Health Policy Research.

ACCOUNTABILITY
The Reference Group will report to Ms Leanne Sultan Acting Director of Operations, North Metropolitan Area Adult Mental Health Services.

REFERENCE GROUP RESPONSIBILITIES
Each member of this Reference Group is responsible for:
- Ensuring the project adheres to the agreed research protocol and is realistic and practical;
- Working collaboratively with the researchers; and
- Undertaking any additional duties relating to the activities of the Committee.

FREQUENCY, TIME AND VENUE
Meetings will initially be fortnightly, based in the Hawthorn House Staff Room and will be conducted on a Wednesday afternoon.

CONFIDENTIALITY
Information discussed and gained in the working group will be considered “Commercial in Confidence’. All members will be expected to maintain confidentiality as requested. Items will be identified in the course of a meeting and noted as such in the minutes.

QUORUM
The Chair and 50% of members constitutes a quorum.

RECORDS
The project officer will record the meeting and produce a brief summary of the meeting and its Actions within 3 working days of the meeting to be distributed by e-mail to all committee members and delegates. The Minutes / Action Sheets will be confirmed at the next meeting. The record of the meeting will be around decisions and actions. The Reference Group will determine the distribution of information and minutes to those outside the committee.

The files are the property of the DOH and must be preserved in accordance with the State Records Act 2000 and the Freedom of Information Act 1992.

AGENDA
An Agenda and associated papers are to be circulated to members no less than two working days before the meeting is to be held.

It is important that only items that fall within the terms of reference of the working party are placed on the agenda.

CONDUCT OF MEETINGS
In formulating advice or if providing a view, the Reference Group should aim for a consensus view.
PECUNIARY INTERESTS WHICH MAY CREATE A CONFLICT OF INTEREST
Where a member has a pecuniary interest its origin being external to the organisation in a matter, which is before the meeting for discussion, that member should not take part in the discussion and the decision on the issue, unless the Chairperson of the meeting is satisfied that the interest is so trivial as to be unlikely to affect the member’s judgment in the matter. This interest must be declared to the Chairperson and recorded in the minutes.

REVIEW
Terms of Reference and membership of the Reference Group to be reviewed when the tasks are completed or as directed by the owner of the project.

Adopted August 27th 2008.
1. What do you want to come out of this review of Hawthorn House?

2. What is your understanding of why Hawthorn House was established and what outcomes it was meant to achieve?

3. What factors, both internal and external, have had a significant impact on implementation of the service?

4. Are there group[s] of clients for which Hawthorn House has worked well and others for whom it has not worked well?

5. Ideally, what group[s] of clients should a service like Hawthorn House be targeting?

6. What have been the most effective elements of the Hawthorn House service model?

7. In your opinion, are there any changes that could be made to the way that services are organised, managed or delivered that could make them better?

8. Has the staffing of Hawthorn House been appropriate in terms of numbers, training and skills mix?

9. What are the major outcomes that have been achieved by Hawthorn House?

10. Have any unanticipated positive or negative outcomes arisen during the establishment of Hawthorn House?

11. How important do you think has been the policy of following up clients after their discharge from Hawthorn House?

12. Do you think that there will be an ongoing need for a service like Hawthorn House following its closure or can the needs of the clients be met within existing or planned services?

13. In your opinion, what has been learned from the experience of operating Hawthorn House that can be generalised to the wider mental health system?
REFERENCES

