Evaluation of Marathon Health’s Partners in Recovery Care Coordination Model (Specialist Support Coordination Team Program)

Summary of Findings
December 2018
Acknowledgements

Charles Sturt University acknowledges and pays respect to the elders, both past, present and future, of the lands where CSU students and staff reside. In particular, CSU acknowledges the Wiradjuri, Ngunawal, Gundungarra and Biripai peoples of Australia, who are the traditional custodians of the land where the University’s campuses are located.

The authors acknowledge the wide range of terms often used to describe people with a lived experience of mental illness, such as patient, service user, consumer, client, person with lived experience and psychiatric survivor. These terms reflect local contexts, historical moments, political influences and preferences. Given the prevalence of the term “people living with mental illness” we have adopted it for this report. This term focusses first on the person and then their journey with mental illness. It does not define them by the illness. It also recognises that many people who live with mental illness do on access or receive services. Finally, it emphasises the personhood and agency of people to be active partners in their wellness planning and recovery. We appreciate the use of language is important, and that this is a contested area. For those people living with mental illness who have used the SSCOT service we have used the term ‘consumer’. However, we acknowledge the critique and limitations of all terms.

The opinions and stories within this report may or may not be generalisable to wider populations or other people in similar situations; rather they are the unique perspective of the person who shared them. Pseudonyms have been used to ensure anonymity, but all quotes are unaltered to accurately reflect participant opinions.

This document represents a summary of the evaluation. There is a full technical evaluation report associated with SSCOT. You can request a copy by contacting Marathon Health or the authors listed on the back page of this document.
Glossary

CANSAS
Refers to the Camberwell Assessment of Need Short Appraisal Schedule.

CBT
Refers to Cognitive Behavioural Therapy, which is centred on individuals challenging unhelpful thoughts, feelings or behaviours and aims at re-learning healthy thoughts, feelings or behaviours.

Consumer
Refers to a person living with mental illness who was a direct recipient of the SSCOT program services.

HoNOS
Refers to the Health of the Nation Outcome Scales assessment.

K-10
Refers to the Kessler Psychological Distress Scale—10.

LSP16
Refers to the Life Skills Profile—16 assessment.

Recovery
Used to describe the process from psychological distress and functional limitations towards optimum health.

Referral
A process by which a consumer is referred to the SSCOT program, for example, by a general practitioner, as opposed to inquiring directly about the service.

Service Partner
This refers to the other health and human services that also provide support to SSCOT clients.

Service Provider
This refers to SSCOT staff.

SSCOT
Refers to Specialist Support Coordination Team. This is the program evaluated within this report.

WEM-WBS
Refers to the Warwick-Edinburgh Mental Wellbeing Scale.
The Specialist Service Coordination Team (SSCOT) program is the result of an innovation grant from NSW Health. Running in conjunction with Marathon Health’s Partners in Recovery (PIR) program, it provides a detailed assessment and care coordination service to people living with severe mental illness whose recovery journey has stalled or who show signs of cognitive impairment. The SSCOT team’s ‘step-in, step-out’ work provides a wellness and recovery action plan based on a comprehensive suite of specialist assessments. This plan is developed in partnership with local service providers who then implement the plan. The SSCOT program is an exemplar of contemporary mental health policy in action. The evaluation revealed very high consumer, carer and partner satisfaction with the service. This included the respectful nature of the service and the focus on life goals, including carers as partners in the recovery journey, and the competence of SSCOT staff.

The service also showed high levels of program fidelity across the clinical assessment and care planning process, though not all benchmarks achieved the 85% target. Increased emphasis on communication with GPs and focus on physical health assessment present opportunities for service improvement. The program would also benefit from increased attention to completing its standardised assessments, and recording client-related and service development activity data. This data would have greatly assisted the evaluation team to assess service effectiveness and service efficiency.

The staffing deployment appears efficient and effective in meeting its objectives. The multidisciplinary team of psychologists, occupational therapist, social worker and speech therapist work part-time in SSCOT and also work for other services. This helps program sustainability and facilitates connection to other services. The model prioritises engagement with partner providers and the development of a shared recovery plan. The specialist assessment, collaborative planning and wellness focus are essential elements of this model.

Several praiseworthy aspects of this program warrant mention:
- A structured and planned approach to local collaboration and partnership
- High levels of service recipient satisfaction
- The use of a comprehensive suite of specialist mental health assessments
- Working in partnership with carers
- A strengths-based, life goals approach to wellness and recovery planning.

The fundamental challenge associated with this initiative does not lie with the SSCOT program itself. It lies with the ability of service partners to reliably implement the wellness and recovery action plan.

The evaluation concluded that the SSCOT program provides a sustainable and valuable contribution to mental health. It enables local services to provide more effective and efficient care to people living with severe mental illness. This is a valuable contribution to mental health care and recovery in the region. The model appears transferrable to other regions and would also be applicable to NDIS services for people living with mental illness.
What Does SSCOT Do?

SSCOT provides specialist assessment and care planning and runs in conjunction with the Partners in Recovery (PIR) program. The program is for PIR participants with cognitive deficits or whose recovery journey has stalled. The focussed activity of the SSCOT program is designed to take 8-10 weeks and it is a ‘step-in step-out’ model, where the team ‘steps in’ to conduct a series of specialist assessments, facilitates a process of cross-agency care planning and commitment, and then ‘steps out’ of the process when the care planning is completed.

The SSCOT team works in partnership with local service providers to:
- Identify suitable participants in their program
- Arrange initial referral and assessment
- Provide a comprehensive cognitive assessment and life skills assessment
- Develop a detailed wellness and recovery action plan
- Arrange and allocate care packages
- Coordinate an integrated approach to ongoing care and recovery support.

These plans are strengths based across 13 domains (CDS, 2005) and ‘owned’ by the consumer. Every attempt is made to engage consumers and their carers as active partners in their wellness and recovery planning.

Principles of the SSCOT Model

Underlying this approach to care planning are a number of key principles for program success:
- The program builds on established relationships. To this end it seeks to have the PIR support facilitator present at the assessments and to meet with the specialists, and participate in the development of the shared care plan
- The program works to get the care providers engaged in the process
- The program partners may include employment, mentoring, mental health specialist services, physical health, housing, and recovery support services.

This program exemplifies many of the key principles of contemporary Australian mental health policy including:
- Care for people living with severe mental illness
- An integrated approach and localised service planning
- A strengths based approach to wellness and recovery.
Consultation and Research Design Process

An initial research co-design stakeholder workshop was conducted. This workshop derived views of mental health from multiple perspectives.

The evaluation framework was co-designed with:

- people living with mental illness
- carers
- service partners and
- service providers.

What makes a good mental health service?

The co-design workshop concluded that a “good” mental health service:

- Respects, cares and listens to consumers
- Provides clear and continual communication
- Will support consumers while navigating through the mental health system
- Has the resources and capacity to provide what consumers need
- Is capable, aware of and partner with other services
- Values cooperation and multi-disciplinary, multi-organisational relationships
- Makes the consumer the priority and has a shared vision for their care
- Prioritises the consumer’s health, safety, happiness and personal goals
- Has passionate, capable and consumer-focussed leadership.

These insights and conversations informed the research questions for the qualitative interview stage of the evaluation. The evaluation team included a person with a lived experience of mental illness.
Process and Method

Five sources of data were collected and analysed:

1. **Policy analysis** testing alignment with state and national contemporary practice
2. **Interviews and surveys** with consumers, carers, service providers and service partners.
3. **File audits** for program fidelity
4. **Standardised psychometric measures**
5. **Staffing, funding and activity data.**

Qualitative Analysis: Interviews

Participants who provided consent were interviewed and surveyed. The interviews were conducted in person or via phone with 20 participants during a 3-month period.

Interviews were audio recorded, transcribed and then analysed using NVivo software. Analysis of the qualitative data was guided by Yin’s (2010) five phases of analysis:

1. Compilation of the database
2. Disassembling of the data extracted responses
3. Reassembling of the data into potential themes
4. Interpreting the data and cross-checking themes
5. Identification and summary of key findings.

The interviews explored opinions and experiences of the SSCOT program, based on themes developed from the stakeholder co-design workshop.
The SSCOT program serves people living with severe mental illness with cognitive deficits and ongoing mental health concerns. As such, few participants were in a position, or willing to give interviews. The experiences of two SSCOT consumers are presented as vignettes.

Emily lives with schizophrenia and has been hospitalised numerous times due to severe psychotic episodes. Emily’s cognitive functioning has been affected by her mental health condition, which has resulted in problems with memory and affected her ability to organise and follow through with her plans. She cannot live on her own without becoming unwell. Emily successfully completed drug rehabilitation and has not used drugs for over two years. She developed a strong interest in staying healthy and wanted to start working focussed on helping others. She also wished to remain engaged with her family and her children, who were in the care of their grandmother. Emily’s main goal was to move into her own unit. Over several weeks, an SSCOT psychologist met with Emily and completed an assessment of her cognitive functioning to understand Emily’s strengths and areas in which she needed support. The psychologist also met with Emily’s family and care providers to get a holistic picture of her current functioning and needs. Emily then completed a functional assessment with an occupational therapist, focussed on understanding her strengths and areas of difficulty in aspects of daily functioning. Working with the SSCOT therapists, Emily developed her own Rehabilitation and Recovery Plan. Based on Emily’s goals and current level of functioning, the plan identified strategies that Emily and the staff who provided her with daily care could use to support her to live in her own unit. Emily has lived successfully on her own for over a year. With the support of daily local care services, Emily has not used recreational drugs or been admitted to hospital. She has also achieved some of her relationship goals, being in regular contact with her family, participating in volunteering and starting to look for employment. SSCOT has meant that Emily has a range of strategies tailored to her needs and assistance to navigate support services so that those strategies can be put in place consistently. For Emily, this has meant being able to “move forward in my recovery”.

George is an indigenous man who lives with mental illness, which has impacted on his memory and ability to live independently. George lives with his partner, who also has mental health concerns. His extended family is scattered around and he feels he doesn’t have friends in his area. For George, the most important thing about any mental health support service is knowing that there is someone who is reliably available to help him. The thing about the SSCOT program that impressed him most was that the staff took a real interest in him as a person, taking time to talk about his goals and interests, and even facilitate some of his hobbies. George noted that the SSCOT program did what it was designed to do, and he would recommend SSCOT to others. But he also indicated that he didn’t enjoy the process of cognitive assessments, and that the length of each session was particularly tough for him. He thought it would be helpful to change the way assessments were done; having more sessions with the psychologist so they could run for a shorter period of time. It had been at least a few months since George had seen his recovery plan, and he didn’t remember what was in it. He also wasn’t sure which services might have it, but seemed interested in reviewing it with SSCOT more regularly. The assessment results and recovery plan had been used to support George’s application for the NDIS.

Recommendations

- Support staff should, at regular intervals, discuss the wellness and recovery action plan with the consumer their carers and take the opportunity to review and update the plan as appropriate.
Interviews: Carers

It was difficult to find available carers to participate in an interview for this evaluation. Only one pair of carers accepted the invitation.

Findings

The carers were very positive about the program and the staff they worked with. In particular, they praised SSCOT staff for their skills in their role, and for listening and building rapport. The felt the staff they had worked with had passion about the role, were experienced working with people with mental health concerns, were compassionate and “never ever let us down in any way”. On this basis, the carers would be happy to recommend the service to other people.

They indicated that they looked for a service which helped their son to identify his own strengths, and supported him “to move forward in a positive manner”.

The Wellness and Recovery Action Plan prepared with the SSCOT service was of particular importance in the experience of these carers. In this case, the carer felt the plan was comprehensive, taking into account the consumer’s “needs, strengths and weaknesses”, and was detailed, practical and simple for the consumer. Initially, the service partner followed the shared care plan, with good outcomes for their son. He was living independently and ready to engage in paid work. However, with a change of service provider, the shared care plan was not adhered to. This led to a deterioration of his condition resulting in drug abuse, hospitalisation and loss of his tenancy.

“The organisation looking after Tom didn’t follow the plan ... They didn’t think it was necessary and Tom got sick.”

“A very detailed plan was developed and they didn’t stick to it.”

The carers were scathing about one of the partner agencies. They had met with the CEO of that organisation to express their dissatisfaction and complain about the quality of care. They were disgusted with his response. He “seemed distracted and to not care less about our concerns”.

The carers were very positive about how the SSCOT service had helped them navigate the NDIS application process, which they found “just so complicated”.

“The SSCOT staff never ever let us down in any way”.

Recommendations

The carers did not make any recommendations about SSCOT. However, they were frustrated with the context in which SSCOT operates. The program relies on service partners for implementation. The quality of this care is variable, and there are no meaningful complaint or grievance mechanisms in the NGO sector as exist in public health services.

There is a need for transparent accountability, grievance and complaint mechanisms for NGO partner agencies.
Interviews: Service Providers

Findings

The service providers (the SSCOT staff) were very positive about the SSCOT program and the impact it was having on consumers. Providers were excited that the model allowed for a multidisciplinary, strengths-based, person-centred approach to care.

Service providers were adamant that their work should be consumer focussed, placing the person-centred attitude over specific interventions. They felt this attitude was missing in many other mental health services, and were convinced that strengths-based practice, coupled with empowerment and advocacy, achieved results. Service providers also felt that consumers were thankful for a say in their own care.

“It’s client centred and holistic, really actually listening to the client and understanding their needs and wants and being responsive to that. And then of course they’ve identified goals to go forward ... so can we break those goals down? Really, actually giving ownership to them and letting the client have a feeling of control.”

Many providers articulated frustration with other organisations who they felt did not follow through on their commitment to the strengths-based approach or care plan. Providers told of examples when care plans were signed-off and then discarded, and felt that there should be some accountability for those who do not follow through. While they understood this was outside of SSCOT’s control, they believed increased partner commitment would result in better outcomes.

Service providers reported numerous consumers had improved since starting the program, and had stories of staff finding both issues and goals that had gone unnoticed by other services for years. All service providers considered it a privilege to journey with their consumers towards recovery.

“The parents were saying ‘our son, we have never seen a service understand his needs and try to get those needs met in such a way’, they were overwhelmed actually ... The man broke down in thanking us, saying ‘We don’t think that there’s ever been a service that’s understood our boy the way that you have.’”

Recommendations

The SSCOT service providers identified several areas for improvement:

◆ Inclusion of health assessments in KPI’s rather than assuming GPs will catch anything of importance
◆ More time spent with carers (and potentially consumers too) to ensure they understand the role of SSCOT
◆ Clear communication and handover when staff and/or managers change jobs/role
◆ Better sharing of information when partnering with other services
◆ Partners travelling together on long trips to support communication & productivity
◆ Adequate training for all staff across: principles of recovery, NDIS, strengths-based approach to wellness and recovery
◆ Continuing the program beyond a pilot, as it is profoundly improving consumers’ lives.
Findings

Service partners were overwhelmingly positive about the SSCOT program. This included the impact they saw the program having on consumers, and the interactions they had had with the team.

Service partners spoke highly of SSCOT's:

- Holistic, person-centred view of the consumer
- Strengths-based approach
- Reliable and flexible models of care
- Collaborative decision making and care planning
- Capable and compassionate staff.

Service partners reported:

- Marked clinical improvement with increased trust and optimism in the consumers they referred to SSCOT
- Hospitalisations decreased
- Increased independence and improved health.

“It keeps people out of hospital, gets people functioning better within their community ... I don’t think there’s anything but benefits really.”

Many of the areas of improvement identified by service partners were related to establishing a new program and the limitations of a pilot.

Recommendations

Communication on commencement

Some service partners felt that the start of the program was somewhat undirected, and it took time for different parties to come on-board and understand the shared vision.

Ongoing partner communication

Early changes in leadership led to some confusion about aspects of the program. Staff changes should be communicated clearly to ensure this does not affect service provision.

Broader referral criteria

Service partners wanted more freedom to refer into the program but understanding this would require additional resources and staff capacity.
**Person-centred: SSCOT's approach to care**

The survey results indicated service partners and service providers were positive regarding SSCOT’s approach to consumers, with most average scores between 3 (agree) and 4 (strongly agree). The strongest ratings were for:

- The shared care plan
- Goals focus
- Individualised support.

### Perceptions of SSCOT's Approach to Clients: Partner Providers

<table>
<thead>
<tr>
<th>Perception</th>
<th>Score</th>
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<tbody>
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<td>Having a shared care plan was beneficial for consumers</td>
<td>3.1</td>
</tr>
<tr>
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<td>2.6</td>
</tr>
<tr>
<td>Consumers felt well-informed about what the service was doing</td>
<td>2.9</td>
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<tr>
<td>Consumers felt like they had options and choices</td>
<td>3.0</td>
</tr>
<tr>
<td>The service made consumers feel in control of their health journey</td>
<td>2.9</td>
</tr>
<tr>
<td>The support consumers received was individualised/tailored to them</td>
<td>3.4</td>
</tr>
<tr>
<td>Consumers received the kind of support they wanted</td>
<td>2.9</td>
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### Perceptions of SSCOT's Approach to Clients: SSCOT Providers

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### Recommendations

The survey scores suggest that:

- Additional time be spent engaging and explaining the nature of SSCOT to the consumers
- Additional modes of communication about SSCOT be regularly provided to consumers.
SSCOT staff perceptions

SSCOT staff (service providers) responses to all questions were positive. Particular areas of strength were “relationships with consumers” and their “ability to make a difference”.

Although the average scores were still positive, opportunities for career advancement and increased access to training achieved the lowest average scores.

Service partners’ perceptions

The service partner survey scores were high across all questions. The commitment of SSCOT staff and the value of the Plan were rated very highly. Better communication between SSCOT and partners achieved the

Recommendations

- Sufficient support and resources be available to SSCOT staff
- Regular and ongoing communication with service partners be prioritised.
The importance of accurately recording the extent and range of service activities cannot be overstated. This data is essential for the evaluation of service efficiency and ongoing reporting.

The amount of time and capacity needed to thoroughly consult, plan and introduce new services is almost always underestimated.

Integration takes time. Accurate recording of time spent planning and coordinating shared care and other critical “partnering activities” is very important. Accurate recording of these activities would be of great benefit to planning and funding of future initiatives.

**Recommendations**

It is recommended that new and existing programs ensure clear recording of:

- ‘Face-to-face’ contact time
- Other client related activity
- Service establishment activity time
- Consumer/carer/partner communication
- Training and development
- Care coordination and care planning time.

**Findings**

There were 6.6 full-time equivalent (FTE) staff involved in SSCOT. They comprised clinical psychology, psychology, social work, nursing and occupational therapy staff. The average face-to-face contact time by SSCOT personnel was 12.9 hours per consumer. This was accompanied by an average of 38.2 hours of PIR support worker time per consumer.

Australian public mental health services have efficiency targets for the percentage of staff time spent in “client-related” activity. It was not possible to compare SSCOT against these targets for several reasons:

- Not all ‘face-to-face’ time was recorded by SSCOT staff
- No client-related activity that was not ‘face-to-face’ (e.g., report writing, care planning) was recorded
- The program relies on intensive partner engagement and integrated care planning. This client related activity also was not recorded
- SSCOT has a major training and workforce development component. This time was also not recorded.

Nonetheless, some observations can be made:

- Providing detailed wellness and recovery action plan based on comprehensive assessment enabled partner community services to be focussed on the areas of most benefit, appropriate to the individual consumer’s goals, assets and cognitive capacity. This results in better targeted and therefore more efficient support.
- Employing staff who also work in other program streams, the model seems to constitutes an efficient use of personnel and contributes to service sustainability.
Five standardised outcome measures were used by SSCOT—the **CANSAS**, **LSP-16**, **HoNOS**, **WEM-WBS** and the **K-10**. All consumers completed an initial LSP16 and HoNOS. Completion of review and follow-up outcome measures was variable. Due to the small number of repeated measures, statistical analysis could not be conducted to determine effectiveness. The available data indicates a wide range of distress and functioning across the service recipients. The HoNOS, LSP16 and the Camberwell scores indicate respectively that, on average, SSCOT consumers had:

- Severe difficulties and high service needs
- High complexity
- Very high needs.

### Recommendations

Without objective measures of mental health and functioning, evaluations have to rely on subjective reports of progress. The collection rate of standardised measures by the SSCOT is **much higher** than that achieved by public mental health services generally. Nonetheless, there is much room for improvement and it is strongly recommended that:

- Key standardised measures are diligently collected at intake, review and discharge.
Program Fidelity

Based on the service model provided, a quality checklist was devised by the evaluation team to assess the fidelity of program implementation. Consumer files were examined for the presence or absence of elements of assessment process and care planning against the model description. The results of this audit are presented in the table below.

A file audit of 22 SSCOT consumers was completed in August 2018. After screening, 18 files met the criteria for auditing.

<table>
<thead>
<tr>
<th>Item</th>
<th>Percentage of compliant files (n = 18)</th>
</tr>
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<tbody>
<tr>
<td>Intake documentation, including referral</td>
<td>100%</td>
</tr>
<tr>
<td>Case notes from initial interview</td>
<td>83%</td>
</tr>
<tr>
<td>CANSAS: Initial and follow-up</td>
<td>83% 44%</td>
</tr>
<tr>
<td>K10: Initial and follow-up</td>
<td>55% 11%</td>
</tr>
<tr>
<td>HoNOS: Initial and follow-up</td>
<td>100% 33%</td>
</tr>
<tr>
<td>LSP16: Initial and follow-up</td>
<td>100% 33%</td>
</tr>
<tr>
<td>Warwick: Initial and follow-up</td>
<td>66% 11%</td>
</tr>
<tr>
<td>Physical Health Assessment</td>
<td>82%</td>
</tr>
<tr>
<td>Cognitive Assessment</td>
<td>88%</td>
</tr>
<tr>
<td>OT Assessment</td>
<td>83%</td>
</tr>
<tr>
<td>Social Work Assessment</td>
<td>44%</td>
</tr>
<tr>
<td>Speech Therapy Assessment</td>
<td>5%</td>
</tr>
<tr>
<td>Smoking</td>
<td>50%</td>
</tr>
<tr>
<td>Alcohol and other drugs</td>
<td>50%</td>
</tr>
<tr>
<td>Evidence of consumer participation in care planning</td>
<td>83%</td>
</tr>
<tr>
<td>Evidence of carer availability / participation in care planning</td>
<td>61%</td>
</tr>
<tr>
<td>Shared care plan / evidence of care plan in process</td>
<td>50% 22%</td>
</tr>
<tr>
<td>Evidence of goal setting / achieved</td>
<td>100% 0%</td>
</tr>
<tr>
<td>Evidence of wellness focus</td>
<td>61%</td>
</tr>
<tr>
<td>Evidence of contact with a GP/ other service providers</td>
<td>22% 83%</td>
</tr>
<tr>
<td>Letter to GP with care plan</td>
<td>0%</td>
</tr>
<tr>
<td>Evidence of service coordination / multidisciplinary planning</td>
<td>94%</td>
</tr>
<tr>
<td>Evidence of review of goals (group meeting)</td>
<td>5%</td>
</tr>
<tr>
<td>Follow up measures reports</td>
<td>5%</td>
</tr>
<tr>
<td>NOG transition planning</td>
<td>100%</td>
</tr>
</tbody>
</table>

Strengths

♦ Goal setting was completed with all consumers
♦ Where possible, consumers and carers were active participants in this goal setting
♦ Service co-ordination and multidisciplinary planning was an obvious strength in line with the aims of the service
♦ 13 consumers either had a Wellness Recovery Action Plan, or were in the process of developing a plan.

Recommendations

♦ Regular physical health assessments should be ensured, and recorded. People living with severe mental illness are 10 times more likely to die prematurely of avoidable physical illness than by suicide.
♦ Communication and collaboration with GP’s could be increased and made a priority. This may require advocacy by the SSCOT staff and partner agencies on behalf of the consumers.
♦ A review of goals, with consumers, carers and service partners should be conducted regularly. There was limited evidence in the case notes of the progress consumers made towards their goals.
The initial pilot was supported by an innovation grant of $520,000 from
the NSW Ministry of Health. Marathon Health also committed resources
to support the program. A number of characteristics of this program sup-
port its sustainability and generalisability.

Links with existing services to support effective care
The service is provided by a small specialist team conducting a brief but
intensive period of assessment, which informs the development of
shared care plans to be implemented across multiple agencies. This adds
value to service partners facilitating more effective, appropriate and
therefore efficient care.

Requires only a small part-time workforce
The ‘step-in step-out’ model only requires a small workforce for a rela-
tively short period of time. Also, with an average of 13 hours of face-to-
face clinical time, workforce turn-over does not threaten its viability.

Draws on existing capacity
With 6.6 FTE across 10 part-time staff members, most of the specialist
staff can come from existing local workforce. Therefore it did not re-
quire the establishment of an additional organisation and associated set-
up and infrastructure costs.

Broad staffing base
With a total 10 staff involved in this program, it is not dependant on one
or two people. This made the program more robust to staff movements
and vacancies.

Summary
The ‘step-in step-out’ model of SSCOT using 10 staff members means the
program is robust to staff movements and recruitment challenges. It also
does not rely on the continuity of staffing, as the entire specialist assess-
ment and care planning is carried out as a discrete element of care, and
then given to a partner care provider service to implement the care plan
over an extended period. These factors suggest this model is sustainable,
and generalisable to metro and rural settings.
Conclusion

The provision of mental health services in Australia is a challenge. Agencies responsible for mental health service provision often have limited resources for service delivery for a particular population group, and even fewer resources to support integrated and coordinated care. The SSCOT program provides a ‘step-in step-out’ service for people living with severe mental illness and supports local service providers. Within the local service context it offers:

- **Comprehensive assessment** of functional ability and cognitive capacity
- **Carer and consumer participation in recovery planning**
- A focus on **consumer goals** and life aspirations
- The development of **individualised wellness and recovery plans** taking into account consumers’ cognitive capacity and support networks
- **Coordinating partners** to implement the agreed shared wellness and recovery action plan.

Partner agencies, consumers and carers regarded the program very positively and value its contribution. By putting in place systems to coordinate and translate the results of the assessment into a shared wellness and recovery action plan it enables better coordinated and more effective care for partner agencies. In the transition to the NDIS for people living with severe mental illness, a program such as this could be extremely valuable in providing detailed, evidence-based recommendations for care packages.

The service requires a relatively small panel of specialised mental health professionals. Thus it represents a model that would be readily transferable to other regions. The main limitation of this program is the capacity and commitment of partner agencies to implement the Plan.

Greater attention to accurate recording of all client-related and partnering activities, and standardised measures would strengthen the evidence base of future evaluations. Giving greater priority to tracking consumers’ progress in achieving their goals and communication with local GP services would also enhance this service.

In the context of a complex system with multiple service providers, the SSCOT program offers a valuable and cost effective contribution. Its contribution is primarily in providing thorough clinical assessment and care planning, to support existing mental health and human services in the local community. SSCOT has demonstrated it can deliver this contribution on a modest budget and staffing. The program is sustainable and transferable to other communities and service contexts, including the NDIS for people living with severe mental illness.

Combining comprehensive assessments which underpin the development of detailed wellness and recovery action plans in partnership with consumers and carers, with an emphasis on local integration in care planning and provision, the SSCOT program presents a model that should be considered for ongoing support and for implementation in other regions.
References


The Chief Investigators received valuable insights and assistance from three Research Assistants: Dr Jenni Greig, Jessica Sowden, and Rachel Rathbone.

Investigative Team

**Associate Professor Russell Roberts** began his career as a Clinical Psychologist in rural South Australia and in Queensland, and before becoming an academic, he served as Executive Director of Mental Health in Western NSW, 2001-2014. This involved leadership of a comprehensive mental health service organisation (1000+ staff) responsible for the entire spectrum of care in mental health including promotion, prevention, early intervention, community care, community partnership, hospital care, tertiary care and emergency care across the lifespan. He is also the Editor in Chief of the Australian Journal of Rural Health and Chair of the Australian Rural and Remote Mental Health Symposium.

**Professor Oliver Burmeister** specialises in healthcare technologies. He leads the cross-faculty Health Services Research area at CSU. He is also a Senior Research Fellow until October 2020, co-leading the CSU “Flourishing Communities” research sphere; one of the three research spheres in the CSU strategic plan. His focus is on both health and community engagement. His health related interests are reflected in his publications both in clinical journals as well as in technology journals.

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