



# An evaluation of a tailored care program for complex and persistent mental health problems: Partners in Recovery program

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## ABSTRACT

Partners in Recovery (PIR) is a nation-wide Australian program designed to improve coordinated care for people with severe and persistent mental health problems. This study evaluated PIR's effectiveness for individual and system-level outcomes. A total of 25 PIR participants (male = 7, female = 15, not stated = 3) provided data for the evaluation of the program across six community mental health service providers in Canberra, Australia. Individual-level measures included quality of life, social inclusion, and perceptions of recovery. System-level individual measures included confidence in the health system, perceptions of organisation of care, and network analyses. Global single-item scores were measured at baseline (retrospectively), midpoint, and endpoint. Scaled scores for quality of life and social inclusion were measured at midpoint and endpoint only. Multi-level fixed effect models demonstrated significant improvements in global quality of life ( $p = .008$ ), social inclusion ( $p = .025$ ), perceptions of recovery ( $p < .001$ ), and confidence in the health system ( $p = .013$ ) from baseline to endpoint. Mean scaled scores did not improve from midpoint to endpoint. Two network analyses demonstrated the central role of the support facilitator. This study provides preliminary evidence for increasing quality of life, level of social inclusion, and perceptions of recovery for people with severe mental illness and complex needs.

## 1. Background

Around 600,000 (2–3%) Australians experience severe, persistent and complex mental illness across their lifetime (Department of Health and Ageing, 2013). This group experiences high rates of mortality including from physical health problems (De Hert et al., 2011). Comorbidities such as drug and alcohol abuse, as well as overlapping problems such as low education, impaired self-care abilities, and homelessness are also common (Jablensky et al., 2000). Despite the severity of these problems, around half of Australians with mental health disorders do not receive any form of treatment during any given year (Slade et al., 2009; Whiteford et al., 2014). Many people with severe and persistent mental illness require healthcare and social services but are not able to access this care. A recent study by Morgan et al. (2012) demonstrated that from a survey of 1825 Australians with psychosis, over one-quarter reported that they were in need of, yet could not access the required services during the previous 12-months. This population is highly vulnerable to 'falling through the cracks' in care (Commonwealth of Australia, 2009); therefore, provision of a co-ordinated support network is a promising approach to increase access to care and increase the likelihood of ongoing engagement with care.

Providing services to people with severe and persistent mental illness is complex as it requires both coordinated and collaborative efforts between multiple sectors. This includes primary mental health and health care, as well as income support services, employment, education, housing support and non-government sector organisations such as alcohol and drug treatment services (Australian Department of Health and Ageing, 2011). Due to the difficulties in navigating services, care for people with complex needs is often inefficient and lacking. Care coordination has been identified as a person-centred response to this difficulty in meeting the needs of people with serious mental illness. However, the evidence for effectiveness is currently limited. Some care coordination programs that have demonstrated success suggest that it is a caring and personal relationship with the care coordinator that is the defining element (Brophy, Hodges, Halloran, Grigg, & Swift, 2014; Craig, Eby, & Whittington, 2011). Banfield et al. (2013) explored how information continuity supports coordination and found that, although necessary, the availability of information alone is not sufficient to ensure a patient experiences continuity of care for those with complex conditions, but rather it was the 'active involvement of a person in care rather than the passive availability of information' that ensured an experience of continuity (Banfield et al., 2013, p. 1). Further reviews

Abbreviations: PIR, Partners in Recovery; SF, Support Facilitator

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cite system change and patient autonomy in terms of decision-making and self-management to be a key factor (Bodenheimer, Wagner, & Grumbach, 2002; Brophy et al., 2014).

### 1.1. Partners in recovery program

The Partners in Recovery (PIR) program is an Australia-wide mental health initiative funded by the Australian government, first implemented in 2013 (Department of Health and Ageing, 2012; Hancock, Smith-Merry, Gillespie, & Yen, 2016). Consistent with the observation that coordination in mental healthcare involves team-based care across health and social care boundaries (Haggerty et al., 2003), the program was specifically designed to target the needs of people living with severe and persistent mental illness and their carers, through the development of a more efficient and integrated health care support network (Brophy et al., 2014). The program aimed to integrate community health and human services, and comprises a consortium of local organisations and service providers within local regions who coordinate care across the relevant sectors, addressing current service delivery gaps. Key mechanisms of PIR are 1) the facilitation of coordinated clinical and support services to deliver ‘wrap around’ care tailored to the individual, 2) the creation of stronger partnerships and links between these clinical and support services, 3) improvement of referral pathways to and between services, and finally 4) the promotion of a community-based recovery model that underpins the services delivered (Department of Health and Ageing, 2012). Delivery of the initiative required flexible roll-out in individual locations depending on existing services, a client-focused and recovery-oriented model of care, and coordination between existing services at each PIR location (Department of Health and Ageing, 2012).

The program was intended to produce outcomes at two levels: the individual client level and the health system level. At an individual level, the goals of the program were to improve participant quality of life, social inclusion, and recovery (Banfield and Griffiths, 2014). At the system level, goals included improved partnerships between services, implementation of a local model of coordination and subsequent improvements in coordinated care for people in the target group (Department of Health and Ageing, 2012).

A core aspect of the program is the ‘Support Facilitator’ (SF) role, described as most similar to brokerage case management (Smith-Merry, Gillespie, Hancock, & Yen, 2015). Sutton, Isaacs, Dalziel, & Maybery (2017) provide a detailed description of the role, functions, and competencies of the Support Facilitator in PIR, which will be described briefly here. Responsibilities of the Support Facilitator vary slightly across PIR sites, but their primary tasks are to assess needs, manage referrals and develop partnerships for participants’ recovery goals (Smith-Merry et al., 2015). This includes identifying their specific needs such as access to stable housing, and then locating and facilitating access to services. The purpose of this role is to ensure that people with mental illness are engaged and are not lost to gaps between services. This provides the ‘wrap around’ care required, which is tailored, integrated, and facilitated through a single process to comprehensively meet the individual’s needs (Commonwealth of Australia, 2009). However, the funding for the support facilitator role was limited on the assumption that networks between services would be strong enough not to require this role after a period of 2 years. PIR also provided a small amount of ‘flexible funding’, which could be accessed as required for participants to access services and additional supports that could not be sought elsewhere (Department of Health and Ageing, 2012). Brophy et al. (2014, p. 396) reported that these support facilitators being well-prepared and competent was the key in PIR in “addressing the barriers to effective care and treatment across complex service delivery systems”.

Previous research conducted in Sydney, Australia assessed and demonstrated that PIR was effective at engaging the target population (Hancock et al., 2016) and was establishing a new work role within Australian mental health that is applicable beyond the PIR program

(Smith-Merry et al., 2015). An analysis of routinely collected participant data from two PIR programs in Sydney, Australia found that the program significantly reduced consumer’s unmet needs and increased self-reported mental health recovery for participants in this region (Hancock, Scanlan, Gillespie, Smith-Merry, & Yen, 2017). To our knowledge, this is the only previous study to have assessed the effect of the PIR program on quantitative individual level outcomes and no previous studies have assessed quantitative *system-level* outcomes. In addition, given the program was delivered flexibly evaluation at each study site across Australia may provide unique contributions to overall program assessment. Thus, the aim of the current study was to evaluate the impact of the PIR program in the Australian Capital Territory (ACT) on both individual and system level outcomes.

## 2. Methods

Ethics approval for the study was granted by xxxx Human Research Ethics Committee (2015/148). Written informed consent was obtained from all participants.

### 2.1. Evaluation framework

A realist approach was chosen to frame the evaluation. Based on a realist philosophy of science, realist evaluations ask questions such as ‘what works?’ and ‘for whom, under what circumstances, and how?’ (Pawson & Tilley, 1997; Wong et al., 2016). The use of realist evaluations is increasing due to the recognition of the complex problems and challenges encountered when assessing complex interventions. Such problems operate at both individual and systems levels, with many interconnected components, and hence what works in one community or individual may not work for another. As a realist evaluation can consider the above questions, and in varying contexts, it is well suited to address the challenges present in health services research (Wong et al., 2016).

The evaluation framework, comprising the design, measures and procedures for the evaluation, were developed in consultation with consumers, carers, PIR Support Facilitators and the PIR Consortium of service providers and other key ACT mental health stakeholders (Banfield and Griffiths, 2014). The research team initially selected validated measures developed with consumer, carer and service provider input. These were then discussed with a focus group of consumers and carers, the Support Facilitators and at a PIR Consortium Meeting, to ensure the framework addressed the key areas of importance for these groups and that the proposed implementation was feasible and acceptable (Banfield and Griffiths, 2014; Wadsworth, 2011). Changes that were made to wording of measures as a result of this process are noted in the description of the measures in the current study.

The evaluation design included data collection across multiple time points to detect changes in key outcomes over time to inform continuous improvement cycles of local applications of PIR (Wadsworth, 2011). Administration of client measures on entry to the Program, at the approximate mid-point of the Program and on exit from PIR was intended to build evaluation into the existing assessments and record-keeping. Regular use of the system level measures with providers was designed to create a more complete and inclusive quality assessment and improvement process (Banfield and Griffiths, 2014).

The evaluation comprised quantitative measures of client quality of life, social inclusion, recovery, client experience, carer quality of life and service provider experience, together with qualitative data. Qualitative and quantitative experience data collected via interviews and face-to-face surveys for clients, carers and service providers is reported separately (Authors, in preparation). The current paper reports client quality of life, social inclusion and recovery at the individual level, and two quantitative client experience items that measured system-level outcomes. These quantitative data were complemented with a social network analysis of the available administrative data for

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