Care Coordination Literature Review and Discussion Paper

Mental Health Service Coordination and the Community Managed Mental Health Sector in the Context of the National Health and Hospitals Reform Agenda

July 2011

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How to Respond to the Discussion Paper?

The *Care Coordination Literature Review and Discussion Paper* was distributed to MHCC members and other interested people on 10 August. It has been developed to help inform directions for MHCC's *Service Coordination Strategy.* You can respond to the Discussion Paper in either of the following two ways:

1) By attending an MHCC Regional Forum to be held between 10:00AM and 4:00PM on the following days and locations (more information about these events is available on the MHCC website).

    - 2 August – Newcastle, Civic Hall
    - 5 August - Wagga Wagga, Council Chambers
    - 8 August – Dubbo, Convention Centre
    - 12 August – Ballina, behind Library (Regatta Room)
    - 15 August – Nowra, Shoalhaven Entertainment Centre
    - 17 August – Sydney, Wesley Conference Centre

2) You can submit a written response then to the discussion questions presented in this document by **Friday 30 September** (extended from 2 September) to:

    Attention: Tina Smith – MHCC *Service Coordination Strategy*.

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1. Executive Summary

In recent times greater understanding and discussion of the interconnection between mental health, physical health and social wellbeing has resulted in attempts to break down the barriers between service systems. As a result there has been increased involvement of generalist health care providers in mental health as well as providers of housing, employment services, education and training and a host of other support services in the delivery of mental health care. This involvement of an increased range of players has in turn led to a greater emphasis in mental health policy for service coordination and service partnerships.

This complex mix of service requirements of many people experiencing mental illness are provided by organizations operating in different locations and settings with different traditions, philosophies and modus operandi and who are increasingly accountable to different levels of government and an to an increasing array of funding programs within each level of government. People with different professional and/or experiential backgrounds whose familiarity with other service systems and sectors varies greatly endeavour to provide the required services. Coordination is made difficult by the boundaries that exist within and between service systems and sectors as well as by the differences between service provider organization and the people providing the services.

The non-government community managed mental health sector in NSW, like other community sectors throughout Australia, currently find themselves surrounded by rapid and extensive change with implications for how health and community services are to be funded and for how they are to operate. Some of this change has included the introduction of *Better Access to Mental Health Care and Psychological Services* and the announcement of the introduction of Local Health Networks, Medicare Locals, a Preventative Health Agency, e-health infrastructure and the recently released Australian Government Ten Year Road Map for Mental Health Reform which includes Flexible Care Packages and provisions related to Care Coordination.

Associated with these developments are to be major changes in Commonwealth/State responsibilities and in funding arrangements and models. Though just where community managed mental health services fit in the scheme of things remains unclear, agencies have become increasingly aware that they will be required to work in local partnerships and be a player in integrated and coordinated care locally and regionally; and, be able to demonstrate that their services are evidenced-based, locally relevant and provided by staff with appropriate practice skills.

Purpose of the Discussion Paper

This literature review and study of service coordination relates to progressing Recommendations 3 & 5 of Mental Health Coordinating Council's (MHCC) 2010 *Sector Mapping Project*:

> ***Recommendation 3:*** *Mental health consumers have access to the range of community managed organization (CMO) service types and experience continuity of care between components of the mental health service system.*
>
> ***Recommendation 5:*** *CMOs develop and adopt a Care Coordination Strategy that will promote pathways and linkages across the mental health sector.*

This study seeks to provide guidance to the sector on achieving systems of integrated service delivery and consumer self-directed care with both MHCC member organizations and other stakeholders and provide planning direction for the *Service Coordination Strategy.*

Methodology

The peer reviewed literature was examined and findings reported in relation to a number of key areas of service coordination including:

- relevant terminology;
- the concept of service and care coordination; targets, timing, basic principles, participants, levels of applicability within the service system;
- core requirements for implementation;
- the evidence base supporting the efficacy of service and care coordination; and,
- The strategies, roles and governance arrangements required.

Additionally, the practice of service and care coordination was examined by reference to the practice skill sets required as well as relevant practice standards and initiatives to support care coordination practice both in Australia and internationally.

Findings of the Literature Review

Many of the concepts of fundamental importance to service coordination remain ill defined, poorly articulated, under-developed and untested. The peer reviewed literature on care coordination in mental health though limited is complex and difficult to understand. It is also often contradictory. The relevance of much of the literature to Australian settings is also difficult to ascertain.

This review revealed an absence of literature about how coordinated care might be enacted in contexts involving cultures and communities where the collective takes on a greater importance. It is likely that the implementation of coordinated care across cultures may require different strategies (Betancourt et al, 2003). To date, the research on coordinated care has not attended to this important area.

Further research is required to address the identified shortcomings and to address the more complicated components of the concept for which knowledge is often assumed or viewed as self-evident.

Though the peer reviewed literature on mental health service and care coordination is limited, there is growing evidence to suggest that collaborative and coordinated care delivers the best quality mental health services.

Further, and despite the identified research shortcomings in relation to a number of key aspects and components of care coordination, a level of guidance was found for the following important areas of service coordination. The learnings in relation to each of these areas form the basis for the model of service coordination introduced in this Executive Summary, elaborated upon throughout this paper and summarised in the table provided as the Appendix *"Model Emerging from the Review of Literature and Jurisdictional Experience")*

Findings of the Review of Jurisdictional Experience

The UK experience with care coordination points to a number of important characteristics that appear to be fundamental to effective implementation. These characteristic include:

- A systematic and not rushed developmental and implementation process;
- Service coordination must carry sufficient 'authority';
- The implementation process must offer a support structure, operational guides and training and ongoing professional development for practitioners; and,
- The system and processes of care coordination must be subject to further development based on evaluative review.

The Victorian Statewide Service Coordination Framework and Strategy in Primary Health Care is one Australian imitative that is inclusive of most of these enabling characteristics.

The New Zealand experience with regional structures for coordinated and integrated health care, possibly points to the imperative of ensuring that the interests of people with mental illness are strongly represented in decision making and resource allocation within these structures. If this does not occur it is likely, given the New Zealand experience, that limited recognition will be given to the care coordination needs of people with mental illness. The New Zealand experience also possibly points to the need for diligence by the community mental health sector in ensuring its place around the decision making tables during the implementation of Medicare Locals – similar structures to the regional coordinating structures in New Zealand.

Much can be learned from the National Care Coordination Trials conducted in Australia in the late 1990s and early years of this century. A number of key learnings are of relevance to today and include the following:

- If trials are to be conducted, they need to be for a sufficient time period.
- Before any trials commence, a training needs analysis in relation to service coordination is required.
- Processes must be in place from the outset for working, training, practice development and ongoing professional development.
- The problems associated with workforce recruitment and retention of staff skilled in service coordination must be identified and addressed to the extent that is possible
- Consideration prior to the commencement of any trial must be given to how workloads can be recognized, adequately resourced and managed.
- Financial incentives and purposively formulated funding models are required to facilitate the coordination of complex service mixes across time, settings and sectors.
- Prior to commencement of any trial s or developmental process, arrangements must be set in place for governance of service coordination.

Finally, the complexity and difficulty of service coordination as both a practice skill set and a method of service delivery must not be underestimated. A realistic appraisal or understanding is needed of the difficulty of moving from conceptual models to implementation of care coordination.

Model of Service Coordination Proposed in this Paper

The review of the literature and of jurisdictional experience with service coordination revealed its complex, multifaceted and multidimensional nature. The model of service coordination provided in this paper seeks to reflect the complex nature of the concept and to provide a guiding platform for the community managed mental health sector in NSW as it seeks to develop its *Service Coordination Strategy.*

Some of the facets and dimensions that are suggested by the research conducted in this study and reflected in the proposed model discussed in this paper include the following:

Guiding framework - comprising aim, definition and guiding principles.

Domains – contingencies that must be considered and which influence the shape of service coordination in particular situations and with particular groups.

Levels – the different levels at which service coordination needs to operate.

Governance and leadership – a framework of rules, practices and processes ensuring accountability, transparency, fairness and safety and quality of service coordination.

Practice and workforce development – processes for embedding the practice skill set required for effective service coordination in the workforce.

Service coordination strategies – the means by which service coordination is achieved including actions, plans, shared tools and instruments, marshalling and allocation of resources.

Within this model, service coordination is viewed as both a practice skill set and a type of service delivery.

Service coordination is viewed as relational and requires strong working relationships between services users and their families, supporters, peers and communities, mental health workers, service provider agencies, funders and policymakers.

Service coordination ensures the right services, at the right time and at the right place and includes:

1. Coordination and management of services that are tailored to meet individual needs, promote recovery, enhance independent living, facilitate social connection, address social disruption and diminished functioning arising from mental illness and assist people to live satisfying lives in the community;

2. Coordination of providers to encourage team work, shared knowledge and expertise, interdisciplinary practice and integrated responses; and,

3. Coordination of service delivery organizations to create an integrated network or service system.

Service co-ordination is particularly important during transitions, such as discharge from hospital to home or transition back into employment, to ensure continuity of care, as well as care that is safe and of a high quality.

Progressing the Service Coordination Strategy

Though the peer reviewed literature on mental health service and care coordination is limited, there is growing evidence to suggest that collaborative and coordinated care delivers the best quality mental health services.

Though the identified research shortcomings in relation to a number of key aspects and components of care coordination could be viewed as a problem for the community managed mental health sector in NSW, it can also be viewed as an exciting opportunity for the sector.

Since there is a level of guidance on key aspects of service coordination in the literature, this provides the sector with the opportunity to be a key contributor to building the evidence and practice base of a type of service delivery that promises to significantly improve the quality and outcomes of mental health care.

This paper, its findings and the suggested initial model of service coordination, provides a level of direction for the sector to collaboratively devise, plan and implement a systematic process as well as further developing service coordination as both a practice skill set and a method of service delivery.

A starting point is discussion of the key areas and components of service coordination identified in this paper.

- Components of a guiding framework;
- Domains or contextual considerations of care coordination;
- Levels at which service coordination needs to occur;
- Governance models and challenges;
- Practice skills and competencies;
- Workforce development requirements; and
- Service coordination strategies.

The sector would be assisted in moving forward on service coordination by scrutinising, studying and discussing the lessons emerging from recent care coordination. Importantly, there is much to be learned from the bold national care coordination trials conducted in Australia from the early 1990s to the early part of this century. The trials, though possibly ahead of their time, reveal the promise and strengths of care coordination as well as its pitfalls, and the challenges it faces in moving from a concept and policy to a practice and a service delivery reality.

2. Introduction

Suzie's Story

Suzie is a 45 year old woman who was placed in foster care after her mother died when she was aged three. Her early placement lasted until the age of eight and a series of placements followed culminating in her leaving 'home' at age seventeen following a period in which she was sexually abused and violently threatened by her foster carer. She lived on the streets for a number of years and throughout her adult life has been transient, never staying in the same place for more than a few months.

She has had numerous admissions to hospital with physical and substance misuse issues, has been involved with many mental health and other emergency services over the years, and four months ago she was diagnosed with bipolar disorder following a psychiatric crisis that resulted in hospitalisation. After discharge she moved yet again.

Suzie first approached No Wrong Door Inc. seeking financial assistance. The multi-problem and precarious nature of Suzie's existence was obvious. However, on this first contact the worker she dealt with was only able to respond to her immediate request for assistance and encourage her to return to see whether further assistance could be provided with Suzie's need for cheaper and more stable accommodation.

Suzie was not easy to engage with the services available to her through No Wrong Door Inc. However, on her second visit and on subsequent occasions on which the worker was able to meet with Suzie on her home turf, introductions were made.

These introductions were assisted by the 'No Wrong Door" ethos and collaborative method of working that had been established in the local health and community services network.

This method of working had been established over time and with great effort but was reflected in the teamwork approach established within No Wrong Door Inc. and in partnership with other agencies whereby the direct involvement of workers able to mobilize a broad range of services, programs and responses could be called upon at short notice and with great reliability.

The method of working was well supported in practice by the joint leadership and commitment of major service providers across the region; by developed agreements and protocols which established the authorization for collaborative working and the ability to pool resources drawn from different funding programs; by years of workforce preparation – training in collaborative working and the establishment of shared supervisory and review mechanisms in particular; and, by the investment which had been made in documenting, evaluating, reviewing and adapting arrangements made over time.

For Suzie, her journey with No Wrong Door Inc. and their local service network meant that, for the first time in her life, she found herself engaged with a network of service which was able to respond to the breadth and depth of her need. She didn't accept this easily. She didn't accept it quickly. But her life definitely improved.

Although emotional wellbeing, mental health, physical problems and social problems are highly interconnected, Australian service systems like many other western systems tend to be structured in ways that inhibit effective coordinated and connected care. For people experiencing mental illness whose needs naturally extend beyond clinical mental health services to an array of other health and community services, navigating the relevant supports can be a challenge. While programs have increasingly been conceptualized to align with this reality, limited or ineffective coordination among service providers places the continuity of care for those with serious illness at risk, contributing to possible deterioration in health status, social functioning, re- hospitalization, housing instability, and the undermining of recovery gains.

In recent times greater understanding and discussion of the interconnection between mental health, physical health and social wellbeing has resulted in attempts to break down the barriers between service systems. As a result, there has been increased involvement of generalist health care providers in mental health as well as providers of housing, employment services, education and training and a host of other support services in the delivery of mental health care. This involvement of a diverse range of service providers has in turn led to a greater emphasis in mental health policy for service coordination and service partnerships.

This emphasis in policy utilises a range of different terms and emphases to promote the common aim of working together to enable the right services to be provided, at the right time, in the right place. An example of this is the interchangeable use of the terms ‘service’ and ‘care’ coordination throughout this Discussion Paper while noting the need to strive to clarify the diverse meanings that these and related words may have for different people who share the common goal of wanting to improve outcomes for people affected by mental illness through integrated and coordinated service delivery.

The introductory section briefly outlines the contextual background to the literature search, the concerns of the community managed mental health sector in sponsoring the review, the review methodology and an outline of the paper.

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National Context and Background

The mental health sector in Australia consists of a complex and increasingly fragmented mix of public/government, private for-profit and not-for-profit non-government community-managed organization (NGO/CMO) service providers with multiple layers of Commonwealth and state/territory government policy, planning, and funding levers. People experiencing mental illness and their families also require services and support from a wide range of other service systems.

This complex mix of service requirements are provided by organizations operating in different locations and settings with different traditions, philosophies and modus operandi and who are increasingly accountable to different levels of government and an to an increasing array of funding programs within each level of government. People with different professional and/or experiential backgrounds whose familiarity with other service systems and sectors varies greatly endeavour to provide the required services. Coordination is made difficult by the boundaries that exist within and between service systems and sectors as well as by the differences between service provider organization and the people providing the services.

The changing nature of the mental health service delivery environment requires that close attention be paid to the knowledge and skills needed to achieve effective and integrated service coordination and care coordination. The increased government interest in service and care coordination is reflected in Action 18 of the Fourth National Mental Health Plan:

> *Improve communication and the flow of information between primary care and specialist providers, and between clinical and community support services, through the development of new systems and processes that promote continuity of care and the development of cooperative service models (2010, p. 40).*

Prior to the Fourth Plan's reaffirmation of the importance of care coordination, the COAG National Action Plan on Mental Health 2006-2011 had also given priority to care coordination. However, relatively poor outcomes were associated with the largely un-funded care coordination priority area. Recent Federal Budget initiatives discussed later in this paper have refuelled the imperative for the community managed mental health sector to take leadership in developing a framework for understanding and implementing effective care coordination.

Relevance to the NSW Community Managed Mental Health Sector

The non-government community managed mental health sector in NSW, like other community sectors throughout Australia, currently find themselves surrounded by rapid and extensive change with implications for how health and community services are to be funded and for how they are to operate. Some of the change and developments have included the introduction of *Better Access to Mental Health Care and Psychological Services* and the announcement of the introduction of Local Health Networks, Medicare Locals, a Preventative Health Agency, e-health infrastructure and the recently announced Australian Government 10 Year Road Map for Mental Health Reform which includes Flexible Care Packages and provisions related to Care Coordination.

Associated with these developments are to be major changes in Commonwealth/State responsibilities and in funding arrangements and models. Though just where community managed mental health services fit into the scheme of things remains unclear, agencies have become increasingly aware that they will be required to work in local partnerships and be a player in integrated and coordinated care locally and regionally; and be able to demonstrate that their services are evidenced-based, locally relevant and provided by staff with appropriate practice skills.

This literature review and study of service coordination relates to progressing Recommendations 3 & 5 of MHCC's 2010 *Sector Mapping Project*:

> ***Recommendation 3:*** *Mental health consumers have access to the range of CMO service types and experience continuity of care between components of the mental health service system.*
>
> ***Recommendation 5:*** *CMOs develop and adopt a Care Coordination Strategy that will promote pathways and linkages across the mental health sector.*

The study seeks to provide guidance to the sector on achieving systems of integrated service delivery and consumer self-directed care with both MHCC member organizations and other stakeholders.

Review Methodology

A comprehensive search of biomedical, psychological and social databases was conducted to find papers published between 1998 and 2011 (May). Databases were selected for their reporting on mental health, primary health, psychosocial, health service and consumer content. Databases used included MEDLINE, Embase, Psychinfo, Cinahl, ProQuest, Sociological Abstracts, Family and Society Plus, Meditext and all Evidence Based Medicine (EBM) Reviews (e.g., the Cochrane library databases) and other evidence based medicine review databases.

Grey literature that could be accessed via the internet was also examined.

Overview of the Paper

This Discussion Paper is divided into three main parts.

1) The first provides an analysis of the concept and practice of service and care coordination in peer reviewed literature.

2) The second provides a discussion and analysis of how service and care coordination has been approached at a number of different jurisdictional levels: national, international and within Australian states and territories.

3) The final section provides a model of service and care coordination that emerges from the literature and from the analysis of jurisdictional experience.

It is hoped that the proposed model will assist the community managed mental health sector in NSW to consider and discuss what service coordination means, and how it might be embedded in both practice and service delivery as well as inform MHCC regarding next steps for the *Service Coordination Strategy*.

3. The Mental Health Peer Reviewed Literature

Introduction

This review of Australian and international literature sought to examine the concept and practice of service/care coordination in mental health as revealed in published academic literature, service reviews and public policy documents. Information was sought on the use of terminology i.e. care coordination and any related concepts; on the way in which 'care coordination' is represented and proposed for action in policy documentation across different jurisdictions; as a collaborative practice concept at the interagency level; as a mechanism for interdisciplinary practice; and as a service delivery tool utilised by practitioners and accessed by clients.

In conducting the review, consideration was given to the use and application of the concept of service and care coordination in health and community service sectors outside of mainstream mental health service provision.

This section of the review commences with a discussion of relevant terminology; considers the concept of service and care coordination as revealed in the literature; identifies the targets, timing, basic principles, participants, levels of applicability within the service system; core requirements for implementation; the evidence base supporting the efficacy of service and care coordination; and the strategies, roles and governance arrangements required. Additionally, the practice of service and care coordination is examined by reference to the practice skill sets required as well as relevant practice standards and initiatives to support care coordination practice both in Australia and internationally. The section concludes with a summary of limitations and gaps in the literature and a brief summary of the areas in which the review found some guidance.

Terminology

Schnapp (2006) described the component parts of the modern community mental health system as: encompassing community (in the sense of catchment or specified geographic area); comprehensive (in terms of range of services available); coordinated (in terms of overarching policy frameworks and management processes); continuity driven (in terms of enabling engagement over time); case management directed (in terms of managing the collaborative and cost effective provision of services across a range of service needs); and, culturally aware and consumer and family sensitive (in terms of responsiveness to different understandings and spectrum of needs).

All of these elements are present in the concerns canvassed within the major mental health service system critiques and policy planning frameworks published over the past twenty years (Human rights and Equal Opportunity Commission, 2005; Mental Health Council of Australia, 2005; Senate Select Committee on Mental Health, 2006; Commonwealth of Australia, 2009).

Within this context and understanding of community mental health, the terms care coordination, continuity of care, case management, managed care, person centred care, self-directed care, shared care, interdisciplinary/multidisciplinary/trans-disciplinary team practice; seamless service delivery are identifiable in the literature as descriptive concepts which appear to have, to some degree, an interrelationship of meaning describing essential elements of the community mental health approach. Each of these concepts, however, can be understood by its usage to individually establish or emphasise different elements of the relationships which exist between consumer/ client/family, practitioner/s; service/ agency/s; funding program/s; and other elements of policy and practice frameworks.

Person-directed or self-managed care – viewed as fundamentally transforming the person/support worker/professional relationship into a collaborative partnership. Thus:

Person-centred care refers to the recipient/s of the care coordination process being identified as the focus for care. This approach to service provision is increasingly evident in the philosophies and practices of disability and health and mental health services worldwide (Imison et al., 2011, p. 2; Glover, 2006).

Continuity of care is a reference to the provision of care over time and across different service providers.

Shared care has been defined as *... the joint participation of primary care physicians and specialty care physicians in the planned delivery of care* (Malinowski et al., 2009). Thus, in this approach to care coordination the range of services involved is limited. In the mental health field in Australia, shared care has also been understood to include shared care arrangements involving primary care physicians and allied health professionals.

Team practice refers to the provision of care services by a unitary team of service providers. The variants in this approach to care coordination include the range of services and professional (or other) care services involved in the team; and the ways in which the team actually works together to achieve a coordinated approach to service (Kuhlmann. 2005; Dyer, 2003).

Case management refers to the idea that care coordination requires someone to 'manage' the provision and receipt of care. Thus, someone must be identified as manager for the process of care planning - identifying care needs and matching need to service availability – and for organising the provision of service and ensuring continuity of care and the best use of scarce resources (Case Management Society of Australia, 2009).

Joined up and seamless care is described by the UK Care Quality Commission as a smoother journey through care. People want the different strands of their care to be properly integrated so that their care feels seamless. They want their journey through the care system to be as simple as possible, and not to be passed 'from pillar to post' before their needs are met. This relies on different services working together in a well-coordinated way that isn't limited by bureaucratic boundaries (2009, p. 12).

Service/Care Coordination can be broadly defined as the: *delivery of systematic, responsive and supportive care to people with complex chronic care needs* (Ehrlich et al., 2009, p. 619). It is likely to involve coordination between a range of care providers including, not only professional service providers but family and friends (Haggard, online). Further components of care coordination are provided in the definition offered by Brown (2009):

> *Care coordination is a client-centred, assessment-based interdisciplinary approach to integrating health care and social support in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care (2009, p. 1).*

Care coordination and integrated service provision are closely linked concepts, which from a 'clinical'/service provider and 'patient'/service user point of view may be indistinguishable.

In this paper, we use integration as the overarching term to denote different ways in which services and practitioners (i.e., both mental health and other health and community service providers) can

work together. Care coordination is used more specifically to refer to particular roles, behaviours or mechanisms that can be used to achieve integration of care (Ham, 2007). Both in the literature and in practice it appears that these terms are commonly used interchangeably. They are also used broadly to depict practitioners and organizations working together to ensure that people experiencing mental illness receive the services they most need. MHCC has a preference for the term 'service coordination' as it is a more neutral term without inference or intonation of the potential for unequal relationships between the service provider and the service user.

How service coordination is achieved varies but has included enhanced communication, the sharing of key aspects of a person's care and support, shared intake, assessment, referral and service planning and review processes, collaborative and joint education and training, and collaborative and joint program and service system planning

As service coordination is relational and involves interplays between services users and their family, friends and supporters, mental health workers, service provider agencies, funders and policy setters, it is important to acknowledge the different perspectives on coordination that ensue.

The Concept of Service and Care Coordination

In a Kings Fund publication Imison et al., (2011) use the phrase '*care coordination through integrated health and social care tea*ms' and describe this concept as person-centred care that is:

> *More coordinated across service settings and over time, particularly for people with long-term chronic and medically complex conditions who may find it difficult to navigate fragmented health care systems (*2011, p. 7*).*

In describing how to do care coordination, Imison et al., suggest that here is no one model of care coordination but that the evidence suggests better outcomes if a number of components are present including a multi-professional team with generalists working alongside specialists, a focus on case-management and support for people in their homes and communities, coordinated assessments, joint care planning, personalised health care plans and shared protocols and clinical records across the multi-professional team and in some instance shared budgets.

From this definition it is clear that service coordination is both a practice skill set and a type or form of service delivery.

MHCC suggest that 'service and care coordination' and their equivalents could include any model or practice that aims to facilitate better outcomes for clients through:

- A person or persons who take overall responsibility for initiating and coordinating the processes, services and resources that assist a person's recovery;
- The process is based on a holistic plan, implementation and review done in partnership with the client;
- The process involves working with a variety of agencies and sectors (as identified in the plan); and,
- Organisational and systemic arrangements to facilitate the above (such as policy, referral pathways, role delineation etc.).

In an Australian study, according to Ehrlich et al., (2009), care coordination heavily relies on complicated concepts such as partnerships, networking, collaboration, knowledge transfer, person-centred practice and self-management support. Ehrlich reports that the literature's analysis and discussion of these concepts is: *relatively superficial with little discussion of the actual practices that might be implemented in order to enact them* (p. 619). After an extensive review of the literature Ehrlich noted that a common understanding of coordinated care is often assumed or

implied and that despite frequent use of the term, the elements that constitute coordinated care remain ill-defined and poorly understood.

> *Indeed, the term 'coordinated care' is used simultaneously and interchangeably to conceptualise structural aspects of care delivery (i.e., what care is provided and when); the process of care delivery (i.e., how care is delivered); the philosophical aspects of care delivery (i.e,. why care is delivered in a particular manner); and, the interpersonal aspects of care delivery (i.e., who delivers care to whom)* (2009, p. 620).

The study by Ehrlich et al., though focusing on care coordination in primary health provides a helpful starting point for better understanding the concept and attributes of coordinated care.

Perkins et al., (2001) similarly argue that given the complexity and confusion surrounding the concept of coordinated care, a much clearer understanding of the roles of the different elements of care coordination is required (p. 169). A number of other commentators agree that because care coordination has rarely been thoroughly examined as either a concept or a practice it has become an all-inclusive and not overly helpful concept (Munn et al., 2003; King and Meyer, 2006).

When and for whom

According to Branca and Lake (2004) and Ehrlich et al., (2009) coordinated care is required when people's service needs are complex and require service delivery from multiple service providers. Whilst Weternberger et al., (2006) and Bowler (2006) emphasize that coordinated care is critical to ensuring the provision of safe, systematic and responsive services for people with long-term conditions and complex service needs.

In relation to people with mental disorders, service and care coordination are essential for those people whose recovery and wellbeing requires treatment, support and assistance from a number of services which will vary according to individual need but might include clinical mental health services, recovery support services, primary health care, specialist health care, housing and accommodation, employment, Centrelink, education and training, child care and family support, Home and Community Care (HACC) and other in-home services. Service and care coordination is particularly important for people with severe and long-term mental illness, comorbidity and/or, co-existing physical health care conditions. It is also important for people with early psychosis and those who are acutely unwell and requiring timely and integrated responses from a number of service providers to stabilize their health and to promote or sustain recovery.

An unresolved dilemma or tension is the relative emphasis given to, on the one hand, service and care coordination as a practice skill set to be practiced with all people; or, on the other hand, care coordination as a type of service delivery for specifically targeted groups, generally people with severe mental illness with complex needs. Currently, it would appear that the latter is emphasized more than the former.

Important principles

Important principles of service and care coordination identified by Imison et al., (2011) include the need to be person directed and driven and tailored to meet individual need so that service provision is engaging of and relevant to the needs of the service recipient. It should also be recovery oriented and socially inclusive so as to direct service outcomes to the person's whole of life well-being, and provided in a culturally appropriate and safe manner, respectful of cultural sensitivities, interpretations and expectations of behaviour, family and community involvements.

People involved

The person experiencing mental illness, their families, significant others and supporting peers are viewed in the literature as key participants in the coordinating service team along with service providers (Segal et al., 2004; Stille et al., 2005; Wertenberger et al., 2006).

Glover (2006) differentiates self-directed care from managed care by the level of responsibility and involvement exercised by the individual targeted by the care management process, in particular, the care planning process. Her critique of care planning practice in mental health reveals varying levels of involvement by the targeted individual relative to those of the service provider. In her typology:

- **Managed care** involves a high level of input and control by the service provider;
- **Person-centred care** provides for input by a service provider, the individual targeted and a range of others, including family, friends, other health and community service providers;
- **Self-directed or self-managed care** involves a high level of input and control by the targeted individual who may choose to involve any of a range of others in the care planning process.

Self-directed care acknowledges the person with mental illness as an active and equal partner in discussion and decisions:

> *We acknowledge that you are in the best position to understand your unique experiences of distress, ultimately contributing to your ability to self-direct your care and self manage (*Glover, 2006, p. 1*).*

The different cultural values and expectations of different population groups will influence whether and who a person wishes to be involved from among their families, friends and other supports both formal and informal. For some people, it will be culturally appropriate for family and/or community elders or leaders to be involved in the coordinating service team (Betancourt et al., 2003).

For care coordination to be effective, sustained partnerships between practitioners, service providers and service users are necessary; the role of 'key worker' or 'care coordinator' is emphasized in the literature; and in instances where a person's illness has resulted in isolation from family and friends, a person may wish to have a peer worker involved in their coordinating service team (Perkins et al., 2001; Shannon 2002; Stille et al., 2005; Wertenberger et al., 2006).

Toward a working definition

Ehrlich et al., (2009) view coordinated care as a core function of team-based primary and community care that:

> *… delivers systematic, responsive and supportive care to people with complex chronic disease care needs and includes: coordination and management of health care services for an individual client to create a comprehensive and continuous experience; coordination of providers to encourage team work and shared knowledge; and, coordination of service delivery organizations to create an integrated network.*

Implicit in this definition is that care coordination needs to operate at the level of service delivery with the person, at the level of teams, whether they be intra-agency, inter-agency or cross-sectoral and at broader service system level. The aim is to ensure the delivery of systematic, responsive and supportive services to a person with complex needs. Thus, care co-ordination is important in ensuring that providers in different parts of the health and social care system work in a 'joined-up' way enabling patients and clients to be cared for in the most appropriate setting. Care co-ordination is particularly important during care transitions, such as discharge from hospital to home, to ensure continuity of care, as well as providing care that is safe and of a high quality. It is also critical in relation to unscheduled and emergency care (Ham et al., 2009, p. 3),

Adapting Ehrlich's definition in relation to people with mental illness with complex or multiple service needs would require the coordination of a broader range of services, i.e., more than just health care services that would include clinical, community support and disability support services tailored to meet individual needs, promote recovery, enhance independent living, facilitate social connection, address social disruption and diminished functioning arising from mental illness and assist people to live satisfying lives in the community (Roberts, 2010).

Levels

Consistent with the conceptualization of Ehrlich et al., (2009), Powell Davies et al., (2006) report that the activities described in the literature suggest that service and care coordination occur at a systems level, a service provision level and a client level. Some of the key concepts discussed in the literature in relation to service and care coordination at each of these levels are outlined below.

Concepts at the level of working with a person

Service and care coordination begin with an assumption that individuals can be assisted to access all the services and care they require across levels and settings at the point and in the locations those services are required – i.e., right services, right place and right time. Important concepts for service and care coordination with an individual person include: person directed and centred service delivery; assessment; planning; monitoring and review; and self-management support and client education.

Important themes and considerations with person-directed and centred care include: advocacy, services matched to individual need, empowerment, support to enable the person to identify goals for themselves, rights-based practice and service delivery and the tailoring of services and how they are delivered to match cultural values and expectations (Segal et al., 2004; Wertenberger et al., 2006; Schifalacqua et al., 2000; Ehrlich et al., 2009).

Ehrlich et al., (2009) report that the assessment process associated with coordinated care is holistic and comprehensive but not well defined (p. 623). Wertenberger et al., (2006) stress the need for reassessment to monitor progress and outcomes and to identify unmet or changing need.

Service and care planning are identified in the literature as being essential to coordinating and engaging an optimal mix of services and treatments to comprehensively address needs (Segal et al., 2004; Morin et al., 2005; Coughlin et al., 2006) and to promoting multifaceted and multidisciplinary service delivery (Rosenthal et al., 2007).

Service planning also includes crisis prevention planning, advanced care directives and developing an emergency response plan (Aiken et al., 2006). The service planning processes and documentation enable efficient and accurate communication between members of the service team (Segal et al., 2004).

Monitoring and review of the service plan and of service delivery of coordinated care is emphasized in the literature and is noted to occur through team meetings, service management discussions and service coordination conferences (Bowler, 2006).

Ehrlich et al., (2009) described self-management support as a further essential aspect of service and coordination (p. 624).

Concepts at the team/service level

Key concepts at the service delivery level of teams, whether they be intra-agency, interagency or cross sector, identified in the literature include a structured framework, guidelines and protocols, effective communication, communities of practice, and flexible service delivery systems.

Ehrlich et al., (2009) suggest that conceptually, service and care coordination cannot occur without structured framework that facilitates the coordinated delivery of services. Their review of the literature led them to conclude that:

> *The optimal method of delivering coordinated care was through a multidisciplinary primary care team that functioned as a cooperative cohesive unit … (to provide visible, transparent, relevant and sustainable care* (2009, p. 624*).*

The importance of the roles and responsibilities of each member of the service coordination team being identified, communicated and understood is emphasized in the literature (Bowler, 2006).

Guidelines and protocols provide an essential operational framework for the multidisciplinary teams and are optimally observed when they have been collaboratively developed (Wertenberger et al., 2006; Rosenthal et al., 2007).

A lynch pin within the care coordination team framework identified in the literature is that of a service or care coordinator who assumes a leadership role (Aiken et al., 2006). Each person is designated a care coordinator who facilitates and oversees timely and integrated responses and ensures that the person is connected to the range of services required.

Ehrlich et al., (2009) also note the literature's emphasis on effective communication and enabling communication processes for promoting cohesion, the sharing of expertise and knowledge, collaborative practice and integrated service delivery (p. 624). The importance of communities of practice for establishing and sustaining service coordination is also highlighted (Wertenberger et al., 2006) and is discussed in more detail in the section below entitled *Practice*.

Finally, service coordination teams need to sit and operate within flexible service delivery systems (Rosenthal et al., 2007) that might be achieved through the establishment of service networks, partnerships, coalitions or alliances (Munn et al., 2003).

Concepts at a systems/sector level

The concept of service and care coordination implies that services and programs are connected and coordinated to form a service system or overarching service network. Ehrlich et al., (2009) note that key concepts or activities required for an effective and coordinated service system include: resource management and alternative, if not innovative funding models, information management, organizational integration and organizational commitment to collaboration (p.265).

Cost effective and enabling funding models, the capacity to leverage resources, fund pooling, resource mobilization and brokerage were among the key elements of resource management identified in the literature (Ehrlich et al., 2009, p. 264-5).

Discussion in the literature of information management and the systems and mechanisms developed to address information needs at all levels and between all players differed according to whether service and care coordination was focused on individual clients, or was focused on

service delivery systems (Munn et al., 2003). The literature outlines some of the ways in which funding decision making processes and models can undermine service coordination, particularly when decisions are made at levels far removed from the point of service delivery. Funding models based on localized decision-making or involving person directed or held funds have sought to augment service coordination processes. Some of these models are discussed below in the sections on experience with service coordination in different jurisdictions.

Organizational integration identified in the literature focuses on streamlining and joining up service delivery across program, organizational and sector boundaries and across locations and sites (Rosenthal, 2007).

Coordinated care was absent unless the people within organizations worked together to deliver the right care to the right person in the right place at the right time (Ehrlich et al., 2009, p. 625).

Core requirements

It is clear from the review of the literature that service and care coordination do not occur without an understanding that no one organization or program can meet all of a person's needs and without a commitment to collaborate at the key levels of:

- Individual practitioner;
- Intra-agency;
- Interagency;
- Cross sector; and
- System wide.

The review of the literature suggests that achieving service and care coordination requires a number of key elements including: organizational leadership demonstrated through an active commitment to work in a coordination and cooperation with others; integrated organizational networks that collaborate the effective, efficient, timely and synchronized communication of information between practitioners and service providers; the management and use of resources in ways which support or leverage buy-in.

Practice development is a further requirement added by Ehrlich et al., (2009):

> *Additionally, providers of coordinated care form cooperative multidisciplinary learning communities of practice that use evidence and communication processes to facilitate timely interactions and flexible care provision. Finally, holistic health, social and risk assessments are used to identify those most in need of coordinated care and to ensure that the care they receive is person centred, relevant, planned, supportive of self-management and is regularly assessed, monitored and reviewed (2009, p. 265).*

A number of commentators stress the importance of self-management to the sustainability of service coordination (Aiken et al., 2006; Bowler, 2006; Ehrlich et al., 2009). For example, one group of researchers concluded that:

> *Coordinated care appears to depend on effective transfer of information and communication, but also on self- management support. Indeed, self-management is perhaps the most important contribution to the provision of coordinated health care over time and across contexts, given that the person with complex care needs is likely to be the only constant element within this constantly changing environment (Ehrlich et al., 2009, p. 625).*

This finding is consistent with the commitment of the community managed mental health sector in NSW to walk alongside people and families experiencing mental illness and support them to work toward their own recovery goals and to have a direct role in service delivery.

Summary of the Evidence Base

After reviewing the literature, Imison et al., (2011) concluded that robust evidence on health and recovery outcomes as a result of service coordination is limited, but that a number of studies show initial evidence that service coordination can improve outcomes and quality of life. Fuller et al.,(2011) in a systematic review of service linkages in primary mental health care (a strategy often identified as being critical to service coordination) reported that most of the evidence supporting linkages was generated from trials of adults with high prevalence disorders (usually depression):

> *These trials reported clinical benefits such as symptom reduction, reduced severity, better treatment response, and improvements in physical and social functioning. Also reported were improvements in service delivery such as targeted referrals, reduced rates of hospitalization and patient engagement with treatment, such as increased use of and self-efficacy with appropriate medication and adherence to other treatments (*2011, p. 7*).*

Fuller et al., (2011) report that there is less evidence about service links for the low prevalence severe mental disorders (e.g., schizophrenia).

> *We found very little evidence in the peer reviewed literature about primary mental health service links outside of the health sector (housing, employment and welfare) which would be most important for the implementation of a recovery model. The recovery model is a treatment concept where a service environment is designed so that patients have primary control over decisions about their own care. While there are evaluations of such linkages in program reports, these have not yet been published in the peer-reviewed literature (*p. 7*).*

They also provide a level of evidence concerning the effectiveness of service linkages in mental health service delivery:

> *The strongest body of evidence was for those interventions that used a combination of broad linkage categories that included at least one component from each of the "direct collaborative activities", "agreed guidelines" and "communication systems" suite. These were associated with statistically significant positive clinical, service delivery and economic outcomes. There was no evidence to support service agreements as either a single strategy or in combination with other strategies. These findings suggest that successful collaborative clinical programs in primary mental health care use multiple linkages that impact on the direct work of clinicians, more so than on management level agreement across services (*p. 8).

Fuller et al., (2011) further reported that in studies where the economic benefits of linkages were examined, just over half of the studies report that costs were either lower or 'acceptably' higher given the additional associated health outcomes and service delivery benefits.

Given the small number of systematic reviews in the mental health literature, the primary health care literature was also examined with findings emerging concerning the effects of coordinated care which included the following:

Improved quality of life and better health outcomes - Improved service and care co-ordination was observed to have a significant effect on the quality of life of the frail elderly and people with multiple long-term conditions (Hofmarcher et al., 2007).

Best quality mental health care – Australian researchers (Hickie & McGorry, 2007) report that there is growing evidence that collaborative service delivery delivers the best quality primary mental health care and services.

Support for vulnerable populations - Service coordination was observed to enable vulnerable populations to be better supported across the care continuum (Dorman Marek et al., 2005).

Reduce duplication and address unmet need - Service coordination was observed to reduce service duplication (Schifalacqua et al., 2000). Some studies concluded that service coordination could assist to promote the identification and subsequent addressing of unmet service needs (Perkins et al., 2001; Segal et al., 2004).

Assist medication management - There was evidence to suggest coordinated care could deliver effective medication management and reduce complication and adverse effects rates, contribute to early detection (Dorman Marek et al., 2005; Bowler, 2006).

Improved service access - Assist to improve service access (Wertenberger et al., 2006).

Reduce relapse and crises - A number of studies suggested that service and care coordination could assist in reducing the number of health crises people experience (Bowler, 2006).

Reduce costs and achieve corporate outcomes - Impacts of service coordination on costs and cost-effectiveness were reported as more difficult to assess and measure and were thought unlikely to be observable in the short-term because of upfront costs and investments (Ehrlich et al., 2009). Despite this, there were a number of studies suggesting that service coordination was associated with lower costs (Singh & Ham, 2005). A number of corporate outcomes were reported to have been observed as a result of using service coordination including for example: better understanding of service demand, reduced hospital admissions, decreased waste and increased capacity to deliver the right services at the right time and place (Wertenberger et al., 2006).

Improved client experience - Importantly, service systems that emphasize continuity and coordination of care were found to be associated with better client experience and with higher levels of client satisfaction (Bodenheimer, 2008). There was also evidence that service coordination promotes independence and self-management (Bowler, 2006; Wertenberger et al., 2006).

Strategies

The review of the literature revealed little peer reviewed research about strategies for service coordination for people with severe and long-term mental illness and/ or with complex needs. Furthermore, most of the peer review research is from the primary health field.

Coordinating and integrating

In a North American study, Kodner (2006) identified a number of strategies that appear to be most helpful in supporting more integrated care at the service delivery level. These are:

- umbrella organizational structures to guide integration at strategic, managerial and service delivery levels;
- case-managed, multi-disciplinary team care, with a single point of contact and coordinated care packages;
- organized provider networks, with standardized referral procedures, service agreements, joint training and shared information systems etc.; and,
- financial incentives to promote buy-in and accountability.

Linkages

One study by Fuller et al., (2011) examined the evidence from peer reviewed literature regarding the effectiveness of 'service linkages' as a strategy for improving service delivery and clinical outcomes and for achieving economic benefits. The rationale for the study was explained as follows:

> *Although mental and physical problems are highly interconnected, western treatment systems tend to be structured in ways that inhibit effective connected care (Unützer et al, 2006).Hence, even though policies continue to emphasize the importance of effective mental health linkages between primary care, specialist and community health services, the form these linkages should take remains unclear. This narrative review was conducted in response to key national government policy priorities relating to the need for improved service linkages in the Australian health care system* (p. 2).

The definition of service linkage provided by Fuller and colleagues is instructive for considering the purview of service and care coordination and the range of stakeholders that need to be involved.

> *1. The linkage is the process used to connect two or more services in the provision of clinical primary mental health care.*
> *2. One part of the linkage must involve a primary health care practitioner such as a GP, community nurse or practice nurse. The other part of the linkage can be any health or human service entity including hospital or community based mental health specialists, private practitioners, or non-health agencies such as housing, education or welfare etc. Linkages must be two-way which excludes a single referral without feedback or continuing relationship* (2011, p. 2*).*

The review further examined 119 studies and found ten linkage types that were thematically grouped into four broad categories of strategies:

> *Direct collaborative activities – e.g., link working, co-location, consultation liaison, shared care management (assessment, review, follow up, linking with other services, defined care pathways);*

> *Agreed guidelines – e.g., protocols for assessment, treatment and referral, stepped care and transitions;*
> *Communication systems – e.g., team/partnership meetings, shared client records, client held records, consistent processes for notifications, standardized letters, referral and reports, templates for meetings, invitations and for recording minutes and outcomes, enhanced referral processes; and*
> *Service agreements – e.g., formalized contracts or funding mechanisms about how services will work together* (2011, p. 3).

The research pointed towards the linkage strategies for which positive outcomes were most commonly associated were care management, enhanced communication, consultation liaison and local protocols (p. 5). As discussed above, this research suggested that the linkage strategies that impact directly on the work of practitioners show greater outcomes than those strategies that are focused on management level agreements across services.

Team building and partnerships

In Glasby et al., (2008), the researchers discussed the importance to coordinated care of the strategies team building and partnership strategies finding that the effective implementation of these strategies requires commitment to shared underpinning ideals of cooperative and coordinated practice. This commitment can be promoted through the fostering of a 'common purpose' and 'collective identity'.

Networks

Fleury et al., (2002) describe the way mental health service networks can offer a means of developing a system of coordinated care for people with severe and long-term mental illness. Mental health service networks are described as a set of organizations and the relationships between them that act as channels through which communication, referrals and resources flow which then provide guidelines and processes for their staff to work with each other in a coordinated fashion. Wiktorowicz et al., (2010) describes the goal of mental health service networks as being to develop:

> *…virtual 'programs of care' by coordinating primary, secondary, tertiary health and social services to simplify clients' access to them* (2010, p. 2).

By 'virtual programs of care' the researchers mean that services and assistance required by a person and assembled around that person irrespective of where or at what point the person enters the service system. Researchers (including Fleury et al., 2002 & Wiktorowicz et al., 2010) argue that network coordination, though often assumed to be simple, is complex and difficult as it involves translating policy into activities with both the people requiring services together with the different mental health and community workers involved with service delivery. Compounding the complexity is the coordination needing to be mediated and effected both within individual organizations and their programs and teams as well as across numerous organizations.

Wiktorowicz et al., (2010) report that a major challenge confronting service networks is establishing appropriate and strong governance arrangements that are suited to local community infrastructure and traditions and to local service configurations and contingencies. Without attention to governance, the researchers suggest that the service network will not be sustainable and will fail in achieving coordinated and integrated service delivery.

Strategies at the service provider and individual client level

Powell Davies et al., (2006) from the University of NSW conducted a systematic review of the literature focusing on strategies of coordination of care within primary health care and other sectors in Australia in a number of comparable countries including: the United States of America, Canada, the United Kingdom, the Netherlands and New Zealand. Most primary studies were concerned with one of three areas of health care: chronic diseases (cardiovascular disease, diabetes, asthma, chronic obstructive pulmonary disease and AIDS/HIV - 38.9%), mental health (including substance abuse - 28.2%) and aged care (including palliative care - 17.6%). The greatest number was concerned with the interface between primary health care and a specialist provider or service (47%). A number of studies also covered the interface between primary health care and hospitals and the linkages between providers or services located within primary health care.

Strategies identified for service and care coordination at the service provider and individual client level fell into two main groups. The first relates to processes used by clinicians or program staff to coordinate care. These included communication between service providers, support for service providers and support for the person. These varied in formality: for example, communication ranged from regular and formal case conferences to an expectation that members of a specialist team would keep the GP informed of progress and changes in care.

The second group of strategies related to structural arrangements that were put in place to support these coordinating activities. These included the use of systems to support coordination (for example: shared records, templates for communication or consistent decision support), structuring the relationship between service providers and/or the roles and responsibilities they had in providing care (co-location, case management, multi-disciplinary teams or assigning a patient to a specific primary health care service provider) and the coordination of clinical activities to promote continuity of care, including shared assessments, joint or coordinated consultations and arrangements for patients to have accelerated access to services (p. 33).

Outcomes were assessed in terms of the percentage of studies reporting health or patient satisfaction outcomes that had significant positive results. In terms of health outcomes, the most successful studies were those addressing relationships between service providers, arrangements for coordinating clinical activities and use of systems to support coordination. For individual satisfaction, the most successful were those addressing relationships between service providers, support for clinicians, communication between service providers, and support for each person.

Powell Davies et al., (2006) went on to suggest the following opportunities for supporting successful strategies for coordinating care in Australia:

- Supporting coordination of clinical activities.
- Developing service networks and arrangements for improve access to allied health and other community based services for early intervention and prevention.
- Strengthening relationships between service providers and developing stronger service networks.
- Co-locating general practice and other services, and investing in the systems to support coordination of care between co-located systems.
- Adopting shared or common tools, instruments or systems to support coordination of care.
- Further developing tools (e.g., common assessments, care plans, decision supports) that can be used by a range of providers across both national and state funded services and integrated in the care provided by different services.

The research also emphasized the importance of effective and efficient systems for communicating or sharing information between collaborating service providers and indicated the possible need for administrative or corporate structures, particularly at a local and regional level that are able to develop processes and systems enabling and supportive of coordination.

Roles

An important role of service coordination discussed in the peer reviewed literature is that of 'care coordinator'. Goodwin et al., (2010) in reviewing the role of care coordination in the UK Care Programme Approach (CPA, discussed further below) describe the role as including: the collaborative development of a care plan with each individual and with colleagues and other services; ensuring consistency with any specialist service care plans; overseeing the delivery of the multidisciplinary care set out in the care plan; measuring outcomes; and, reviewing plans with each person and with colleagues and service partners as necessary (p. 5). The CPA experience demonstrated that care coordinators require two complex skill sets:

> *…skills and competencies to act both as care managers to individual patients (with often very complex and challenging needs) as well as have the power to exert the authority to ensure that care plans are implemented (*Goodwin et al., 2010, p. 8*).*

Goodwin and colleagues make the point that available evidence suggests that managing across networks of diverse providers to create an integrated care package is problematic because care coordinators often lack the power or authority to mandate or sufficiently coordinate care delivery amongst other agencies:

> *The role requires coordinators to be developed as skilled professionals, properly financed and supported, with access to appropriate and timely information* (2010, p. 8).

Crucially and according to Goodwin et al., in an earlier publication, the role requires an ability to wield financial incentives available to gain responsiveness from care providers (2004).

in reviewing the evidence about effectiveness of service linkages in mental health care, Fuller et al.,(2011) found that where studies assessed service delivery outcomes, the benefits over the long-term were attributed amongst a number of factors to the role of case manager or care coordinator who had access to 'expert supervision' (p. 8).

Other important roles in service coordination include practice leaders and supervisors, liaison and partnership building and partnership managers. Guidance about these roles, their characteristics, impacts and the circumstances under which they effectively contribute to service coordination could not be found in the peer reviewed literature.

Governance Models

Wiktorowicz et al., (2010) in reviewing publicly commissioned reports found mental health care coordination in Canada insufficiently established to achieve and ensure the continuity of care, arguing that a weak link has been the governance arrangements for service integration and coordinated care. They suggest that current conceptualizations of mental health service networks would benefit from a greater understanding of the governance processes that foster inter-organizational coordination.

Wiktorowicz et al., (2010) proposed three different types of governance arrangements to support care coordination through service networks:

Mutual adjustment is based largely on voluntary exchanges (e.g., client referral) between pairs of organizations, but no formal mechanism of coordination;

Corporate structure involves an overarching formal authority that integrates management and care (e.g., through control of psychiatric hospitals and community mental health centres); and,

Alliance involves autonomous agencies who form a coalition. The level of coordination is more formalized than in mutual adjustment, but the member agencies retain their autonomy (2010, p.2).

Provan and Kenis (2007) propose a similar but alternative set of governance arrangements:

- *shared* governance mode, where all network organizational members participate directly in network level management and strategic decision-making;
- *a brokered* governance form involving a dominant or *lead organization* that takes on the central role in network level management; and,
- a second and different brokered governance mode centred on a separate *network administrative organization* (NAO) formed by network participants to coordinate and manage their collective efforts (pp. 233-237).

They suggest that the NAO may be:

> *Modest in scale, consisting only of a single individual, often referred to as the network facilitator or broker, or it may be a formal organization, consisting of an executive director, staff, and board operating out of a physically distinct office (*2007, p. 236*).*

They continue to propose that four key structural and relational contingencies determine the effectiveness of shared governance:

> *The level of trust between the participating organizations;*
> *The size of the network or the number of organizations involved with service coordination;*
> *The level of goal consensus among the participating organizations; and*
> *The need for network-level competencies (i.e., external demands for effective coordination (*2007, p. 237*).*

Depending on the circumstances and contingencies, these conditions can influence inter-organizational solidarity and coordination or fragmentation. The challenge in governing networks or care coordination is to determine the model of governance most suited to the situation and that will lead to participating organizations engaging in collective and mutually supportive action in which conflicts are addressed and network resources are used effectively and efficiently.

Wiktorowicz et al., (2010) in their research sought to clarify the conditions under which certain governance models and instruments are more likely to support coordination than others. They found that in mental health service networks whose key informants indicated progress was made in coordinating services, the predominant governance model was a network executive committee with representation from local organizations through which consensus was attained and decisions were made. The researchers outlined their conclusions:

> *A corporate structure supported by regionalization offered the most direct means for local governance to attain inter-organizational collaboration. The likelihood that networks with an alliance model developed coordination processes depended on the presence of the following conditions: a moderate number of organizations, goal consensus and trust among the organizations, and network-level competencies. In the small and mid-sized urban networks where these conditions were met their alliance realized the inter-organizational collaboration sought. In the large urban and rural networks where these conditions were not met, externally brokered forms of network governance were required to support alliance based models* (2010, p.1*).*

A number of studies have reported that governance of large metropolitan networks faced even more complex challenges. First, maintaining communication and coordination among a multitude of organizations was more difficult. Secondly, the larger the number of participating organizations the more difficult it can be to develop and maintain effective working relationships with staff turnover being one important factor. Thirdly, the greater the number of players the greater the diversity of cultural and philosophical perspectives and the higher the likelihood of divergent views remaining and goal consensus and trust being weaker (Bodenheimer, 2008; Wiktorowicz et al., 2010; Provan & Kenis, 2007).

Interestingly, Wiktorowicz et al., (2007) found that the presence of a psychiatric facility or a large clinical mental health service within a network could make service coordination more complex, possibly because the operating environment of large organizations of any type is less conducive to community building. Their size, diverse programs and services make it possible or easier for them to disengage from service networks and coordination building exercises.

Provan and Kenis (2007) provide insight into a number of common governance tensions faced by organizations who are seeking to provide coordinated care through service networks or partnerships. The tensions identified and discussed by the researchers are: efficiency versus inclusiveness; internal legitimacy versus external legitimacy; and, flexibility versus stability (2007, pp. 242-246). They discuss examples of the effects of the interplay of these tensions:

> *For example, if a network is highly inefficient or lacks internal legitimacy over an extended period of time, participating organizations will be likely to drop out of the network or greatly reduce their involvement and contributions. Alternatively, if a network is stable but not flexible, its capacity to perform key functions, like integrating service provision or comprehensive project planning, is likely to decline, especially as critical environment conditions change and as new members join (*2007, p. 246*).*

Governance arrangements are clearly key to service and care coordination. Participating organizations as part of the governance processes they set in place to support care coordination, must recognize and manage any resulting tensions.

A further important consideration is how governance arrangements might evolve over time or have change thrust upon them. Although there is little peer reviewed literature concerning how governance arrangements in care coordination networks evolve over time, organizations need to be open to the possibility that change in governance might occur or be required.

Practice

As stated above, service coordination as well as being a type of service delivery is also a set of practice skills. Though there are a number of publications outlining and discussing mental health practice standards and competency frameworks in Australia and internationally that include sections on care coordination or service integration, there is an absence of peer reviewed literature concerning the sets of practice skills that are required for effective care coordination. There is also scant research concerning the sets of skills that are more important at different service delivery levels, in different settings, with different population groups, different professional groupings and with organizations from different service sectors and systems. There is also little peer reviewed literature about how those working with people experiencing mental illness might be supported to develop the necessary practice skills for effective care coordination. Also missing is research concerning the perceptions of service users about which skills and attributes make a difference to both their experience of service delivery and its outcomes.

Herrick and Arbuckle (2006) make the point that coordinated care requires collaborative and interdisciplinary practice. However, each discipline has traditionally been educated and trained separately from each other resulting in interdisciplinary practice being frequently discussed but infrequently taught or practiced. Although there are expectations that mental health workers will practice collaboratively, and despite assumptions that interdisciplinary practice is the norm, it remains difficult to accomplish and many mental health workers continue to struggle with it. Reasons for this struggle identified by Martin-Rodriguez et al., (2005) include different language, jargon and views about appropriate service responses that can lead to misunderstanding, conflict and distrust. A further reason arises from the difficulty practitioners experience in putting to one side their traditional boundaries and developing a mutual regard for the roles and expertise of team members from other disciplines.

Interdisciplinary practice requires strong interactional skills that for many take time to develop. Rossen et al., (2008) describe some of the key skill sets:

> *Good interpersonal skills are vital, including good communication skills to convey clear messages and good listening skills to understand different perspectives. Team members also must have negotiation skills, as well as willingness to compromise. Team members should value diversity and accept individual differences, including talents and limitations. To be effective team members, participants must also be aware of their own talents and limitations, as well as their biases* (Bope and Jost,1994; Bronstein, 2003; Herrick et al., 2006).

Interdisciplinary team members need to understand group dynamics, and attention must be paid to the group process to foster effective functioning. At times during the developmental process the team may experience rough periods. An understanding of the various stages of group development will support team members' commitment to the goals and purposes of the group, so that frustrations are overcome by a shared vision of improving care for patients and families (Bope & Jost, 1994).

Rossen et al., (2008) argue that because interdisciplinary practice 'doesn't just happen' or come naturally for participants, it is imperative that interdisciplinary practice be emphasized during the education and training of community and health care workers. Florence et al., (2007) suggest that the benefits of interdisciplinary collaborative practice being taught in education and training programs include more positive attitudes and greater commitment to interdisciplinary collaboration and a conviction among practitioners that interdisciplinary practice is not only essential but that it is eminently possible.

Practice skills required for effective care coordination including interdisciplinary practice have been outlined to varying degrees in recently developed competency frameworks. Relevant practice standards or competency frameworks both in Australia and internationally are discussed in the following sections.

Relevant Australian mental health practice standards

A relevant standard from the Australian National Practice Standards for the Mental Health workforce (2002) is Standard 8 – Integration and Partnership:

> *Mental health professionals promote the integration of components of the mental health service to enable access to appropriate and comprehensive services for consumers, family members and/or carers through mainstream health services. They provide continuity of care through integration and partnerships with other health service providers and a range of other organizations to ensure the needs of consumers, family members and/or carers are met (*2003, p. 28*).*

The standard outlines the capabilities required by mental health workers in the following broad terms.

> *Mental health professionals demonstrate an ability to:*
> *assist managers of services in implementing policies, procedures and protocols aimed at effective integration of specialist mental health services to develop partnerships between mental health services and a range of other service providers and organizations;*
> *actively support consumer and carer networks and self-help support groups;*
> *practice in partnership with general practitioners and the primary health care sector;*
> *link with and support emergency services to ensure the safety and care of consumers, their children and other family members and/or carers;*
> *utilize and work with specialist services for all age groups and with other support and welfare services provided by a range of organizations;*
> *communicate effectively with other organizations and service providers and refer consumers, family members and/or carers to appropriate individuals, organizations or services, where applicable* (2003, p. 29*).*

The 'Partnership and Communication' content of the over-arching 'Principles of Recovery Oriented Mental Health Practice' in the Australian National Standards for Mental Health Services (2010, p. 43) are also relevant.

> *Recovery oriented mental health practice:*
>
> *acknowledges each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them*
> *values the importance of sharing relevant information and the need to communicate clearly to enable effective engagement*
> *involves working in positive and realistic ways with individuals and their carers to help them realize their own hopes, goals and aspirations.*

Both of these descriptions are broad and general and do not break the requirements down into sets of skills, knowledge and attributes. The existing Australian frameworks for mental health practice and service standards and the peer reviewed literature frequently assume common or shared knowledge and understanding of the skills involved with key care coordination tasks

including ‘practising in partnership’, ‘linking with other services’, ‘utilising and working with other services’, ‘negotiate with service partners’, ‘collaborating’, ‘liaising’ or ‘sharing relevant information’.

Importantly, despite this assumed knowledge base evident in literature and practice frameworks, and contrary to that assumption, the Community Services and Health Industry Skill Council’s Environmental Scan 2011 (p.14) identified service coordination as a discrete skill and practice set which is not well-embedded or supported in training and practice. It also noted that a new national mental Health Workforce Strategy and Plan is under development.

Relevant mental health practice standards and frameworks internationally

The UK National Occupational Standards in Mental Health (2003) provides more detail than the Australian Mental Health Practice Standards about the actual practice skills relevant to care coordination, if only at the level of individual service delivery. The relevant occupational standard is Standard N - *Influence the way in which organizations and agencies interact to the benefit of those who use mental health services.* It lists the following practice skills.

Enable workers and agencies to work collaboratively (N1)

- Enable workers and agencies to understand their respective contributions and recognize areas of mutual interest and benefit
- Support collaborative work between workers and agencies
- Enable workers and agencies to evaluate the effectiveness of collaborative work

Develop, sustain and evaluate collaborative work with others (N2)

- Explore and assess the potential for collaborative working
- Initiate and develop collaborative working relationships
- Sustain collaborative working relationships and arrangements
- Review and evaluate collaborative working

Develop and sustain effective working relationships with staff in other agencies (N3)

- Develop effective working relationships with staff in other agencies
- Sustain effective working relationships with staff in other agencies

Work with others to facilitate the transfer of individuals between agencies or services (N4)

- Implement agreed referral procedures
- Work with others to evaluate and improve referral processes and outcomes

Assist in the transfer of individuals between agencies and services (N5)

- Support individuals as they prepare for transfer
- Make agency preparations for individuals’ transfer
- Supervise individuals during transfer

Represent one’s own agency at other agencies’ meetings (N6)

- Obtain information from other agencies’ meetings
- Make contributions to other agencies’ meetings

Lead the development, implementation and improvement of inter-agency services for addressing mental health needs (N7)

- Lead the development of inter-agency services for addressing mental health needs
- Monitor, evaluate and improve inter-agency services for addressing mental health.

A related competency framework in the UK is the Ten Essential Shared Capabilities (ESC): A Framework of the Whole of the Mental Health Workforce (Hope, 2004). A capability of relevance to service and care coordination is ESC 1 which is described as follows:

> *Working in Partnership. Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in care.*

This capability requires the engagement of all involved in receiving or providing mental health care, maintaining those relationships and bringing them to an appropriate end. The person and their families are viewed as active partners as against passive service receivers. This capability requires multidisciplinary teamwork, cross boundary work and work with wider community networks.

In order to demonstrate this capability, the ESC states that mental health workers will often be required to be assertive in their engagement with and follow up of service users, particularly for those with more complex problems.

The ESC outlines the practice skills required to work in partnership:

> *Have the ability to explain in an understandable way, their professional role and any parameters that they work within*
> *Have the ability to communicate with all the stakeholders involved in an individual's care*
> *Understand their role and that of others within a multidisciplinary setting*
> *Be able to engage service users in a collaborative assessment process*
> *Acknowledge the part that families and carers play in the service users support network and be able to engage them as partners in care*
> *Be able to communicate across disciplinary, professional and organizational boundaries (*2004, p. 13*).*

Together, the Occupational Standards in Mental Health and the Partnership ESC begin to create a shared language, understanding and acknowledgement of the common set of purposes and practices that lie at the heart of working in partnership, a key requirement for service coordination.

One competency framework dealing specifically with care coordination is the Care Coordinating Competencies and Functions of the UK Care Program Approach (CPA; Hardcare, 2008). However, the skills outlined are general ones and do not provide detail on the skills required for coordinating care and for working in an integrated way with other service providers.

Overall, the three UK mental health practice frameworks outlined offer a basis for identifying and further developing key competencies required for individual practitioners working within a care coordination paradigm.

Initiatives to promote coordinated care practice skills in mental health

An example of mental health initiative that sought to promote practice skills required for collaborative and coordination is the Australian National Institute of Clinical Studies (NICS) sponsored Mental Health Emergency Care Interface Project. This project was established in 2003 to:

> *…help connect the wide range of clinicians and health managers involved in the delivery of emergency care. It provides a mechanism through which health professionals can share their knowledge of how to effectively close evidence-practice gaps and improve patient care* (NICS, 2006, p. 36).

The aim of the project was to improve the processes of collaborative care based on best available evidence for people presenting to emergency departments with a mental health problem. The project focused on improving the processes and practices of care from the point of referral through to a plan of management for discharge from the emergency department in collaboration with community, primary care, mental health and tertiary care services. The project used the concept of 'Communities of Practice' to denote these collaborative processes and shared practices. The concept of 'communities of practice' was first posited by Wenger (1998) and was defined as:

> *…networks that have been established to increase and promote the sharing and use of information and problem solving in groups with a common interest; groups who do similar tasks, have similar issues and are faced with similar problems* (p. 12).

The objectives of the communities of practice in the Mental Health Emergency Care Interface Project included: assisting the uptake of evidence-based practice in emergency care; providing access to evidence-based research information and practical solutions relevant to emergency care; identifying and working on common challenges facing the emergency care environment (e.g., improving care for mental health patients); and developing processes for making best use of good quality clinical care data.

Key elements of the mental health emergency community of practice were:

- Leadership to champion the community of practice;
- Having an identity the community can relate to, e.g., emergency care;
- Providing a range of opportunities to be involved;
- Making it easy to participate in the community of practice;
- Being responsive to the issues facing the local community; and,
- Sharing a common interest, e.g., improving emergency mental health care.

This conceptual approach emphasises the work-in-progress and ongoing nature of the task of improving the quality and safety of emergency mental health care and of developing and embedding evidence-based practice. This approach is useful for the development of practice skills for care coordination and collaboration more generally as it emphasises working relationships at both a practice level and an organisational level, between all agencies and staff involved with managing and responding to mental health emergencies within a local area. The focus on those with a common interest in improving coordinated care requires the inclusion of the very people who may require that care, their families and their representatives, into the local community of practice. The concept of communities of practice also implies that the service responses, partnerships, strategies and solutions developed will be locally determined and will vary from area to area in response to different local circumstances, needs and service contingencies change.

A further initiative that has focused on specifically developing and promoting collaborative and interdisciplinary mental health practice is the establishment of the Mental Health Professional

Network (MHPN) with funding from the Australian Government. The MHPN has been responsible for promoting interdisciplinary communication and networking between psychiatrists, general practitioners, psychologists, mental health nurses, social workers, pediatricians and occupational therapists to achieve its aim of increasing collaborative mental health care. The Centre for Health Policy, Programs and Economics (CHPPE) at the University of Melbourne was contracted by MHPN to undertaken an independent evaluation of MHPN's activities from July 2009 to June 2010 (Fletcher et. al., 2010).

The evaluation report states that the MHPN has sought to promote interdisciplinary practice through activity in three inter-related areas:

> *… running interdisciplinary workshops, supported by education and training materials; fostering ongoing, self-sustained interdisciplinary clinical networks; and hosting a website and web portal (MHPN Online) and a 1800 phone line. To date, much of its effort has involved rolling out interdisciplinary workshops across the country. It ran almost 1,200 initial workshops (30% in rural areas) from March 2009 to July 2010, yielding 14,993 attendances by 11,930 unique individuals from a range of professional groups.*

The evaluation report further concluded:

> *MHPN has, as yet, really only had the opportunity to 'scratch the surface' in terms of promoting interdisciplinary collaboration. There is a good case for the continuation of MHPN. The emerging networks are not yet sustainable and further support from MHPN is necessary for them to 'stand on their own two feet.*

The evaluation suggested that the MHPN should concentrate its immediate efforts on consolidating existing membership of existing networks, but ultimately it might expand its activities to creating bigger and more numerous networks, possibly with a broader mix of private and public mental health professionals. It should explore different models, systems and processes of networking that may work best in particular circumstances. It should also continue to develop and implement MHPN Online as a tool to keep mental health professionals engaged. Paid network/and or regional coordinators will also be necessary if the emerging networks are to avoid floundering.

This focus on skills development by the MHPN is an important development in the establishment of collaborative practice. However, it is narrowly focussed on a part only of the broader workforce development requirements identified by the Community Services and Health Industry Skills Council's Environmental Scan 2011.

Limitations of the Literature

This analysis has revealed an absence of literature about how coordinated care might be enacted in contexts involving cultures and communities where the collective takes on a greater importance. it is likely that the implementation of coordinated care across cultures may require different strategies (Betancourt et al., 2003). To date, the research on coordinated care has not attended to this important area.

Many of the concepts of fundamental importance to service coordination remain ill defined, poorly articulated, under-developed and untested. The peer reviewed literature on care coordination in mental health though limited is complex and difficult to understand. It is also often contradictory. The relevance of much of the literature to Australian settings is also difficult to ascertain.

Further research is required to address the identified shortcomings and to address the more complicated components of the concept for which knowledge is often assumed or viewed as self-evident.

Summary

Though the peer reviewed literature on mental health service and care coordination is limited, there is growing evidence to suggest that collaborative and coordinated care delivers the best quality mental health services.

Further, and despite the identified research shortcomings in relation to a number of key aspects and components of care coordination, a level of guidance was found for the following important areas of service coordination:

- Components of a guiding framework;
- Domains or contextual considerations of care coordination;
- Levels at which service coordination needs to occur;
- Governance models and challenges;
- Practice skills and competencies;
- Workforce development requirements; and,
- Service coordination strategies.

The learnings in relation to each of these areas form the basis for the model of service coordination proposed in this paper. These learnings are further informed by review of jurisdictional experiences with service and care coordination which is considered next.

4. Jurisdictional Experiences of Care Coordination Practice

Service and care coordination is both a policy and a practice concept. Supportive policy frameworks are a requirement for underpinning the development and implementation of effective practice. This section of the review examines those frameworks as they exist at national and state level across Australia and internationally.

National Level

Fuller et al., (2011) summarize historical developments in the Australian national mental health planning process from the focus on mainstreaming of mental health services emphasised in the First National Mental Health Plan in 1992 to a growing acknowledgement of the need for 'partnership' and care coordination involving different health and human service sectors.

> *The first Australian National Mental Health Policy in 1992 set out to move care from institutions to mainstream health and welfare services. Since that time the importance of partnerships between different health and human service sectors has been promoted. The 1998 Second National Mental Health Plan and the 2004 Australian National Mental Health Strategy called for joint planning, coordination of services and the development of links between different providers. This was further articulated in the Council of Australian Governments (COAG) National Action Plan for Mental Health and most recently in the Fourth National Mental Health Plan. In 2009 the Australian National Health and Hospitals Reform Commission reported that access to and collaboration between support services are key to recovery and self-determination for people with mental illness* (p. 1).

This section outlines some of the major points along the journey of service and care coordination at a national policy level.

COAG Care Coordination Initiative

The COAG National Action Plan on Mental Health committed to a system of coordinated care: *for people with severe mental illness and complex needs who are most at risk of falling through the gaps in the system.*

The system for 'linking care' involved a 'clinical provider' and a 'community coordinator' either of whom could be drawn from Commonwealth or State funded health and community services. The purpose of these new arrangements was:

> *… for people with a mental illness (to have) the ability to better manage their recovery by giving them clear information on who is providing their care, including information on how to access 24-hour support, and who can help link them into the range of services they need. It was aimed at encouraging communication across professional boundaries, across programs funded at Commonwealth and State level and at ensuring continuity between different clinicians when one is relinquishing their role to another* (COAG, 2006, p,5).

COAG developed Principles and Implementation Guidelines Underpinning the Care Coordination Model (2007). The strategies outlined for the implementation of care coordination by COAG were to include the following:

Strategies for effective implementation of care coordination are a responsibility at either jurisdictional or local level and should include (p. 2)*:*

At jurisdictional level

Identifying the target population *– and establishing eligibility criteria.*

Identifying existing models/frameworks *that support care coordination at the local jurisdictional level – this could include identifying appropriate community coordinators, clinical providers and appropriate services available for coordination.*

Developing or reviewing existing jurisdictional/local relationships and service provision, *including arrangements for communication, particularly those pertaining to key transition points. New relationships and arrangements may need to be established with a broader range of services.*

Identifying services and referral pathways *– this may include a range of Commonwealth and State/Territory funded clinical and non-clinical services, which may meet the needs of the target population.*

Monitoring and evaluation *- development of a consistent State/Territory based framework for reporting on the nature of services and coordination.*

At the local level

Establishment of local working groups *to prepare, implement and promote system changes.*

Establish processes for improving and supporting access *– may include establishment of local arrangements for supporting the appropriate model of care and building upon existing infrastructure and services.*

Establishment of a Recovery/Care Plan *– all eligible individuals will have a recovery/care plan. The plan should include the following elements:*

- *Identification of a care coordinator – client orientation would include information on client's goals and preferences in deciding on a care coordinator*
- *Identification of clinical care provider/s*
- *Clarification of roles and responsibilities*
- *Identification and prioritizing service requirements to best meet the recovery needs of clients*
- *An emergency plan*
- *A review process*
- *An agreement with the client that information be shared, as required, in order to produce a relevant and appropriate plan*

Each Australian jurisdiction was responsible for developing their implementation plan and strategy for this initiative. No funding was allocated in the COAG Plan for the care coordination initiative. Some state governments provided additional funding for implementing care coordination. For example, the Queensland Government allocated $4.8 million for 20 Service Integration Coordinator positions to support the implementation of care coordination locally, as well as a full-time position with the COAG Mental Health Committee to drive the initiative statewide. These positions were not to be case managers and the incumbents were not intended to have contact with individual consumers participating in the program. Rather the coordinators were for engaging existing government, non-government and private sector local service providers to actively participate in the care coordination model.

In 2008, the Australian Senate Standing Committee on Mental Health in reviewing the implementation of the COAG Coordinated Care initiative concluded that:

> *The evidence to the committee indicates that despite the efforts made under the COAG Plan, coordination of mental health care in Australia remains inadequate…*
> *By including 'Care Coordination' as a flagship initiative, the COAG Plan took an important step in recognizing that funding more services is not the only element to improving mental health care in Australia. Making sure that services fit together in response to individuals' needs and circumstances is equally essential. On the basis of the evidence given to the committee, care coordination is one of the lesser developed concepts in the COAG Plan. Its fit with other initiatives such as PHAMs and the likelihood of comprehensive implementation, without any specific funding, is not clear.*
> *(http://www.aph.gov.au/senate/committee/clac_ctte/mental_health/report/c03.htm)*

The Committee also concluded that as well as the Commonwealth not having provided additional funds for care coordination, a further complicating factor was the different approaches being taken across the states and territories.

Fourth National Mental Health Plan

Priority Area 3 of the Fourth National Mental Health Plan focuses on service access, coordination and continuity of care. Some of the proposed actions of relevance to service and care coordination include:

- The establishment of regional partnerships of funders, service providers, consumers and carers and other relevant stakeholders to develop local solutions to better meet the mental health needs of communities;
- Improved communication and the flow of information between primary care and specialist providers, and between clinical and community support services, through the development of new systems and processes that promote continuity of care and the development of cooperative service models.
- Work with emergency and community services to develop protocols to guide and support transitions between service sectors and jurisdictions.
- Improve linkages and coordination between mental health, alcohol and other drug and primary care services to facilitate earlier identification of, and improved referral and treatment for, mental and physical health problems.
- Develop and implement systems to ensure information about the pathways into and through care is highly visible, readily accessible and culturally relevant.

Further proposed action is the better targeting of services and addressing service gaps through cooperative and innovative service models for the delivery of primary mental health care.

National Standards for Mental Health Services

The revised National Standards for Mental Health Services (2010) contain a number of provisions that are relevant to service coordination including the following.

Standard 6: Consumers - Consumers have the right to comprehensive and integrated mental health care that meets their needs and achieves the best possible outcomes in term of their recovery.

Standard 8: Governance, leadership and management - The mental health service is governed, led and managed effectively to facilitate the delivery of quality and coordinated services.

Standard 9: Integration - The mental health service collaborates with and develops partnerships within its own organisation and externally with other service providers to facilitate coordinated and integrated services for consumers and cares.

Implementation Guidelines for Non-government Community Services (2010) accompany the Standards. Guidance is provided for continuity and coordination of care, support for interdisciplinary teams, collaborative planning, and links with primary health care providers; each of which are stated as being *'partially applicable to the sector'.* Guidance is also provided for interagency and inter-sectoral links, which in contrast, is considered to be *'applicable to the sector'.*

It appears that published national standards and guidelines applicable to care coordination in Australia offer little practical assistance related to their implementation and ongoing application and incompletely address the comprehensive range of stakeholder involvements, responsibilities and relationships.

National Primary Health and Health and Hospitals Reform Agenda

In an effort to address the fragmented nature of the primary health care and hospital systems in Australia, the Australian Government is pursuing two major initiatives that if implemented will reshape how health care is funded and delivered. The first of the initiatives, the Health and Hospitals Network has largely stalled but the second initiative, Medicare Locals, a national network of primary health care organizations, is proceeding. A small number of Medicare Locals will start operating by mid-2011. The remaining Medicare Locals will start operating by mid-2012.

The description of Medicare Locals provided by the Australian government is as follows.

> *Medicare Locals will be independent legal entities (not government bodies) that have strong local governance, including broad community and health professional representation, plus business and management expertise. They will have strong links to Local Hospital Networks, local communities, health professionals and service providers including GPs, allied health professionals and Aboriginal Medical Services.*
> *Medicare Locals will be responsible for providing better integrated care, making it easier for patients to navigate the local health care system. The roles of these organizations could include:*
>
> *Facilitating allied health care and other support for people with chronic conditions;*
> *Working with local health care professionals to ensure services are integrated and patients can easily access the services they need;*

Planning to ensure the availability of face-to-face after hours services for their region;
Identifying groups of people missing out on GP and primary health care, or services that a local area needs, and responding to those gaps by targeting services better;
Working with Local Hospital Networks to assist with patients' transition out of hospital, and if required, into aged care; and,
Delivering health promotion and preventive health programs to communities with identified risk factors (in cooperation with the Australian National Preventive Health Agency, once it is established).
http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-gp-01

Despite this definition, just what these new primary health care organizations will actually do, how they will operate, what their role in mental health care will comprise and how they will relate to other players including community mental health service remains unclear.

Coordinated Care and Flexible Funding Packages

In January 2011, the Commonwealth Department of Health and Ageing released a Discussion Paper for comment on a proposal to provide Flexible Care Packages (FCP) to provide support for up to 25,000 people with severe mental illness to:

- Purchase clinical support services ($58.5M over four years);
- Fund case coordinators to assist clients to navigate the clinical and social support they need; and,
- Fund and purchase required community and social support services and enable more effective and flexible involvement across the range of specialist clinical, vocational and community support services ($60M over four years).

MHCC's April submission in response to the FCP Discussion Paper provides more detailed information about our thoughts at that time regarding planning and implementation of coordinated care services.

The Coordinated Care and Flexible Funding initiative for people with severe, persistent mental illness and complex care needs - $343.8 million over the next five years - was subsequently announced in the Federal Budget 2011-12 as part of the Ten Year Roadmap for Mental Health Reform (2011-2012 Budget National Mental Health Reform, p. 18).

The following description of this new initiative is provided:

Currently the mental health system is confusing and people don't know where to get help. What services they get – particularly the sickest who have the most complex needs – is a lottery and they often don't get all the services they need.
This measure will provide a single point of contact – a Care Facilitator – for around 24,000 people with severe and persistent mental illness and their families. Care Facilitators will be responsible for ensuring all of the patients' care needs, clinical and non-clinical, and as determined by a nationally consistent assessment tool, are being met.

The Care Facilitator will be part of a regional organization identified through a tender process using Medicare Local boundaries. Eligible organizations are expected to be drawn from Medicare Locals and other non-government organizations. Care Facilitators will have access to a flexible pool of funds to help fill service gaps, but the majority of services will come from existing Australian Government and state programs, such as Medicare

> *subsidized psychiatric consultations, the Personal Helpers and Mentors (PHaMs) services and state specialist mental health services*

The initiative also involves the introduction of a nationally consistent assessment process. Multi-agency agreements for individuals with severe and debilitating mental illness will be developed as part of this measure to bring the different Government funded agencies together to provide coordinated care to this group of targeted people.

> *This will mean that, for the first time, there will be a single consistent way of measuring an individual's needs which will link to an integrated and coordinated care experience to support people to get the services they need when they need them* (Budget National Mental Health Reform, p. 18).

The Australian Government's existing commitments to FCP will be redirected to the flexible funding pool to be held by Care Facilitators under this new measure (excluding 2011-12 funding for the original Flexible Care Packages which will still be rolled out through the first Medicare Locals, i.e., $16.7M).

It is clear from this description that non-government community managed mental health organizations will be a key player in providing and contributing to care facilitation under the new Coordinated Care initiative. Effective implementation of this role, however, is premised on the assumption that the community managed mental health sector commands the necessary skill sets, and the authority, standing and working relationships necessary to the care coordination process. This will require the sector to give priority to the task of building the skills, expertise and attributes that are required across the different levels of individual practitioners, intra-agency, interagency and intersectoral practice.

National Coordinated Care Trials

The National Coordinated Care Trials (CCT) were a large-scale initiative of the joint Commonwealth, state and territory governments aimed at strengthening primary health care to better meet the challenges associated with chronic disease management. Accordingly, in September 1995 the then Commonwealth Department of Human Services and Health invited expressions of interest from parties to conduct 'trials' of systems of care coordination. The intention was to explore and test innovative approaches to the funding and delivery of health services more in line with and responsive to the needs of the client group – people with chronic and long-term health conditions.

The first round of trials occurred between 1997 and 1999 and consisted of nine 'mainstream' trials and four Indigenous trials. Although the experience from the first round trials showed that there are no quick and easy fixes in improving care for people with chronic and complex care needs, the need to carry out further trials improved care arrangements for the people who remained.

Five second round trials (CCT2) were operational between 2002 and 2005. They consisted of two 'mainstream' and three Indigenous trials, each with a unique design plan for the funding and delivery of coordinated care.

The national evaluation of the CCT led to the conclusions that the outcomes of the coordinated trails were disappointing (Esterman & Ben-Tovin, 2002, p. 469).

> *In general, the trials did not demonstrate improved health and well-being of the participants. A significant reduction in hospital admissions in the intervention compared with the control group was seen in only three of the trials, and for most trials an accrued operating deficit was found.*

A number of shortcomings were identified in the trials design including the following:

> *Each trial was funded for two years, but the first six months were devoted to recruitment and the last six months were a wind-down phase. Thus, in many trials, the actual intervention was for 12 months or less, a very short period in which to make an impact on complex illnesses*.

There were also significant problems in recruiting and retaining staff with appropriate expertise.

> *Difficulty in recruiting sufficient numbers of participants forced many trials to relax inclusion criteria, with the result that many individuals entered in the trial were inherently unable to benefit from coordinated care, since they were not sick enough, or had insufficiently complex problems to warrant care coordination.*
>
> *Despite these shortcomings, much of the qualitative evaluation showed that participants in the intervention groups appreciated the extra coordination of their care.*

The Evaluation Report of the Second Round of Coordinated Care Trials made a number of findings that are most relevant to current care coordination initiatives both nationally and in the states and territories (Commonwealth Department of Health and Ageing, 2007, http://www.health.gov.au/internet/main/publishing.nsf/Content/19F44B315755217ECA2573DE007AF9DA/$File/FINAL%20CCT2.pdf).

Relevant findings include the following (p.14-19):

The importance of training and practice and workforce development - The evaluation indicated that 'care coordination' is an area of care-related activity in its own right, with the contribution of health service providers other than solely GPs essential to successful delivery.

> *At all points in the continuum of care, trained health professionals appropriate to their community environment are needed. Where training lagged, delivery of care coordination was undermined.*

Recruitment and retention of appropriately skilled staff – Difficulty in recruitment, retention and inappropriate staffing levels plagued most trials at various points.

> *The dramatic peaks and troughs in recruitment to the trials and flow-on care coordination demands meant that, in some cases, demand for trained health staff far outstripped their availability. Heavy workloads contributed to a range of lags and lapses that appeared in some care coordination activities, particularly in regards to participant follow-up.*

Difficulty in estimating workloads – At times staff faced heavy workloads at other times they didn't.

> *It is clear from the evaluation data that a convention is required to facilitate the estimation of care coordination and service coordination workload that takes into account the complexity and acuity of individual participants. Some method of 'case streaming' may further facilitate positive management and outcomes.*

The complexity and difficulty of coordination of complex care – Crucial learning from CCT2 was the abundant evidence of the complexity of delivering high-quality care coordination. The difficult nature of care coordination was underestimated both from the outset and throughout the trials.

> *For all of the trials, the conceptual understanding of the processes involved in care coordination was reasonably well formulated. However, as trials moved to delivering care coordination, weaknesses in process began to emerge as the true complexity involved in delivering coordination to a cohort of clients started to impact the trials. This is likely to reflect, at least in part, an underestimation of the complexity involved in moving from conceptual models to implementation of care coordination. The overall message that remains is that the effort required to achieve care coordination must be built into future programs.*

The need for financial incentives to facilitate coordination of complex care - the findings of the national evaluation suggest that consideration of additional financial incentives to facilitate the coordination of complex care is warranted given that inherent complexity of relationships and the need for their collaboration rather than competition is crucial.

Importance and difficulty of governance – The difficulty of governance was also underestimated. Neither sufficient attention nor funding was allocated to developing the right governance model for each trial. The evaluation report concluded:

> *…that large and expensive multi-jurisdiction initiatives across years of operation will not succeed to their full potential within a governance framework which comprises the typical 'project director/ project officer' of existing stakeholders. A more formal arrangement that ensures continuity and responsibility over time is required.*

Further, the Evaluation Report concluded that a generic approach to 'managing' the trials through a variety of project officers and contract managers appointed by each funding body was problematic. The evaluation suggested that this form of governance would be unlikely to succeed outside of a trial.

In fact, the evidence from the evaluation suggests that difficulties in the implementation of trials led to an atmosphere of uncertainty and lack of trust among key stakeholders in the live phase of trials.

> *The sponsorship and funding 'vision', therefore, takes on the character of a willingness of funders to commit to the allocation and sharing of a portion of resources to a governing body which must maximize the flexible use of these shared resources.*

Despite all of these significant shortcomings, the evaluation report affirmed the benefits of coordinated care for reaching groups with complex care needs and for addressing unmet health needs and health inequalities and are an outstanding feature of the overall results.

The complexity of the system and its navigation was clearly a barrier to access for optimal chronic disease management for mainstream clients – a difficulty addressed by care coordination.

The Indigenous trials were reported to have demonstrated the benefits of taking a population health approach within a care coordination framework to deliver culturally appropriate services.

State and Territory Level

The discussion in this section is by no means exhaustive but is included to provide examples of how service and care coordination have been approached in a number of Australian jurisdictions,

namely, Queensland, Victoria and NSW. Evaluation data for the discussed service coordination initiatives has not yet been published.

Queensland

In 2007, Queensland Health committed to the implementation of a statewide model of care coordination involving, in developments to date, three significant components:

- 20 Service Integration Coordinator positions;
- Funding to implement the 'Partners in Mind' framework establishing collaborative working relationships between seven Divisions of General Practice and key elements of the mental health services network; and,
- Development of a Memorandum of Understanding committing relevant Queensland government agencies to participate in the care coordination model.

Importantly, Service Integration Coordinators are responsible for service system change, not case management or clinical practice. Their purpose is to engage service providers locally and across government, non-government and the private sectors, to participate in care coordination activities and systems development. The nominated target group is people with severe mental illness and complex care needs requiring clinical and community supports tailored to their personal circumstances.

These developments, over four years, have demonstrated a consistent approach across the state focussed on capacity and partnership building, on communication, and on building relationships inclusive of all sectors. Placement of Service Integration Coordinators within public health agencies appears to have been beneficial through the development of relationships across government and the engagement of resources and relationships available through parallel service development programs.

Engagement and resourcing of community managed mental health sector services has been assisted by provision of an annual funding grant for three of the last four years to the Queensland Alliance for Mental Health to support capacity building and infrastructure development across the sector. This initiative could have been strengthened by a longer-term funding commitment enabling incremental building of community capacity at a regional level.

Victoria

In Victoria, the Care Coordination for People with Severe Mental Illness and Multiple Needs Initiative aims to address the entrenched social exclusion and disadvantage often experienced by this population group. From 2009/10, this initiative has attracted $2.0 million recurrent from the State Budget.

The initiative involves the creation of new care coordination positions in selected areas to:

- Lead the development and monitoring of the integrated Recovery Plan in collaboration with the consumer and carer/s. The standard elements of the Recovery Plan include clinical, psychosocial rehabilitation, physical health care and social support services.
- Actively engage local service providers in the development and delivery of relevant elements of the individual's Recovery Plan. Facilitate case conferencing with relevant service providers as needed.
- Support/actively participate in cross program/service coordination to resolve systemic issues and identify more effective ways of meeting consumer needs.
- Advocate on behalf of the consumer if required.

Therefore, in contrast to the approach to care coordination underway in Queensland, this Victorian initiative focuses directly on delivering a care coordination service rather than on systems development. It aims to provide the practical support needed to help people experiencing mental illness and their family access and remain engaged with the range of mental health and general health and social support services they need. Services are provided by a selected group of non-government community managed mental health services.

This initiative sits within the broader statewide Service Coordination Framework and Strategy in Primary Healthcare Initiative focus on care coordination.

New South Wales

The NSW COAG Mental Health Working Group, chaired by the Department of Premier and Cabinet, held a consultation meeting on care coordination in November 2006 with representatives from peak CMOs, consumer and carer groups, and health professions. They later developed a framework for care coordination in NSW (2008, unpublished) that largely mirrored the Commonwealth's Principles and Implementation Guidelines (2007) including incorporation of the 'two coordinator' model. The care coordination framework developed characterised care coordination in mental health as:

- Being centered on the person with severe mental illness and complex needs;
- Inclusive of the person's family, carers and other significant supports;
- Enabling and building the capacity of people with mental illness and their carers to achieve greater stability in their lives and achieve recovery;
- Involving close cooperation and open communication, with a proactive and flexible approach, across all services involved in the person's care and support (in particular, clinical and non-clinical personnel and services will work together, on an equal footing, in order to achieve the best possible outcomes for people with a severe mental illness);
- Facilitating the person's access to services and programs they need;
- Maximising accessibility to care coordinators for the person, including their family and carers where possible;
- Providing seamless and uninterrupted services, including a commitment that clinicians and community coordinators will ensure effective handover of responsibilities when they relinquish their roles; and,
- Involving the sharing of information supported by the consent of the person to ensure effective care and support.

The establishment of Area Advisory Committees were recommended as part of the governance framework. The Second Progress Report on implementation of the COAG mental health plan (2009) reports that NSW established eight demonstration sites corresponding to the sites for the first round of the Personal Helpers and Mentors (PHAMS) program, namely: Sydney, Parramatta, Campbelltown, Ryde, Central Coast, Wollongong, Newcastle, and Orange. It is further noted that an evaluation framework is being developed.

> *Under the NSW Care Coordination initiative, a person with severe mental illness is provided with two care coordinators – a clinical provider and a community coordinator – to provide support from different configurations of services working flexibly to meet their needs. As at June 2008, there were over 100 participants… (and) all sites are progressing. Area Advisory Committees have been established in each area and are focussed on strengthening local level service agreements, communication protocols and referral flowcharts, as well as building the concept of collaborative care area services. Further work is also underway to make clearer referrals for PHAMs participants, and to address concerns expressed by NGOs about managing more than one contract for the purposes of care coordination. Relations have been established between PHAMs providers, mental health services and other key agencies with regular service level meetings being held in all eight areas.*
>
> *The NSW COAG Mental Health Group is developing a framework for the evaluation of the Care Coordination in NSW as well as assisting in identifying when new programs should be incorporated into care coordination. The NSW Group is also identifying opportunities for*

greater collaboration and linking Commonwealth and NSW mental health services for the Aboriginal population in NSW (p. 45).

CMO Sector Approaches

No comprehensive national or state/territory level approaches to service and care coordination in the Australian CMO sector were identified by this review. However, several local initiatives with a high level of CMO participation are worth mentioning given their relevance to improving care coordination service delivery and practice. These are the:

- Victorian Living Options Service;
- NSW Housing and Accommodation Support Initiative (HASI); and,
- Hunter New England Team Care Model.

The Living Options Service was an innovative two year pilot project to create a centralized and integrated regional housing and support information, intake and referral system for people with mental illness. The pilot's development, implementation and utilization is more fully described in a project evaluation conducted by NEAMI in 2001 and recommendations made for extending the concept across Victoria – especially with regard to primary healthcare interface. In NSW, the concept of centralized and integrated regional information, intake and referral systems that are inclusive of consumer, carer and community sector participation were envisioned by the 'Frameworks' for rehabilitation and accommodation support (NSW Health, 2002). However, the progress, impact and outcomes of the strategies contained in the Framework documents are not fully known. A more contemporary care planning and coordination approach would likely also include consideration of shared systems for review (i.e., outcome monitoring)

The HASI program has been operating for about ten years and is a service delivery partnership between NSW Health (funder and clinical mental health service provider), NSW Housing and numerous community managed mental health rehabilitation and support service providers. A unique feature is the use of formal service agreements at the organizational, service provider and service user levels to help inform care coordination approaches including statements of role delineation. A long term independent evaluation of HASI by the Social Policy Research Center at the University of New South Wales is anticipated in 2011.

The Hunter New England Mental Health Team Care Model (2009) describes the respective roles of government and community managed mental health service providers in coordinating service delivery. Service coordination is considered across the following functions: medication management; Community Treatment Order management; assessments; education sessions; risk assessments; consumer review; consumer and carer education; disability support; rehabilitation /recovery; triage and hospitalization; exit/transitioning from hospital; and, sharing duty of care. The model is now being revised against feedback toward improving recovery orientation and person-centered/self-directed care approaches (MHCC, 2010).The model is also being considered by other NSW Area Health Services/Local Health Districts (LHDs) with the Northern Sydney Central Coast LHD recently engaging in a similar role delineation agreement with CMOs in their area. In 2010, MHCC conducted a review of the Team Care Model paper toward providing feedback to increase recovery orientation.

A more comprehensive audit to become better informed about good care coordination practice occurring within the Australian CMO sector is required.

International Approaches

United Kingdom

Introduced in 1991, the Care Program Approach (CPA) is a statutory framework for people requiring specialist support in the community for more severe and enduring mental health problems. The role of CPA has been to integrate care and support across primary and secondary health care; across health and social care and welfare, housing and employment support; and, across the statutory, independent and voluntary sectors.

Centered on care coordination, the CPA is described as a whole systems approach:

> *Having a system which allows a service user access to the most relevant response is essential. The principle is getting people to the right place for the right intervention at the right time. This principle is, of course, particularly important in the case of individuals who need the support of a number of agencies and services and there are some who, as well as their mental health problem, will have a learning disability or a drug/alcohol problem. In all these cases a coordinated approach from the relevant agencies is essential to efficient and effective care delivery. No one service or agency is central in such a system. Service users themselves provide the focal point for care planning and delivery* (DHS, Care Coordination Booklet).

Goodwin et al., (2010) report that up to 2008 there were some 485,000 people (9.5 per 1000 population) in England receiving services under CPA (p.3). The CPA is targeted at adults of working age requiring specialist psychiatric services who have been diagnosed with a more severe mental disorder such as schizophrenia or bipolar disorder. They may well also have complex needs associated with illicit drug or alcohol misuse, and have experienced multiple admissions to hospital when acutely unwell. Many will be single, unemployed and living alone, and may be reluctant to engage with services.

. Hence, CPA is not just about managing a person's specific mental health issue(s) but providing holistic support for their wider needs too.

The four main elements of the CPA are:

- *Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;*
- *The formation of a care plan which identifies the health and social care required from a variety of providers;*
- *The appointment of a key worker/care coordinator to keep in close touch with the service user and to monitor and co-ordinate care; and,*
- *Regular review and, where necessary, agreed changes to the care plan* (Goodwin et al., 2010, p. 5).

The role of care coordinator is pivotal and has remained fundamentally the same since the commencement of the CPA. The Care Program Approach Association (CPAA) issued a Handbook in 2001 offering detailed guidance on the role of the care coordinator including the following attributes:

> *Competence in delivering mental health care (including an understanding of mental illness);*

> *knowledge of service user/family (including awareness of race, culture and gender issues); knowledge of community services and the role of other agencies; co-ordination skills; and, access to resources* (CPAA, 2001, p. 4).

The handbook points out that: *The complexity of the care coordinator's role in any individual's case will reflect the complexity of that individual's needs. The role is essentially one of co-ordination and communication* (CPAA, 2001, p.5).

Goodwin et al., (2010) suggest that while the CPA may have not been implemented perfectly its model of integrated care has been long-lasting and that the four core elements and the role of care coordination have not been challenged or replaced. The current challenge confronting the program is sorting through its interface with personalized care planning and person-held care packages. Goodwin et al detail the nature of this challenge:

> *What is clear, however, is that personalized care planning through the CPA or any other model will not reach its full potential unless a number of preconditions are met including: clear eligibility criteria; standardized measures of service quality based on best practice in patient care; a mix of governance and incentives to hold providers accountable for such quality; and genuine patient involvement in their own care plan* (2010, p. 7).

Goodwin et al., (2010) further suggest that coordinated care needs to focus on issues of inter-professional practice, culture, leadership, and organizational development as well as on its enabling systems and the organizational structures (p. 8).

In contrast to the Australian experience, the approach to care coordination reported in the UK can be characterized as systemic; it carries 'authority'; it offers a support structure, operational handbook and training for practitioners; and, it is subject to further development based on evaluative review.

New Zealand

Brown et al., (2009) report that, in New Zealand, the organization of primary health care through District Health Boards and larger primary health organizations leads to:

> *…much less discussion about the issues of integrating health and social care, compared with the UK. The focus has been more on how to better network and support general practice and other local providers, with the intention of encouraging this part of primary care to adopt a more population health approach, prior to then using the PHO model to fund and develop (and increasingly to manage) a broader range of community services.*

Therefore the focus in New Zealand is on the management of health and disability and a broad range of community services through one, local organizational framework thus, presumably, better enabling the care coordination process to occur through established intra-organizational relationships and mechanisms.

However, Brown et al., (2009) caution that the intended focus of District Health Boards on integration of local care across primary and secondary care priorities has, in many instances, been sidelined by:*… secondary care priorities and funding deficits* (p. 6).

Perhaps there is a lesson here for the Australian context given the uncertain place – and therefore priority – which mental health services, and in particular community mental health services across sectors, have in the emerging structures of Medicare Locals and Health and Hospital Networks.

Lessons from and Limitations of Jurisdictional Approaches

The UK experience with care coordination points to a number of important characteristics that appear to be fundamental to effective implementation. These characteristics include:

- A systematic and not rushed developmental and implementation process;
- Service coordination must carry sufficient 'authority';
- The implementation process must offer a support structure, operational guides and training and ongoing professional development for practitioners; and,
- The system and processes of care coordination must be subject to further development based on evaluative review.

The Victorian Statewide Service Coordination Framework and Strategy in Primary Health Care is one Australian imitative that is inclusive of most of these enabling characteristics.

The New Zealand experience with regional structures for coordinated and integrated health care, possibly points to the imperative of ensuring that the interests of people with mental illness are strongly represented in decision making and resource allocation within these structures. If this does not occur it is likely, given the New Zealand experience that limited recognition will be given to the care coordination needs of people with mental illness. The New Zealand experience also possibly points to the need for diligence by the community mental health sector in ensuring its place around the decision making tables during the implementation of Medicare Locals – similar structures to the regional coordinating structures in New Zealand.

Much can be learned from the National Care Coordination Trials conducted in Australia in the late 1990s and early years of this century. A number of key learnings are of relevance to today and include the following.

- If trials are to be conducted, they need to be for a sufficient time period.
- Before any trials commenced, a training needs analysis in relation to service coordination is required.
- Processes must be in place from the outset for working, training, practice development and ongoing professional development.
- The problems associated with workforce recruitment and retention of staff skilled in service coordination must be identified and addressed to the extent that is possible.
- Consideration prior to the commencement of any trial must be given to how workloads can be recognized, adequately resourced and managed.
- Financial incentives and purposively formulated finding models are required to facilitate the coordination of complex services mixes across time, settings and sectors.
- Prior to commencement of any trials or developmental process, arrangements must be set in place for governance of service coordination.

Finally, the complexity and difficulty of service coordination as both a practice skill set and a method of service delivery must not be underestimated. A realistic appraisal or understanding is needed of the difficulty of moving from conceptual models to implementation of care coordination.

5. Proposed Model for Service and Care Coordination

The review of the literature and of jurisdictional experience with service coordination revealed its complex, multifaceted and multidimensional nature. This section attempts to progress understanding and conceptualization of service coordination. A model of service coordination is proposed for discussion throughout the community managed mental health sector in NSW. This model has the potential to provide a guiding platform for the community managed mental health sector in NSW as it seeks to develop its *Service Coordination Strategy*.

If the concept of service coordination is multifaceted, what are its constituting facets? Some of the areas and components that are suggested by the research conducted in this study include the following

- **Guiding Framework** - comprising aim, definition and guiding principles.
- **Domains** – contingencies that must be considered and which influence the shape of service coordination in particular situations and with particular groups.
- **Levels** – the different levels at which service coordination needs to operate.
- **Governance and Leadership** – a framework of rules, practices and processes ensuring the accountability, transparency, fairness and safety and quality of service coordination.
- **Practice and Workforce Development** – processes for embedding the practice skill set required for effective service coordination in the workforce.
- **Service Coordination Strategies** – the means by which service coordination is achieved including actions, plans, shared tools and instruments, marshalling and allocation of resources.

Each of these areas and components of service coordination are discussed in turn along with discussion questions to help inform MHCC's *Service Coordination Strategy.*

Guiding Framework

Aim

To provide person-directed and centered, systematic, responsive, supportive and integrated services that promote recovery.

An initial working definition

Service coordination is both a practice skill set and a type of service delivery.

Service coordination is relational and requires strong working relationships between services users and their families, supporters, peers and communities, mental health workers, service provider agencies, funders and policy setters.

Service coordination ensures the right services, at the right time and at the right place and includes:

1. Coordination and management of services that are tailored to meet individual needs, promote recovery, enhance independent living, facilitate social connection, address social disruption and diminished functioning arising from mental illness and assist people to live satisfying lives in the community;
2. Coordination of providers to encourage team work, shared knowledge & expertise, interdisciplinary practice and integrated responses; and,
3. Coordination of service delivery organizations to create an integrated network or service system.

Service co-ordination is particularly important during transitions, such as discharge from hospital to home or transition back into employment, to ensure continuity of care, as well as care that is safe and of a high quality.

Guiding Principles

Some of the key guiding principles of service coordination include:

- Person directed, driven and centered;
- Inclusive of family, friends, peers and community;
- Culturally safe and appropriate;
- Recovery oriented;
- Socially inclusive and seeking to address discrimination; and
- Tailored and suited to individual needs & consistent with individual preferences.

Target Group/s

At the level of the individual mental health worker, service coordination is a practice skill set application to all service users.

At the service delivery level and service network or system level, coordination is a way of delivering services that in certain instances and for specific reasons might target certain groups including for example people with severe mental illness and/or with complex needs.

Discussion Question 1

Do you agree with the aim, initial working definition/s, guiding principles and target group/s that have been proposed for the Service Coordination Strategy? If not, what don't you like and what changes would you suggest?

Domains

Contingencies that must be considered and which influence the shape of service coordination in particular situations and with particular groups include the following.

Jurisdictions

Service coordination may involve the collaboration of organizations whose services are funded and/or auspiced by the Australian government, a state or tertiary government and local government or combinations of these. Services coordination might need to occur across government boundaries or across state geographic borders. In a small number of instances, international jurisdictions might also be involved including the United Nations or delegate or another country. Different rules, regulations, eligibility criteria, philosophies, modus operandi and reporting and accountability requirements will be encountered.

Service sectors

Service coordination may need to occur across a range of service sectors including for example, primary, secondary and tertiary health care, mental health, housing, employment, income support, emergency and disaster relief, homelessness services, education, early childhood services, community and family support, disability, aged care, alcohol and drugs treatment services and drought support etc. Service coordination might also need to occur with organizations in the public, private and community managed sectors and often combinations of these. A 'sector' that has emerged as an important player in contributing to the social inclusion and recovery of people with mental illness in recent times includes service clubs and sport and recreational associations.

Program philosophies and values, the training and professional backgrounds of staff and volunteers and their ways of working will vary greatly within and between sectors.

Discussion Question 2
What are the strengths and limitations of service delivery networks in your area?

Level of acuity – The level of acuteness and/or severity of a person's condition will also influence the range of service providers involved and the timing of their input into service planning and coordination.

Level of complexity – Similarly, the level of complexity in a person's health and social circumstances will also influence the range, mix and number of service providers involved.

For example, in recent times considerable effort has been given by all mental health sectors to ensure that mental health and physical care needs are addressed simultaneously. The national Improved Services Initiative has provided significant resources to the alcohol and other drugs community treatment sector throughout Australia to increase responsiveness to people with both alcohol and drug problems and mental health issues.

Discussion Question 3

Is the service network in your area able to respond comprehensively to people with severe and/or complex need?

Settings – Service coordination will occur in numerous settings including people's homes and local communities, and in acute care, primary health care, residential care, correctional facilities, immigration facilities, schools, workplace settings etc.

Geographic contingencies – Issues of geography will also shape the range of players involved, the relative ease or difficulty in achieving coordination and the range of barriers and obstacles encountered. Service coordination may need to occur in major metropolitan, major regional, semi-rural, rural and remote areas. Further complexities arise as resource allocation and program operational decisions are frequently made in capital cities but are then put into practice in far removed locations.

Service and community infrastructure – Service coordination is also shaped by service and community infrastructure with areas throughout Australia differing markedly. Some areas are well resourced across the board or in relation to some services and not other services, whilst other areas are poorly resourced and have limited infrastructure. Some areas are relatively poorly serviced across the board. Telecommunications infrastructure differs across Australia. Some areas might be poorly resourced in relation to services but have high levels of social capital and community cohesion.

Discussion Question 4

How well is your area served by its geographical characteristics, service mix and ability to identify and respond to local need?

Cultural competence issues including:

Life cycle stage & transition points – Different practice skills and different service coordination strategies might also be needed as mental health practitioners work with people at different stages throughout the life cycle. Specials consideration is also required as people pass through important transition points.

Cultural context & considerations – Service coordination also needs to respond respectfully, flexibly and appropriately and by the cultural beliefs, values and expectations of service users.

Population groups and specific needs - The specific and differing needs of population groups add a further dimension and might include children and young people, older people, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse background, people with disability, refugees and newly arrived immigrants, defense force members and veterans, gay and transgender people and people experiencing homelessness.

Discussion Question 5

What life cycle and cultural contexts are of particular importance to effective service provision across the population in your area and how well are they addressed?

Legal frameworks – Individual mental health workers as well as organizations need to be alert to legal frameworks surround their work with people and in different settings. Relevant legislative provisions might relate to involuntary psychiatric inpatient or community treatment, guardianship, protected estates, child protection, the criminal justice system, immigration, income quarantining and other income security issues, tenancy, debt, privacy and professional duty of care etc.

Discussion Question 6

How well is your agency and network able to deal with the range of legal issues which might impact on people with mental illness?

Levels

Service coordination operates at the levels of:

- service delivery with the person;
- at the level of teams, whether they be interagency, interagency or cross-sectoral; and,
- at the broader service system or service network level.

Important aspects of service coordination at each of these levels are outlined in turn.

Person level

Service and care coordination begins with an assumption that individuals can be assisted to access all the services and care they required across levels and settings at the point and in the locations those services are required – i.e. right services, right place and right time.

Important concepts, processes and tasks for service and care coordination with an individual person include:

- Engagement and empowerment;
- Person-directed/centered;
- Inclusive of family, peers, supports and community;
- Comprehensive & collaborative assessment;
- Service coordination role;
- Service planning;
- Referral and follow-up;
- Family support;
- Monitoring and review;
- Outcome measurement and reporting; and,
- Self-management and support.

Team/service level

Key requirements of service coordination at the level of teams, whether they be intra-agency, interagency or cross sector, are management leadership and auspice and the adoption and implementation of care coordination service standards and practice standards.

Other important concepts and requirements include:

- Organizational development and cultural change to support collaboration and integration;
- Establishment and nurturing of interdisciplinary teams ;
- Interdisciplinary practice;
- No wrong door policy;
- Single point of entry;
- Team and service partnerships;
- Articulation of shared roles and responsibilities;
- Service agreements e.g., MOUs;
- Communication; and,
- Practice and learning communities.

Guidelines and protocols provide an essential operational framework for the multidisciplinary teams and are optimally observed when they have been collaboratively developed. A lynch pin within the care coordination team framework identified in the literature is that of a service or care coordinator who assumes a leadership role (Aiken et al., 2006). Each person is designated a care coordinator who facilitates and oversees timely and integrated responses and ensures that the person is connected to the range of services required.

Further, service coordination teams need to sit and operate within flexible service delivery systems that might be achieved through the establishment of service networks, partnerships, coalitions or alliances. Workload estimation, management & monitoring are essential as are collaborative processes for review and appraisal and feedback. Shared safety and quality assurance processes are also required.

Systems/sector level

The concept of service and care coordination implies that services and programs are connected and coordinated to form a service system or overarching service network. Key concepts or activities required for an effective and coordinated service system include: resource management and alternative, if not, innovative funding models, information management, organizational integration and organizational commitment to collaboration.

Other important concepts and requirements at the systems level include:

- Guiding policy framework;
- Operational framework and guidelines;
- Capacity building;
- Support for cultural change within organizations;
- Information communication and management systems, processes and infrastructure;
- Service and program integration;
- Service linkages;
- Establishment of service networks and partnerships;
- Partnership appraisal processes; and,
- Safety and quality assurance across the service system.

Given the limited nature of the service coordination evidence base it is critical that significant investment is made to enable evaluation, research and development, the dissemination of

research findings, the sharing of information about evidence-based service coordination practice and integrated service delivery and the embedding of new knowledge and practice skills throughout the service system.

Discussion Question 7

What mechanisms exist in your agency and across your service networks to assist collaboration?

Governance and Leadership

Governance and leadership needs to be in place across all levels of service coordination:

- Individual practitioner;
- Interagency;
- Cross-sectoral; and,
- The service system.

The challenge in governing networks or care coordination is to determine the model of governance most suited to the situation and that will lead to participating organizations engaging in collective and mutually supportive action in which conflicts are addressed and network resources are used effectively and efficiently.

A collaborative decision needs to be made about the governance model for service coordination. Options include: alliance/shared model; corporate model; and a brokered model through a lead agency or a specifically and purposively created entity.

Other important governance requirements for effective service coordination include:

- Service agreements/contractual arrangements
- Governance operational framework e.g., guidelines, protocols, policies and procedures
- Service and practice governance e.g. service/clinical pathways; practice leadership; and practice and service safety and quality improvement.

Review of governance arrangements is essential to ensure the right arrangements are in place over time and as the partnership establishes itself, grows or experiences setbacks.

Discussion Question 8

Are you aware of examples of leadership and good governance in service coordination locally?

Practice and Professional Development

In developing service coordination expertise, the community managed mental health sector needs to contribute toward the articulation of service coordination as a discrete skill and practice set and work toward embedding service coordination in practice, training and professional development.

Key to building the practice and skills base of service coordination are the following tasks and requirements.

- Articulation of service coordination practice skill set, competencies, attributes;
- Resourcing for practice and professional development;
- Adoption and implementation of service coordination practice standards
- Inclusion of service coordination in professional development programs within organizations, throughout the sector and throughout partnerships e.g.,
    - Induction and orientation
    - Professional development planning and support; supervision & appraisal
    - Training opportunities for staff
    - Collaborative interagency, interdisciplinary and cross-sectoral professional development strategies and opportunities;
- Investment in developing practice development resources; and,
- Service coordination communities of practice.

Consideration could usefully be given to the establishment of collaborative and inclusive field education programs and initiatives. Programs or 'units' could be established locally, regionally, network-wide or state-wide. Programs could also be established in association with TAFES, RTOs and universities. The purpose of these programs would be to provide opportunities for field education placements for vocational, undergraduate and post-graduate students. The placements offered could ensure a focus on service coordination both as a practice skill set and as a type of service delivery.

The practice development and learning needs of non-professionally associated staff as well as volunteers are a further priority.

Discussion Question 9

Are you aware of any current initiatives supporting good professional practice in care coordination?

Workforce Development

A workforce development strategy must also accompany the emphasis on practice development. An important starting point would be a training needs analysis focusing on the practice skill set of service coordination. As with practice and professional development, it is important that non-professionally affiliated staff and volunteers are included in the training needs analysis.

Key workforce development tasks and priorities required to assist the sector achieve effective service coordination include the following:

- A service coordination training and education strategy – interdisciplinary, interagency and cross-sectoral;
- Collaborative training opportunities e.g., work-shadowing, training blocks, secondments etc.;
- Training in service coordination practice skill set embedded in relevant curricula; and,
- Workforce planning, recruitment and retention strategy.

Finally, resources to assist workforce development in the area of service coordination will are important and might include e-learning training packages, instructional webinars and service coordination blogs or forums.

Discussion Question 10

Are you aware of any local or broader initiatives towards development of a more collaborative workforce – across discipline, agency, sector?

Strategies

Given the tendency within disciplines, organizations and service sectors to work in silos, support for organisational cultural change is needed if service coordination is to become embedded as both a practice and method of service delivery.

Alternative and innovation funding models and additional financial incentives to facilitate the coordination of complex care is required given the inherent complexity of relationships and the need for their collaboration rather than isolation or competition is crucial. Different models might include person-held packages, local area pooling of funding, coordinated schemes involving ATAPS and Better Access, uncapped or uncapped needs-based funding, service commissioning schemes and new funding models designed to specifically support service coordination for targeted groups.

Community development and engagement to establish broad community support for and commitment to service coordination and to social inclusion for people with mental illness is also required.

Other strategies to promote and effect service coordination include the following:

- Partnership and network development;
- Co-location;
- Consultation liaison;
- In-reach and outreach;

- Collaborative programs;
- Service linkages;
- Resource management;
- Centralised and shared intake;
- Common/shared assessment, referral processes, forms and templates;
- Common and shared tools and instruments;
- Shared client records and/or person-held records;
- Service planning e.g., planning panels, conferences, committees; and,
- Evaluation and research.

A further strategy includes enhanced information technology support to improve access to, and sharing of, information between practitioners and organizations within service networks.

Discussion Question 11

Are you aware of any local service or community development initiatives which support the cultural change needed to enable or facilitate collaborative service provision?

Discussion Question 12

Are there any other comments you would like to make about the Care Coordination Literature Review and Discussion Paper or directions for the Service Coordination Strategy?

6. Progressing a Service Coordination Strategy

Though the peer reviewed literature on mental health service and care coordination is limited, there is growing evidence to suggest that collaborative and coordinated care delivers the best quality mental health services.

Though the identified research shortcomings in relation to a number of key aspects and components of care coordination could be viewed as a problem for the community managed mental health sector in NSW, it can also be viewed as an exciting opportunity for the sector. That there is a level of guidance on key aspects of service coordination in the literature provides the sector with the opportunity to be a key contributor to building the evidence and practice base of a type of service delivery that promises to significantly improve the quality and outcomes of mental health care.

This paper, its findings and the suggested initial model of service coordination, provides a level of direction for the sector to collaboratively devise, plan and implement a systematic process for further developing service coordination as both a practice skill set and a method of service delivery.

A starting point is discussion of the key areas and components of service coordination identified in this paper, namely:

- Components of a guiding framework;
- Domains or contextual considerations of care coordination;
- Levels at which service coordination needs to occur;
- Governance models and challenges;
- Practice skills and competencies;
- Workforce development requirements; and,
- Service coordination strategies.

The scrutinising, studying and discussion of the lessons emerging from recent care coordination initiatives would assist the development by the sector of a *Service Coordination Strategy*. Importantly, there is much to be learned from the national care coordination trials conducted here in Australia in the late 1990s and early part of this century. The trials though bold and possibly ahead of their time revealed the promise and strengths of care coordination as well as its pitfalls and the challenges it faces in moving from a concept and policy to a practice and a service delivery reality.

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8. Appendix

Summary of the Model Emerging From the Review of Literature and Jurisdictional Experience

Guiding Framework	Domains	Levels	Governance & Leadership	Practice and WFD	Strategies
Aim To provide person-directed and centered, systematic, responsive and supportive services that promote recovery. **Definition** Service coordination is both a practice skill set and a type of service delivery. Service coordination is relational and requires strong working relationships between service users and their family, friend and supporters, mental health workers, service provider agencies, funders and policy makers. Service coordination ensures the right services, at the right time and at the right place and includes: 1) Coordination and management of services that are tailored to meet individual needs, promote recovery, enhance independent living, facilitate social connection, address social disruption and diminished functioning arising from mental	**Jurisdictions** **Service sectors** **Level of acuity** **Level of complexity** **Settings**, e.g., acute care, community, correctional facilities **Geography**,e.g., metropolitan, regional, rural, remote, etc. **Infrastructure**, e.g., well resourced, poorly resourced	Service coordination operates at the levels of: • Service delivery with the person; • At the level of teams, whether they be intra-agency, interagency or cross sectoral; and, • At broader service system level. **Person** • Engagement & empowerment • Person-directed/centered • Inclusive of family, peers, supports, & community • Comprehensive & collaborative assessment • Service coordination role • Service planning • Referral & follow-up • Family support • Monitoring & review	Governance needs to be across all levels of service coordination: individual practitioner; interagency; interagency; cross-sectoral; and, service system. **Governance model** e.g. alliance/shared; corporate; brokered through lead agency etc. Service agreements/contractual arrangements **Governance operational framework** e.g. guidelines, protocols, policies and procedures **Service & practice governance** e.g. service/clinical pathways; practice leadership;	**Practice & professional development** Articulation of service coordination practice skill set, competencies, attributes Resourcing for practice & professional development Adoption & implementation of service coordination practice standards Professional development program e.g. • Induction & orientation • PD planning & support; supervision & appraisal • Training opportunities for staff; • Collaborative interagency, interdisciplinary & cross-sectoral professional development strategies & opportunities • Practice development resources • Communities of practice • Collaborative Field Education program e.g.	• Organisational development & cultural change • Partnership & network development • Community development and engagement to establish broad community support and commitment to service coordination and to social inclusion for people with mental illness • Co-location • Consultation liaison • In-reach & outreach • Collaborative programs • Service linkages • Funding models &

Guiding Framework	Domains	Levels	Governance & Leadership	Practice and WFD	Strategies
illness and assist people to live satisfying lives in the community. 2) Coordination of providers to encourage team work, shared knowledge and expertise, interdisciplinary practice and integrated responses; and, 3) Coordination of service delivery organizations to create integrated network or service system. Service coordination is particularly important during times of transitions, such as discharge from hospital to home or transition back into employment, to ensure continuity of care, as well as care that is safe and of high quality. **Guiding Principles** • Person directed, driven and centered • Inclusive of family, friends, peers and community • Culturally safe and appropriate • Recovery oriented • Socially inclusive • Tailored and suited to individual needs and preferences	**Life cycle stage & transition points** **Cultural context & consideration** **Population groups & specific needs**, e.g., ATSI, CALD, GLBTI **Legal frameworks**, e.g., involuntary psychiatric inpatient or community treatment, guardianship, child protection, etc.	• Outcome measurement & reporting • Self-management and support **Team/service** • Management leadership & auspice • Adoption & implementation of care coordination service standards • Organizational development & cultural change • Interdisciplinary teams • Interdisciplinary practice • No wrong door • Single point of entry • Team & service partnerships • Articulation of shared roles & responsibilities • Service agreements e.g. MOUs • Communication • Practice & leaning communities • Guidelines, protocols & policies and procedures • Cooperative, coordinated and integrated service delivery	**Quality,safety & QI** **Review of governance arrangements**	local, regional, network-wide; to provide opportunities for field education placements – TAFE, undergraduate & post-graduate **Workforce development** • Resources for workforce development • Training needs analysis for practice skill set of service coordination including non-professionally affiliated staff and volunteers • Training & education strategy – interdisciplinary, interagency & cross-sectoral • Collaborative training opportunities e.g. work-shadowing, training blocks, secondments etc. • Training in service coordination practice skill set embedded in relevant curricula • Workforce planning, recruitment & retention strategy	resourcing • Resource management • Centralised & shared intake • Common/shared assessment, referral processes, forms & templates • Common & shared tools and instruments • Shared client records • Person-held records • Service planning e.g. planning panels, conferences, committees • Enabling IT systems • Evaluation & research

Guiding Framework	Domains	Levels	Governance & Leadership	Practice and WFD	Strategies
		• Workload estimation, management & monitoring • Collaborative review and appraisal & shared mechanisms for feedback • Safety & quality **System/sector** • Resourcing & funding models • Policy framework • Operational framework & guidelines • Capacity building • Support for organizational cultural change • Information communication & management systems, processes & infrastructure • Service integration • Service linkages • Service networks &partnerships • Partnership appraisal processes • Safety & quality • Evaluation • Research & development			