



SERVICE COORDINATION WORKFORCE COMPETENCIES:

An investigation into
service user and provider
perspectives

MHCC Service
Coordination Strategy
Phase 2

October 2012





"There is a general vision or feeling that I try to convey [with my painting]. It is a world where things are right and true, a world of knowledge and understanding and truth, of sound philosophy."

Home is a word that describes this ideal. I have not found it in the real world for now only in painting. The forms are homes that I have built with my own hands and imagination."

Bernard Vartuli

"Homes" 2010 - acrylic on paper
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MHCC also thank Jacqui Ford of BushJac Consultants, who facilitated the consumer, carer and service provider consultations and conducted a Vocational Education and Training (VET) qualifications analysis; and Dr Leanne Craze who was contracted by MHCC to author the *Care Coordination Literature Review and Discussion Paper* in 2011.

Language

It must be noted that there is generally no consensus, in theory or in practice, about how terms associated with service coordination are defined. Particularly unclear is the difference between service and care coordination, and at which level these types of coordination occur.

In this paper, the term service coordination will be used to refer to both service and care coordination, except where specifically referring to an individual consumer's care. This is consistent with a view that care coordination is a subset of service coordination.

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EXECUTIVE SUMMARY



1. EXECUTIVE SUMMARY

In 2011, in response to the increasing emphasis in state, national and international policy to develop service coordination frameworks and practices,^{1 2 3} MHCC initiated a *Service Coordination Strategy* project. Phase 1 of the *Service Coordination Strategy* project included the *Care Coordination Literature Review and Discussion Paper* and MHCC Regional Forum consultations. What clearly emerged from Phase 1 is that while service coordination is a type of service delivery, it is also a practice skill. Moreover, there is little evidence demonstrating what these practice skills are, as well as the consumer, carer and service provider views on the competencies required for effective service coordination. Phase 2 of the project addresses this evidence gap.

Phase 2 presents findings from consultations and targeted interviews with consumers, carers and service providers regarding their perspectives of the key characteristics and competencies required (including knowledge, skills and attitudes) to provide effective service coordination and continuity of care. This is a unique undertaking in recognition of the critical importance of informing service delivery with the expertise of consumers and carers.

Key messages expressed by consumers, carers and service providers around effective service coordination include the need for widespread acknowledgement that *all* consumers should experience coordinated service delivery, and that *all* service providers have a responsibility to practice in a coordinated and collaborative way across the human services system. Service coordination must be conceptualised in terms of consumer and carer experience of continuity of care, from early intervention and access through to ongoing support and follow up. Importantly, service coordination does not refer solely to services coordinating with other services, but also coordination with consumers through support for self-directed care, and with carers and significant others who form a significant part of the care team.

An analysis of existing VET qualifications, compared to the competencies identified as key to service coordination, found there was a reasonable level of coverage in the mental health-related qualifications. However a number of competency gaps were identified across a number of categories including:

- Recovery-oriented service provision and support for self-directed care
- Providing continuity of care (supporting transitions, monitoring, follow up)
- Being inclusive and supportive of carers and significant others
- Knowledge of services and resources
- Effective use of information and communication skills
- Relationships and ways of working
- Teamwork and collaboration skills
- Skills associated with key worker and management level competencies

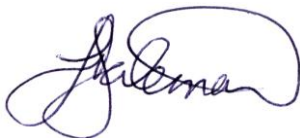
Please see Appendix 5 for a full list of the knowledge, skills and attitudes identified.

These competencies must be promoted and embedded in nationally recognised qualifications to ensure workers are capable of providing service coordination at the practice level. This is particularly critical to the success and sustainability of the Partners in Recovery (PIR) initiative which aims to improve coordination across the service system. While currently targeting those who are deemed most in need, it is hoped that the benefits of PIR will extend over time to those who are not eligible for the program. This will only be successful if appropriate workforce development occurs alongside the systems-level improvements.

Findings suggest that consideration must be given to embedding service coordination competencies in formal education (VET and university curriculums), work placements, workplace inductions and professional development. The importance of culture, effective management and key worker roles, quality improvement, ongoing evaluation and funding that reflects the time and effort required to coordinate services must also be recognised and addressed.

Phase 2 has enabled MHCC to propose a number of recommendations to increase knowledge and understanding of the components of service coordination and to implement the research into practice. Without the evidence and inclusion of service coordination competencies as presented in this document, the language of service/ care coordination as liberally expressed in State and Commonwealth policy documents will remain rhetoric that fails to address service fragmentation and poor continuity of care.

MHCC is confident that this research and these recommendations provide the necessary evidence for the mental health and human service sectors to advocate for capacity building funding to strengthen service/care coordination. The significance of such capacity building will most importantly be reflected in the improved experiences of consumers and carers using services, which is the primary objective of the *Service Coordination Strategy*.



Jenna Bateman
Chief Executive Officer

November 2012

RECOMMENDATIONS

1. Disseminate and promote the findings from Phase 2 of the MHCC *Service Coordination Strategy* by:
 - a. Convening a forum in the first half of 2013 to present the findings and conduct further consultations; and
 - b. Producing a brief promotional piece to promote better awareness and understanding of service coordination, including an understanding of service coordination as a practice skill.
2. Promote the inclusion of service coordination competencies in the mental health qualifications being reviewed by the Community Services and Health Industry Skills Council (CS&HISC) to:
 - a. Build workforce capacity to provide effective service coordination in the mental health sector; and
 - b. Ensure mental health workforce capabilities required to successfully deliver the objectives of the PIR initiative are supported by nationally accredited qualifications.
3. Develop and promote additional training incorporating the essential skills required for effective service coordination including:
 - a. A Certificate IV level unit of competence and/or a service coordination skill-set;
 - b. An additional higher level unit of competence incorporating the essential service coordination skills required for more advanced practitioners and team leaders/frontline managers; and
 - c. A short course based on the units of competence to be offered in the Professional Development Series through MHCC Learning and Development.
4. Advocate for greater inclusion of service coordination competencies in mental health university training curriculums including: psychiatry, psychology, social work, nursing, and occupational therapy.
5. Use the findings from consultations to inform and influence the implementation and development of the PIR program including:
 - a. Capacity building resources for Partners in Recovery Organisations (PIROs); and
 - b. Advocacy for the inclusion of workforce measures in the PIR evaluation.
6. Correspond with the CS&HISC regarding the investigation and findings to inform the development of the Environmental Scan 2013.
7. Advocate for consideration of service coordination as a critical part of practice, not an exclusive separate role, at the State and Commonwealth level in:
 - a. The planning of service delivery and roles, including the development of benchmarks, care packages, the allocation of resources and funding models (e.g. MHCC Sector Benchmarking Project, National Mental Health Service Planning Framework, Activity-Based Funding, etc.);
 - b. The collection of data on current service delivery and workforce activity (e.g. MHCC *Data Management Strategy*).

8. Use findings from the consultations with consumers, carers and service providers to inform progress on Objective 4.2.2 of the *National Mental Health Workforce Strategy and Plan* to promote shared care, service coordination and cooperation across the government, non-government and private sectors.
9. Pursue resources for Phase 3 of the MHCC *Service Coordination Strategy*, and commence service coordination pilots in urban, regional and rural areas. It is likely the Hunter region will be targeted given that it has been identified as the NSW location for the National Disability Insurance Scheme (NDIS) roll-out.

INTRODUCTION



2. INTRODUCTION

Consumers and carers often describe the difficulties they experience in accessing the range of care that they need, and navigating the mental health system in a timely and consistent way.⁴ They report that their experience is often overwhelming and disempowering and that services are fragmented,^{5 6} particularly in relation to discharge from mental health facilities with poor links to services in the community.⁷

The importance of service coordination in supporting self-determination and recovery is critical to fostering ongoing engagement with services.⁸ The evidence clearly shows the benefits of effective service coordination, including fewer hospital admissions, higher levels of functioning, reduced symptoms and improved quality of life, consumer satisfaction and autonomy.^{9 10 11 12 13 14}

Conversely, poor coordination is associated with negative outcomes, including deteriorating health, heightened distress, feelings of hopelessness and helplessness, lower levels of functioning and quality of life, increased hospitalisation, use of crisis services and risk of homelessness.¹⁵

The Australian Context

Over the last few decades there has been a shift in the understanding of how services in the mental health system should be delivered, and who should be involved. It is now recognised that service planning must occur in partnership with consumers and carers and, where possible, in community settings.^{16 17} The workforce is under increasing pressure to update approaches, competencies and work practices in order to meet changing demand and align with new models of care.^{18 19 20}

The service context in Australia is a dynamic environment. Recent national and state policy reforms have changed the way services are funded and operate. Policies characteristically identify the need to improve continuity of care and support self-directed care approaches.^{21 22} Examples are: the 'Partners in Recovery' (PIR) and *Coordinated Care and Flexible Funding* packages; the National Disability Insurance Scheme (NDIS); Living Options models; and specific workforce development initiatives including the Health Workforce Australia initiative to develop competency-based education and training and competency-based career frameworks.²³ The significant initiative undertaken by the National Quality Council (2010) to simplify and streamline the content of Training Packages is also timely. The Community Services and Health Industry Skills Council (CS&HISC) has established a number of Subject Matter Expert Groups (SMEGs) to assist in this process for a number of community sectors, including the mental health sector.

The National Mental Health Strategy aims to support a shift from the medical model to a recovery-oriented approach, and emphasises the provision of person-centred care in the community. It currently includes:

- ☐ National Practice Standards for the Mental Health Workforce (2002)
- ☐ National Mental Health Policy (2008)
- ☐ Fourth National Mental Health Plan (2009)
- ☐ National Standards for Mental Health Services (2010)
- ☐ Mental Health Statement of Rights and Responsibilities (2012)

The Council of Australian Governments' (COAG) National Action Plan for Mental Health 2006-2011 emphasises coordination and collaboration between all providers to deliver continuity of care.

The National Practice Standards for the Mental Health Workforce consist of twelve practice standards for all workers across disciplines, and encourages knowledge and skills to support multidisciplinary collaboration.

Numerous strategy and policy reform initiatives concerning improved care coordination are couched in rather generalised statements, which fail to identify the particular roles, skills and knowledge required to achieve the strategic objectives. Funding is rarely allocated to policy initiatives and little support is offered during implementation. While some models and training curriculums have been developed, they are generally not informed by consumer and carer input or they are inconsistent with the recovery approach. A common assumption is that workers already have the skills needed to deliver the specified outcomes, and there is a lack of understanding of the support and training workers require.²⁴

Ongoing challenges to continuity of care and self-directed care have resulted in consumer disempowerment and dependence, creating a barrier to self-directed care. Research shows that service delivery as a whole does not adequately support or enable self-directed care at the individual level.²⁵ Particular challenges result from the diversity of workers in public, private and community sectors across primary, secondary and tertiary levels of care. Each of these workers has been trained in different disciplines that often involve opposing philosophies and practice approaches^{26 27}. The result is a wide diversity of knowledge, skills and attitudes that impact differently on practice approaches²⁸ and can lead to conflict and other barriers to collaborative care.

Of particular relevance to these consultations is the **Community Services & Health Industry Skills Council (CS&HISC) Environmental Scan 2012** which has identified that:

Workforce changes are occurring in parallel to, and as part of, industry reform, with major change themes including a shift towards interdisciplinary practice and person-centred models of service, an increasing focus on service delivery within the community setting, an emphasis on client functional independence and increasing recognition of complex and multiple needs (p. 15).

The key recommendations made for the continuous improvement of the mental health workforce training packages include:

- Examination of potential for higher-level competency standards, qualifications or skill sets reflecting advanced practice and practice leadership; and
- Examination of expansion of care-coordination roles and skills/practices to support increasingly complex needs, including trauma-informed care and talking therapies. Any development of training package content should be addressed in conjunction with broader community mental health workforce development objectives and identification of a unified body of evidence about psychosocial and recovery-oriented practice.

Service coordination and self-directed care

“Optimal mental health [service delivery] is an individualised process where providers collaborate with service users to tailor the best possible services and supports for that individual, based on the person's needs, strengths, preferences, and recovery goals”.²⁹

The objective of self-directed continuous care has been described as ‘the right services to be provided in the right place and at the right time’, with a high level of consumer and carer control and choice at each step of the recovery journey.

Glover (2006) has placed self-directed care on a continuum of responsibility and involvement as follows:³⁰



Glover's continuum has informed thinking around how to conceptualise service coordination at the consumer and worker level. A common misperception is that care coordination is equivalent to case management, but they are not the same thing. Case management exists solely at the 'managed care' and perhaps the 'person-centred' end of the continuum, whilst care coordination exists at all points along this continuum. As noted in the 'PIR Question and Answer Booklet on the engagement of PIR Organisations', the focus of case management also tends to be on navigation of the 'clinical' care system rather than across the entire human services system including CMOs.³¹

The NDIS utilises the concept of 'choice of provider' and 'self-directed funding' models, where an individual receiving funding can be supported in making decisions about which services meet their individual needs.³² Whilst the mental health sector, including CMOs, is generally supportive of this scheme, reservations have been expressed. Concerns specifically related to service coordination include uncertainty about how consumers will be supported in decision making and self-directing care, including people with impaired capacity, those under guardianship, or those not yet engaged with the service system.³³

In addition, the *NSW Mental Health Act 2007* is currently under review, with consideration of "where the balance between a consumer's rights and the responsibilities of the state to intervene should lie"³⁴ as a key question in the review. One of the principles that underpins intervention has historically involved substituted decision making which aligns with the 'managed care' end of the continuum, however, discussion is occurring around whether the focus should be shifted to supported decision making which exists at the person-centred and self-directed end of the continuum.

Purpose

The *Service Coordination Strategy* project undertaken by MHCC progresses Recommendations 3 and 5 of MHCC's 2010 *Sector Mapping Project*.³⁵

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.

In Phase 1 of this project, MHCC began an investigation of what constitutes care and service coordination and contracted Dr Leanne Craze to complete a comprehensive literature review and discussion paper in 2011 titled, *Care Coordination Literature Review and Discussion Paper*. The original discussion paper is available at:
http://www.mhcc.org.au/documents/Projects/MHCC%20Care%20Coordination%20Discussion%20Paper%202011%20Version%2015092011_WEB.pdf

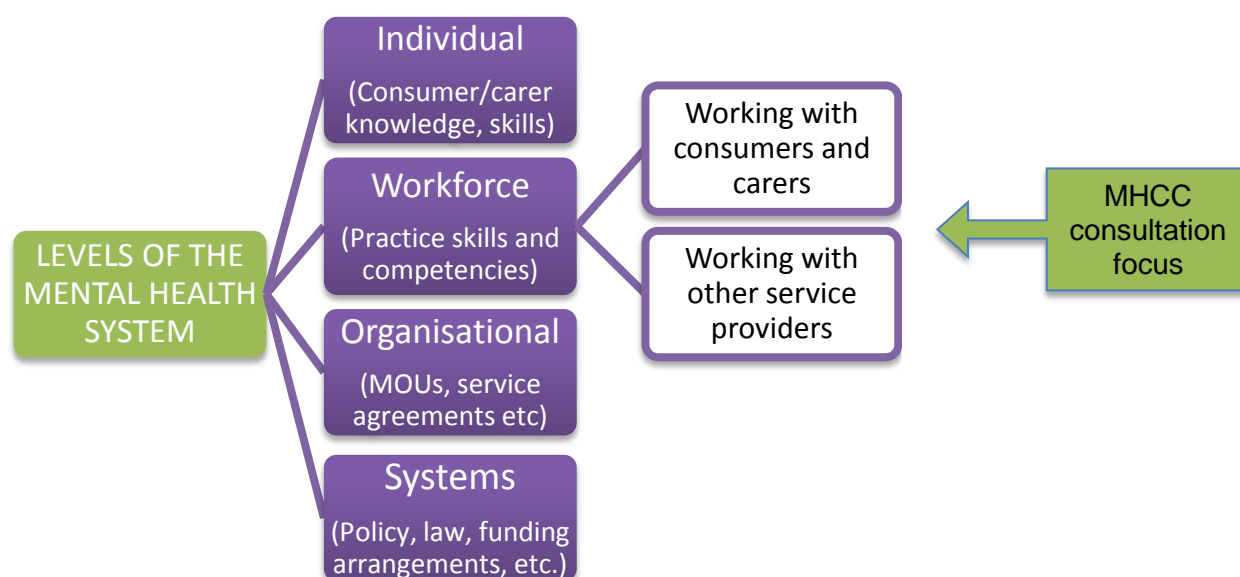
This review of existing literature and jurisdictional experience clearly identified that service coordination is a type of service delivery, but also a set of practice skills. However, there is little evidence of what these practice skills are, or of consumer, carer and service provider views of what characteristics and competencies must underpin effective service coordination.

In August-September 2011, MHCC conducted regional consultations with service providers to explore service provider perspectives of a *Service Coordination Strategy*. A number of priority areas were identified as important to the progression of a strategy. This included the need to consult with consumers and carers about their perspectives of what constitutes good

continuity of care practice, and to conduct a 'needs analysis' with service providers of the competencies (knowledge, skills and attitudes) required to deliver effective continuity of care.

Phase 2 responded to this knowledge gap by facilitating three separate consultations with consumers, carers and service providers as well as targeted interviews with selected interviewees to identify the workforce competencies and skills required to provide continuity of care. Worker competencies were considered at two levels: working with consumers, carers and individuals in supporting self-directed care; and working with other providers in coordinating care.

NOTE: While worker education and training is important to improving the way services are delivered, it is only one level of the system (see below) and in itself will not be enough to change the way services operate.³⁶ Changes are also needed at systems, organisational and individual levels^{37 38}, and these factors will impact on the way in which training can become practice.³⁹ However, the focus of the consultations was specifically on the skills and competencies required at the workforce level.



The MHCC consultations also focused on system-wide competencies. While workers may need specific skills and training for particular roles in different sectors and specialties, the literature points to the importance of identifying overall competency and training needs. For example, the Health Workforce Australia (HWA) Planning and Research Collaboration produced a report in 2011 on competency frameworks using a 'whole of workforce' focus.⁴⁰ The development of shared training and common skill development has the potential to improve trust, mutual regard, and collaboration, and assist in breaking down structural barriers.^{41 42}

The expectation was that the MHCC consultations would gather rich evidence from consumers, carers and service providers to inform recommendations about best practice guidelines and workforce training programs. Phase 2 of this project was also intended to provide recommendations around the progression of the *Service Coordination Strategy*.

Specifically, deliverables from Phase 2 of the project include:

- *Workforce Competencies: Providing continuity of care and supporting self-direction* Background Paper (2012)
- Consumer, carer and service provider consultations facilitated by Jacqui Ford (BushJac Consultants)
- Targeted interviews
- An analysis of existing qualifications conducted by Jacqui Ford
- A qualitative analysis report of the consultations and targeted interviews
- A presentation at THEMHS Conference 2012
- A final report and position paper including recommendations for training, education, and the progression of the *MHCC Service Coordination Strategy*.

WHAT WE DID



3. WHAT WE DID

Participants

Consumer, carer and service provider consultations

MHCC invited Expressions of Interest (EOI) to participate in consultations. The EOI flyer described MHCC's interest in speaking with people with experience of voluntary and/or involuntary mental health services and multiple service providers across service systems, including community and hospital-based services. MHCC was particularly interested in speaking with people who have had positive experiences of providers working well together and achieving effective coordination of services.

The EOI flyer was distributed throughout the MHCC, the NSW Consumer Advisory Group (CAG) and Association of Relatives and Friends of the Mentally Ill (ARAFMI) networks and to other peak bodies including: the NSW Council of Social Services (NCOSS), the NSW Network of Alcohol and Drug Agencies (NADA) and People with Disabilities (PWD). Due to low response rates, some personal invitations were extended and a more active approach to engaging consumers and carers was taken through organisations providing face to face services who were asked to display posters on their premises to promote the activity.

All those who applied met the criteria and were included in the consultations. The consumer ($N = 10$, 8 male) and carer ($N = 12$, 8 female) consultations were a half day each, and the service provider ($N = 12$, 8 female) consultation was a full day. MHCC paid all unfunded participants in the consumer and carer groups \$100, all-inclusive, for the half day.

The participants represented a diversity of individuals with different experiences. Service providers were largely from the CMO sector, however one participant was a private practitioner and another was working in public education. Participants included individuals at the workforce and management levels, including peer workers, with experience in a variety of sectors including mental health, homelessness, refugee support, and the corrections system.

Targeted interviews

The aim of the targeted interviews was to broaden the investigation to include people who represented various sectors, disciplines, roles and areas. People were invited to participate in the targeted interviews because they were identified by MHCC as having particular expertise and experience of the mental health service system.

A total of 11 targeted interviews were conducted (6 female), and the interviewees represented the following:

- Sectors: Public (inpatient and community), private and/or CMO
- Disciplines: Social worker, mental health worker, psychiatrist, psychologist, nurse, lawyer, researcher
- Roles: Deputy CEO, management, team leader, worker, consumer, carer advocate, trainer, researcher
- Populations: Aboriginal and Torres Strait Islander people, people with chronic illness, the homeless, young people, people with intellectual and other cognitive disability, consumers, carers and combinations of the above
- Areas: Mental health, health, housing, DOCS, consumer representation, carer representation, psychosocial rehabilitation, criminal justice, hospital, education, research

- Representation: Guardianship Tribunal and/or Mental Health Review Tribunal (MHRT)

More than one informant disclosed personal experience of mental distress.

Process

Consultation process

A background paper was produced to provide a brief outline of the current service context, and present findings from the literature on workforce competencies in Australia. Information from previous research, policy and practice was included in this paper to stimulate ideas and provide a starting point for discussion. It was not necessary for participants to have read this document before participating in the consultations, as we were keen to ensure that the paper did not limit people's contributions. The consultations focused on individual consumer, carer and service provider perspectives, inviting them to share their experiences and observations.

On arrival, participants were asked to sign a consent form which had been previously emailed for review. During all three consultations, discussion was facilitated around what good continuity of care might 'look like', and the competencies including skills, knowledge and attitudes required to make these characteristics possible.

To minimise potential harm, participants were not asked to focus on negative experiences of care, and it was made clear that the participants were not expected to relay difficult, unhelpful or traumatic experiences. However, given that the content for discussion had potential to cause some distress to some participants, a qualified support person was identified at the beginning of the consultations.

Information was recorded on butcher's paper to enable participants to see that their feedback had been accurately noted and, with the consent of participants, consultations were audio recorded.

Targeted interviews process

Interviewees who accepted the invitation participated in a face-to-face or telephone interview with an MHCC policy staff member. Interviews ran for approximately 30 minutes, and all interviews were audio recorded with permission.

The targeted interviews were semi-structured, so while suggested questions were outlined in the interview schedule, additional questions were asked to allow for elaboration and clarity of particular issues. Please see Appendix 1 for the interview schedule.

Analysis

Consultation data analysis

Thematic analysis of the consultation data was conducted independently by two investigators in order to provide a cross reference. One investigator based their analysis on the extensive notes taken during the consultations. The other investigator used NVIVO10 software to analyse the consultation transcripts using a grounded theory method. This involves a process of developing a theory from the data collected. As themes emerge from the transcripts it becomes possible to compare and link the different categories and concepts, and theoretical ideas emerge around the relationships and gaps between them.

Targeted interviews analysis

The key informant interviews also underwent thematic analysis with NVIVO10 software using grounded theory methodology.

Qualification analysis⁴³

Four qualifications were reviewed:

Service Coordination Qualifications

- CHC70208 Vocational Graduate Certificate in Community Services (Client assessment and case management)
- CHC52008 Diploma of Community Services (Case management)

Mental Health Qualifications

- CHC40512 Certificate IV in Mental Health
- CHC50312 Diploma of Community Services (Mental Health)

The CHC52208 Diploma in Community Services Coordination qualification was considered but not reviewed because it is concerned with the team leader role as opposed to the coordination of services for individual service users.

The performance criteria, skills and knowledge of the units of competency that related to service coordination were reviewed for each qualification. The competencies reviewed in each qualification can be seen in Appendix 2. The competencies were rated against each of the key themes identified by the thematic analysis of the consultation data at one of the following levels:

- High (H) level of content related to the key theme;
- Medium (M) level of content related to the key theme; and
- Low (L) level of content related to the key theme.

The skills and knowledge of the existing qualifications were also reviewed against all of the competencies identified by the consultation groups and gaps were identified.

WHAT WE FOUND



4. WHAT WE FOUND

*“One of the positives of effective care coordination is the whole human service, legal system, everyone works more effectively together because they are used at that practitioner level to collaborate, planning, sharing or problem solving and nutting it out in a professional way”
– Service provider*

“If it is all coordinated properly, you will be off or have reduced your pension, back earning money, paying tax, you’re off the health system, reducing the welfare bill, it all makes sense to get people better and back into society and actually contributing” – Consumer

“It has been my experience that the health system expects the patient to manage themselves long term, so if you have a physical illness then you are responsible for the continuity of your care. It seems that the same expectation is there bureaucratically for those who are mentally ill and they are not...continuously capable of doing that and there is not a formal recognition within the health system itself that that is the case” – Carer

“The agencies are out there –you just wouldn't believe how many are out there – but they are not working together! There is no hub for the spokes of the wheel” – Consumer

“What we see in the community is there is heaps of services out there but it is a maze for a provider let alone a consumer and carer to figure out what they are all about” – Service provider

“I think a person would come away from an initial contact with a service feeling that the service understood where they were at, what they thought was important, what their priorities were at that point in time and were going to work with them on those priorities. So it is that initial point of contact so a person is feeling, ‘Yep, the service understands where I am at, what is important to me, is going to work with me, it is going to be a partnership, decisions aren’t going to be made with other services without me...what I want is going to be the driver,’ and then that the actual services the person is put in contact with or receives or accesses then is consistent with what the person is saying...but that also there was flexibility that as the working relationship continued and as time passed it was responsive to the new priorities and that the person wasn’t just kept to what they said initially, but it was the person directing it. So something that is ‘point in time’, but is not set in concrete and that is responsive to the person” – Interviewee 9

“Obviously it is so linked up with recovery-orientation, engagement, with knowledge of the system and the ability to navigate your way around the system” – Interviewee 7

“More continuous and seamless support between institutions and communities. When I say institutions I mean including prisons, so hospitals, prisons, drug rehabilitation, dual diagnosis programs and particularly as people go in and out of those systems, better communication and a greater willingness for those institutions to collaborate and work with community based workers who provide continuous care” – Interviewee 5

Characteristics and Competencies

“Skilled, trained, qualified, passionate, respectful, flexible and innovative workers are seen as the lifeblood of the system”⁴⁴

Since the characteristics of effective service coordination and the competencies to achieve this were discussed together during the three MHCC consultations, they will be reported together here. Overall, the characteristics and competency themes deemed necessary for effective service coordination identified across all consultation groups and interviewees include:

- A recovery orientation
- A holistic approach
- Support for self-directed care
- Attitudes
- Continuous care
- Inclusive and supportive of carers and significant others
- Knowledge of local services and resources
- Knowledge of compliance with legislation, standards, and evidence-based/best practice
- Effective use of information
- Communication skills
- Teamwork and collaboration skills
- Relationships and ways of working with people
- Medication and mental illness/diagnosis
- Individual role
- Management role

Please refer to:

- Appendix 3 for a summary of the themes and characteristics identified in the consultations;
- Appendix 4 for a summary of the themes and characteristics identified in the interviews; and
- Appendix 5 for the list of competencies identified in the consultations and interviews.

Whilst conducting the thematic analysis, it became clear that a number of characteristics are basic requirements that must inform practice in *all* areas including the recovery approach, holistic practice, support for self-directed care and appropriate attitudes. These areas are interrelated where ideally a true recovery approach includes self-directed care and holistic practice.

Recovery approach

“Professionals...have to be fit for the job, which is to facilitate recovery” – Consumer

“They are the sophisticated skills that we are talking about – the workers have come into this industry with one role and now... we have workers...not really understanding, and nor did the people who employed them, the sophistication of skills required to work alongside people in a recovery-oriented way” – Service provider

“You need to have recovery as a philosophy under your entire course or skill set” – Interviewee 2

All consultation participants and interviewees emphasised that an understanding of recovery is absolutely critical for all service providers. It was identified as a way of ensuring all service providers are ‘on the same page’ and working towards the same goal – supporting an

individual recovery journey - irrespective of different disciplines, training and experience. Specifically, consumers emphasised that service providers must understand a consumer's recovery journey as a long-term, non-linear process unique to each individual. Critical to good outcomes is the need for service providers to foster hope, and focus on strengths rather than deficits.

"Every worker needs to be on board with recovery-oriented practice...this is the only way we are going to be able to bring all of mental health services together" – Service provider

"The recovery model is about not creating a set of rules that apply to all; it is about creating a set of rules that applies to each individual" – Interviewee 4

"The clinician or the worker has to make each person's journey their own, that person's individual journey. You can't say, 'OK, if everybody does X we will all do well,' that just doesn't work" – Interviewee 4

In addition, one interviewee and some carers identified that carers undergo their own recovery journey which also needs to be understood and acknowledged.

Understanding recovery as a concept is not enough. Workers must know how to practice in a way that is recovery-oriented, and implement recovery principles into every aspect of their practice. There was general consensus that recovery is still not widespread in practice.

"[A recovery-oriented approach] is lacking; it varies amongst services, various psychiatrists - not everyone is up to speed on it, and it is critical" – Consumer

"Even within NGOs there are organisations saying they are doing recovery-oriented practice, but on the ground they are still taking over" – Service provider

*"We still hear every day that recovery-orientated services don't exist... they might have a policy or some idea or talk the language, but they don't actually do the practice"
–Interviewee 2*

"One of my friends has been in a rural area in a psych unit and he rang one of the managers in that service whose title was Manager of Recovery and said, 'So I want to know what we are going to do about recovery-orientation in the admission ward,' and he was told, 'Nothing because recovery starts in rehab!' That is the person who actually has the title! So in practice we are falling a long way short. I think there is a lip service that services pay to the notion of recovery" – Interviewee 7

Interviewees identified some tensions between the recovery and medical model including the shift in power from service provider to the consumer within the recovery model, and the recognition that at times this can be intimidating for consumers, carers and service providers. It was emphasised that not only workers, but consumers and carers alike require education.

Interviewees spoke about the need for the complexity of recovery to be taught and explored, including:

- An understanding that recovery-oriented practice goes beyond consumer choice and participation in their own care;
- An ability to practice in a recovery-oriented way with clients in difficult situations including those under the *NSW Mental Health Act 2007* and involuntarily accessing inpatient and community services;
- A better understanding that recovery-oriented practice is not a black and white methodology, but one that requires sophisticated skills to balance concerns such as duty of care and appropriate boundaries;

- An ability to self-reflect and consider one's own role in supporting another person's recovery; and
- A commitment as a worker to ongoing learning and professional development and to improving one's own recovery-oriented practice skills over time.

In order to practice in this way workers must be *“open to the possibility that the person may recover and realise their abilities”* – Interviewee 6.

Existing research has reported that psychosocial rehabilitation skills are largely undervalued and that ongoing use of the medical model continues to impede genuine service coordination, collaboration and shared care.⁴⁵

The concept of recovery is embedded in National, State and Territory policy, including in the *Australian National Standards for Mental Health Services*, however it is clear that recovery is not yet being implemented consistently in practice. Consequently, Dr Leanne Craze was contracted by the Federal Government to produce a *National Recovery-Oriented Mental Health Practice Framework* with an aim to align recovery practices of all workers across multiple disciplines, roles and sectors. This Framework is in its final draft following national consultations, and is awaiting endorsement. This is an exciting development which will better support recovery-oriented practice nationally.⁴⁶

PIROs are required to engage in quality improvement activity to increase and strengthen service coordination. We recommend MHCC's Recovery Oriented Service Self-Assessment Tool (ROSSAT), which is mapped to the *National Mental Health Standards*, as a tool to support individual workers and organisations to improve their recovery-oriented practice.

Holistic practice

“Coordination looks not just at one part of your life but the whole of you, your physical issues, your housing issues, the whole thing and looks at it as a whole and how they interact with each other” – Service provider

“It is not just holistic of the person, holistic of the person within the context of their life” – Consumer

“Everybody having respect for the person as a whole and not just focusing on, ‘This is my skill here so I’ll just do this little bit’” – Consumer

Being recovery-oriented also means practicing holistically. Holistic practice was identified in consultations and interviews as a critical characteristic of effective service coordination including the need to look at more than one aspect of a person; the need to look beyond the role of medication; seeing a person in their environment; understanding the ‘whole of life’ impacts on health and experience; support networks; and community engagement in particular. It was also identified that workers need to see the person in the broader context of what opportunities and resources are available in their geographic area.

Consultation participants and interviewees discussed that improved training and skill acquisition is required to work with and support people with complex and co-existing needs. A number of particularly important aspects of holistic care were identified, including mental and physical health; developmental, cognitive and physical disability; substance use and misuse; criminal justice issues; cultural, social and economic diversity; the impact of interpersonal trauma; and the interrelationship between these factors, and how they might impact on service provision.

“The compartmentalising – psychiatrist: I am going to do medication – psychosocial needs, OK, the psychologist should do that – physical health, your GP should do that. So it means that the damage done by the drugs gets to a severe point before someone does anything. My daughter has had every side effect possible and it has taken years to undo the damage to her metabolism, when she started on it she was 62kg. She went up to 112kg in three months on [medication], so her joints didn’t cope, her liver didn’t cope; they took her off that drug. That was when she was 15. She has just turned 26 and has only now just managed to lose the weight. It has taken that long to regain some self-dignity and confidence in herself and be physically healthy. That is the whole, holistic stuff...it is team-based, everybody [working together]” – Carer

Interviewees agreed that it is the responsibility of the service provider to be proactive in viewing a person holistically and asking about their whole of life needs. They emphasised that it is not just workers on the ground providing services but everyone, including for example, some members of the Mental Health Review Tribunal, who need holistic practice skills.

Evidence shows that people with mental health problems have a high incidence of poor physical health. Multiple associations have been found connecting mental illness with cardiovascular disease, substance use, obesity, diabetes, co-existing disorders and early mortality, to name a few.⁴⁷

Despite this evidence, the system tends to focus on its particular area of interest and manage mental health and physical health issues in two separate systems.^{48 49} The importance of mental health as part of whole of health is not reflected in the allocation of the health budget. The literature emphasises that a service coordination strategy must employ a holistic approach that recognises the relationship between mental and physical health. A strategy must minimise stigma between systems and the workforce and encourage education and training in the relationship between mental and physical health.⁵⁰ In addition, the literature identifies that service and care plans must be expanded to include bio-psychosocial needs.^{51 52}

Support self-directed care

Recovery is not being practiced until consumers are being supported to direct their own care. Service coordination is not just about coordination between services – it must involve a partnership between workers and consumers achieved through support for self-directed care.

“It is our experience, our recovery, our lives; everyone else has gone out to do their profession and do their own job to support us without asking what we need” – Consumer

“Always holding the person, offering the person to speak for themselves, always to make their own decisions...all I keep hearing is the doing, the service is ‘doing to this person’ and I forget sometimes what we are talking about, but we are talking about a person’s life and I think we owe it to people to hold them in that position as much as possible” – Service provider

“One of the goals of care is to help people be self-directed, so the whole notion of a cooperative arrangement is important, and letting people actualise the skills and abilities that they have” – Interviewee 6

Self-directed care was identified as a challenging and complex task. The environment has changed and new demands are being made of workers.

“What we are talking about is a completely different role. We are not the experts anymore, and within two years to suddenly have people who are life coaches – it is a completely different set of skills” – Service provider

"We have 'done to' people for centuries. It is us backing off and holding this person in a position where they lead. How to get this person to be in this position where they are leading requires a lot of skills" – Service provider

The consultation groups and most interviewees agreed that there is a need for sensitivity across the continuum from managed care to self-directed care according to the individual and their particular situation at any given time. The importance of supporting consumers to self-direct care where possible was highlighted as absolutely critical to how care is delivered and coordinated. Discussion occurred about the difficulty of self-directed care in a range of situations when, for example, people have been institutionalised or led to behave passively over long periods of time, when the development of skills has been disrupted and when choice does not necessarily exist. This includes people with forensic histories, people in high-needs group homes, people accessing services involuntarily and/or on a Community Treatment Order (CTO) or under guardianship.

Interviewees identified the importance of recognising that the ability to self-direct care is not only influenced by limitations related to mental illness, but also by a range of other factors including cognitive development, language, culture, education level, financial position, individual temperament and upbringing. In addition, it was noted that the ability to be self-directing can mature over time, along the recovery journey.

While it was highlighted that the term 'managed care' is disliked, consultation participants and interviewees conceded that there were times when it is appropriate for service providers to have increased control and responsibility. However, where people are unable or choose not to self-direct it was emphasised that service delivery must be person-centred at the very least. It was suggested that this process involves more than a decision about whether someone has capacity to self-direct their care or not; it also involves being sensitive to the particular areas where they may be able to self-direct. The consultations emphasised that self-directed care must be conceptualised as the norm and maximised where possible. Only in instances where it is absolutely necessary should workers and carers step in and take more responsibility and control.

"There is a saying, 'nothing about me without me' and that should be the motto"
– Service provider

"If we hold this up as a given and work backwards and forwards from that, and at any point along a journey that person will be able to pick that role back up" – Service provider

"It would be great if it was a given...and we all agree that this is a role the person should be doing themselves – self-directed care. If this person isn't able to do it at this particular time, they need to nominate their negotiator or their coordinator until they are ready to take that back" – Service provider

"If a person is not being self-directive, then I think it is finding out what they can be self-directing about. It might be that by talking to the person about what is important to them, something unlocks their whole motivation to be self-directing" – Interviewee 9

"There are different levels of how much of your own care you can coordinate, and so the normal traditional care coordinator's role is then to find the places where their expertise can fit into the other person's needs, rather than just saying, 'We are going to take over your life,' which happens so much in psych hospitals – 'We are going to take over your life.' Well no, I could say 'I can see quite well you have got no problem feeding yourself but I can see you have got a problem forgetting your medication. Is this something we can help you with, the medication?'" – Interviewee 4

The notion of 'mothering' and taking control for a person was discussed, as was the critical importance of knowing how to support without taking control, whilst balancing risk. This

involves a substantial shift in mindset to better comprehend what your role is as a worker and understand the power dynamics involved in providing support and remaining person-centred at all times. Coaching skills were identified in the consumer and service provider consultations as necessary to assist people to become motivated and to feel capable of taking on more self-responsibility. Consumers noted the importance of concerted efforts to connect with the person to help them re-connect with themselves. Further, it was pointed out that no assumptions can be made that a service provider or carer should automatically step into the care coordinator role.

“We say, ‘Well, what we do is we will throw this around you and talk about wrap-around support,’ and we are already disempowering people; they didn’t even choose anything, and I think that space needs to be more mindful” – Service provider

“Coach training, it is a very different skill set to [establishing a] therapeutic alliance” – Service provider

“If it is a person who has real difficulty managing things on a day to day basis, part of the key support person’s role would be coaching” – Service provider

“Mental health professionals ... have been trained that, ‘I can fix this.’ We all have to, I had to lose my PhD in control because it is not my journey, I am just partnering with others” – Service provider

“Sometimes they think they know what you need. Everybody thinks they know. Unless they have these competencies, the consumer is left out of what they think you need. It is you and the consumer agreeing and only when you are acutely unwell they need somebody else. That should only happen in an acute situation” – Consumer

As described, the skill set that service providers require is a very sophisticated one. Workers need to know when to step in and take more responsibility and control, and when to take a step back and resume a supportive role. It was suggested that this competency involves a significant attitudinal shift for workers, consumers and carers alike.

“You have to have workers who have the attitude and mindset that it is the person who is the expert of where they are at, what they need, what they want. The worker has to have a willingness to be guided, and advocate for the things that person has just told you they want” – Service provider

“It has been a lot of work getting the members to see the value in talking control of their own life as well. They have spent years, a lot of them, being told what to do, a big shift...it is big for everybody... I have had a lot of interesting conversations with carers about the same issue – ‘Why are you telling someone he can make his own decision?’ That has happened a couple of times here, that carers of some of our more chronically ill members have sort of taken [badly] to us telling this person that they are their own person, they can make their own decisions. So the carers have to be somehow included in this process of trying to get people to think things through more, and engaging in a collaborative care...it is not just about the worker” – Interviewee 4

“Of course it is a dignity of risk issue but the duty of care issue kicks in...there would be the occasion where you would have to intervene and say, ‘Well no, I am going to have to force that issue,’ but again we have seen a few people who have become unwell since I have been here, and they have been quite acutely unwell, but every single one of them has gone to hospital willingly in the ambulance or on one occasion a police car because we have actually discussed, firstly, do you want to go to hospital and if they do say no then it is explained, ‘Well the reason we are doing this is for these reasons: we see you are unwell, we see you need some help. Do you mind if I call an ambulance?’ And every time that has happened here (and unfortunately it is too many times) every person has gone off to hospital willingly. Now the alternative way would be for me to literally sneak around, bring an ambulance here and they get a hell of a shock to see there are a couple of policemen or ambulance at the door and that wouldn’t leave [the service] in a good position in terms

of ethos of being an inclusive place and it also leaves that person who is unwell in a very angry place as well. So again it always comes back to, no matter what happens, it needs to be as much as possible to get the person to make those decisions. When you do unfortunately fall into a duty of care situation even then you can still to a large degree get people's consent" – Interviewee 4

These findings align with the literature that people should be able to choose a level of control and responsibility that best suits them. While it is clear that many consumers would like access to more information than they currently have, they do not necessarily want to self-direct their care in every part of the service delivery system.⁵³ Preferences for level of support and responsibility may vary for a number of reasons including:

- Across different services, for example wanting more support from some services and less with others
- Over time, as circumstances and needs change
- Individual differences including age, level of education, cultural background, cognitive ability
- Due to other supports, including family and friends, and their level of involvement⁵⁴

The literature also considers issues of advocacy, services matched to individual need, empowerment, support for enabling the person to identify goals for themselves, rights-based practice and the tailoring of services to meet cultural values and expectations^{55 56 57 58}. It is identified in the literature that *"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"*⁵⁹

Attitudes

"Open-minded, awareness of your own humanity, trust, see you as a human being" – Consumer

"Consumers won't open up [without] an attitude of respect, or if you feel to a service you are irrelevant, if they are patronising, you are less likely to engage in a service you don't believe will support you" – Consumer

"They need to respect the skills of the other services. I mean talk about heart surgeons and brick layers – a heart surgeon cannot build a house but that is vital. It is vital, so you need to respect the other services skills providing that part of the recovery journey" – Consumer

Attitudes of workers were identified as a crucial component of effective coordination and a key factor in the level of engagement a consumer will have with the service system or an individual worker. The key attitudes that must underlie coordinated care were identified as:

- Respect for the person, their carers and significant others and other service providers
- Acknowledging consumers as equal human beings
- Acknowledgment of the person, carers and other service providers as experts and a core part of the care team
- A human rights perspective
- Collaborative attitudes
- Patience
- Open-mindedness
- Non-judgmental
- Self-reflective
- Passionate

- Dynamic
- Flexible
- Creative

“They need to be aware of their own values, the impact of their own values on the work that they do with certain people” – Service provider

“You have to be creative to work with so many different people at so many different levels, and to maintain that individual focus you really do need to have some level of creativity within yourself to be able to change and adapt and be flexible” – Service provider

“It is a question of reciprocity. If you are passionate about recovery, you want the person to be matching you and facilitating along the way instead of having a glum attitude that this is a day at work. That doesn’t really create a type of environment where the consumer wants to ‘go to work’” – Consumer

“Not making assumptions, I mean we had a Consumer Consultant...and I went to his funeral, and because I assumed that he did not know many people it was a shock when we walked into the church – it was filled with many people. He had been a very active member of the church, he had helped teach English to priests from overseas, African and Asian priests who were doing their training, and he loved the choir so they all sang. And here I was thinking, ‘He knows us and the mental health service.’ And many people had brought their children to the service and he knew three or four hundred people! So good lesson to learn...not to make assumptions about people” – Interviewee 1

Interviewees also shared specific information about the need for improved attitudes among young graduates towards people experiencing mental distress, and worker attitudes towards homelessness, homeless people and people who are in contact with the criminal justice system.

These attitudes align with qualities that have been consistently identified as important in the literature, including the need to be flexible, positive, encouraging, and committed to working collaboratively with consumers, their significant others and service providers.⁶⁰

One reason identified in the literature as to why interdisciplinary practice does not occur is 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.⁶¹

Continuity of care

“What are your generic skills? It is all about engagement, assessment, and clearly people have to have the knowledge of a recovery orientation” – Interviewee 7

To achieve effective service coordination, continuity of care must include a number of things. The following aspects of care were identified as needing to be consistent with a holistic recovery-oriented approach supporting self-directed care.

Access to services

Carers in particular connected the importance of accessibility to services to effective service coordination. Eligibility was identified as one of the major barriers to access and it was repeatedly mentioned that the system is crisis-led.

“I have seen the red tape come in, ‘Your case is not severe enough in comparison to the other case,’ but this is where common sense, well, actually, sound judgment comes in” – Carer

“I spent five years trying to get any service, any appropriate service for my son” – Carer

“There was a new administrator; I was acute; someone was new in some administrative role and those that knew my case history were looking to admit me and I did end up getting admitted and she ended up putting on a, ‘What for?’ in front of me while I was acute, about almost a, ‘How dare you think you can waltz up here and think you can be admitted?’ and I was acutely unwell and nearly beside myself with grief at her attitude...” – Consumer

Interviewees proposed that individuals should not only have choice about their care, but who provides their care. More than one spoke about the importance of choice of provider, and ensuring there are enough providers offering appropriate services that people can choose from. There is no ‘one size fits all’.

A key issue when discussing service coordination is consideration for not only how service providers will work together, but also how they actually engage people and provide access for them to begin with.

“Well the only reason this was able to happen is because I have another child with cancer and I can’t take care of them both... my daughter has cancer, and if you ask my daughter – because that was the reason that my son was prioritised – she will put her hand over her heart and say, ‘There is nothing I wouldn’t do for my brother’” – Carer

Consistency

“It is patchy. I am experiencing some good stuff in Sydney but obviously other places not” – Carer

“Living in a regional area means there is hardly any staff with very little time, so they only have time for crisis and none for follow up...So I guess the word I want to emphasise is consistency” – Carer

Carers, consumers and interviewees discussed the extreme inconsistency that exists in the system as a whole across workers, organisations, sectors and regional areas. Some positive experiences were shared around effective service coordination, and some expressed the hope that if it is happening for some, it is possible for everyone.

“I know it can happen so we have to get it happening right across the board, in every health area, right across NSW” – Carer

“If it is happening somewhere in NSW, there is a capacity for it to happen everywhere, so that is encouraging, to know it could be across the board in the future, that area health areas might get their act together and learn from each other and do it that way” – Consumer

Both groups spoke of the importance of moving towards a more consistent service system. Although consistency was sometimes discussed in terms of systems and resources, it was also noted by consumers that gaining consistency requires improvements at the practice level. For example, consistency requires that service providers work together and learn from each other. Interviewees added that inconsistency may be related to a lack of standardised training and skill levels.

Early intervention

Consumers and carers stressed the importance of early intervention when conceptualising continuity of care, and the need to prioritise care before a crisis eventuates.

“Everything is crisis-led, where someone has to get to a severe point to get access” – Carer

“Coordinated care should start way, way, way before a crisis” – Carer

“My son was psychotic almost without relief for five years. The cognitive damage is noticeable. If there had been intervention with the same type of services it would have been more short-term. How do we create, how do we get services to respond at a time when a response can have the maximum effectiveness? Let’s not wait until the person is in a critical condition, when the person is damaged,

when their lives have been so disrupted, not only for the individuals experiencing it but for the families as well. I have seen marriages break up...we need to be looking at how we can prevent that” – Carer

Assessment/inquiry and planning

“Asking the right questions, not making too many assumptions, being person-focussed when talking to them, doing comprehensive assessments, and doing it over time because people tell you different things at different times...” – Interviewee 1

The ability to make holistic assessments that are consistent with a recovery approach received a lot of attention from service providers. To begin with it was noted that the term assessment itself is problematic and a number of alternatives were suggested, such as inquiry or consultation. The importance of encouraging the consumer to ask their own questions about the service and what to expect was also highlighted.

Consumers and service providers discussed the importance of good planning skills, including the ability to prioritise what the consumer identifies as necessary, and getting the most important things done first. Housing was regularly identified as an obvious priority. Interviewees also raised the importance of planning to support consumers to stay well, and consensus was apparent about the need to review assessments regularly and provide ongoing support. As explained by a consumer, *“It is about life changes – nobody is fixed!”*

It was identified as crucial to conduct thorough assessments and planning, to include the appropriate people, to know how to ask the right questions and to spend enough time to ensure you recognise what is important for the person at that time. The significance of including the consumer in the decision-making process during assessment and planning, as well as tailoring care to the individual was raised by consultation groups and interviewees, as was the requirement to identify whose role it would be to do what during the assessment and planning phase.

“How can you walk alongside somebody and guide them when you need them to if you don’t have in your head a frame to sort out what is the most crucial thing that might enable that person to step forward themselves?” – Service provider

“I still think you need to start by asking the person who needs to have that responsibility for thinking, considering. And that is where your work begins – to help identify the person, identify, ‘What should be my next step?’ and the skills come in to support – not ‘help’ – that person” – Service provider

“Again, one solution doesn’t fit all; it needs to be tailored to each individual’s needs” – Interviewee 8

“It is trying to include someone, and the planning process isn’t just about trying to get their consent” – Interviewee 8

There was concern raised by service providers that people can be over-serviced, and that knowing how to avoid this is also a necessary skill. Likewise, assessments are not only about identifying what it is a person needs, but also providing them with what they need which is often the most difficult part.

“It is not about just assessing what is actually needed but it is providing it to them and that is actually the much more difficult proposition. I mean the United States leads the world in all forms of medical research and yet it has got an absolutely hopeless system of actually providing health care to its citizens and it is actually the delivery system which is actually more important [laughs]” – Interviewee 3

Ongoing support, re-access and follow up

*“Everyone needs to at different times come in and out of whatever services people require at the time”
– Carer*

Consumers and carers spoke about the need for recognition that they may need to access and re-engage with services at different points in time.

Consultations identified that to achieve effective continuity of care, services must remain accessible over time, and ongoing follow up by services where appropriate was essential. Whilst a number of service providers said that they engage in follow up practices, the need for more widespread follow up was highlighted.

“When you let go, it is important to feel that if the need arises again the door is open, they don’t close it on you” – Consumer

“I had a great case manager at one time. I thought I could let go of case management. He thought I could let go of case management. So I said, ‘If the case arises that I need case management again...’ he said, ‘Yes.’ Then when I went into crisis a few months later, and I called them, they said the file was closed” – Consumer

“In the first four years he was sick, he nearly lost his life on four occasions, he had eighteen critical admissions. He has not been near a hospital in nearly six years and he has not had an episode. This is what makes a difference. It is the continuous needs being met, and allowing his family to become his family again. For me it is an example of what can be done right” – Carer

Evaluation and quality assurance

The need for service coordination to be included as an outcome measure and key performance indicator to provide incentive for effective service coordination was raised a number of times. It was proposed that all workers should have an understanding of this as a part of their own practice, including the need to be sensitive to individual differences and an understanding of terms such as ‘well’ to begin with. Acknowledgement that qualitative information regarding consumer and carer experience is valid and useful is also required.

In addition, interviewees identified the importance of understanding evaluation processes and personalisation of this process through self-reflective skills.

Meaningful referral and supporting transitions

“What this flags in my head...was how often a referral happens as part of the ‘tick and flick’ process: ‘Goody, I can’t do this. I am referring them to you and they are now yours.’ It is not about that person wanting to go on that path; it is you and your workforce. I used to be a psych nurse so I can speak from practice, the pressure on me to get a throughput of clients; so you are always looking for that exit point, the person you can push onto. So that is a real rubric we are going to have to think about. It is very institutionalised behaviour” – Service provider

“A lot of the time consumers need to understand that at the very beginning – that these health professionals are responsible for the transition between services. So one of the things I experienced myself was the inappropriate, disjointed movement between services” – Consumer

Interviewees discussed the importance of supporting transitions and identified that workers must know how to make meaningful, appropriate and timely referrals. One of the largest gaps consistently identified was discharge planning.

Often when people talk about coordinating care, they talk about referral processes only. Consultation participants and interviewees made it very clear that referrals should not be

understood only in terms of sending people to another service; it is a process that supports transitions including knowing when to refer, knowing who to refer to, referrers working more effectively with referees and support for self-direction where possible by including the person in the process, and providing them with information at each step of the way.

“This is a skill set about transitioning people between services” – Service provider

“When I was last discharged from hospital I was given a note to take to the pharmacy that says, ‘Here is your pills for a week, here is your appointment with a doctor written on a piece of paper with the doctor’s name and go home,’ and that is only unusual because I had been in and out of hospital, I knew what I needed and I stamped foot and waited four and a half hours to get that piece of paper and I was prepared to do that because that is what I knew I needed” – Consumer

“I am bipolar, had enough, ended up in ICU for ten days, I was seen by the mental health team; they discharged me, said, ‘There is your prescription. Go and see your doctor,’ no follow up care whatsoever” – Consumer

The characteristics and competencies outlined as critical to providing continuity of care align with those outlined in the *MHCC Care Coordination Literature Review and Discussion Paper*, which identified that service coordination makes the assumption that individuals can be assisted to access all the services and care they require. It reported that the important concepts for service coordination with an individual person include person-directed and -centered service delivery, assessment, planning, monitoring and review.

The evidence reports the assessment process associated with coordinated care must be holistic and comprehensive⁶² and it is stressed that re-assessment must occur to monitor progress and outcomes and to identify unmet or changing needs.^{63 64} In addition, service and care planning are identified in the literature as being essential to engaging and coordinating an optimal mix of services and treatments to comprehensively address needs^{65 66 67} and to promote multifaceted and multidisciplinary service delivery.⁶⁸

It has also been emphasised in the literature that effective service coordination requires collaborative assessments, monitoring and review.^{69 70 71 72}

NSW Health’s *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals* (2011)⁷³ aims to improve the consumer experience from admission to discharge from hospital by outlining five stages of care, and developing standards for transfer of care. While this is labelled a care coordination policy, it appears to focus solely on discharge processes rather than requirements for continuity of care. MHCC advocates for an increase in community follow up within seven days of discharge from a public mental health unit, and for a review of discharge processes to enhance transfer of care and continuity of care.

Inclusion and support of carers and significant others

“When we consumers are well, carers have a good quality of life and when they are experiencing a good quality of life consumers are more likely to stay well” – Consumer

“They are essential – they see you at your worst” – Consumer

“It is about learning, establishing the relationship, then looking into, ‘OK, who are the family members?’ Because whatever the care worker or coordinator does will impact the decision and needs of the family” – Service provider

“If you try to look at the client in isolation and leave out the key supports then you are not going to build capacity within that group, so if you start looking at what the needs are with those key support people, you need to be providing them with something” – Service provider

Involving carers as an important part of the care team was discussed as a critical element of coordinating care. There was discussion that although the practice of including significant others may be improving, it is still inconsistent.

It was suggested that one of the roles of workers is to identify the supports in a person's life. Consultation participants and interviewees spoke about the benefits of working with families and trusted others to increase cooperation, and to gain access to vital information that a worker otherwise wouldn't have. Carers identified themselves as having crucial background knowledge and, as such, should be recognised as an important resource. Consumers also spoke about the importance of including carers, who are often the closest to them and able to pick up on early warning signs.

“This is where I feel parents are underutilised, because we are the one doing all the work and when it comes to supporting our relative, or wife, or son, that is when we should be utilised in the recovery process with the case workers, to talk about what has worked, what hasn't, where we are at, where we have been” - Carer

“I think it is where family and friends are often the people on the ground who notice it first because they are seeing the person quite frequently and I think that really is where there needs to be some liaison” – Interviewee 10

All consultation groups and some interviewees discussed the importance of educating family and carers, and the need for awareness around family and carer support needs as well.

“I think explaining to the carers and family about what recovery is, helping relationships...it is very important, mostly because they are the ones living with the consumer. I know I put my family through hell, and only because they were putting me through hell, and the relationships while I was unwell were very, very unhealthy. Not only that, it is the family and the people you live with who have the first warning signs that you are becoming unwell. That is your unofficial triage. They can say, ‘I don't think you are doing so well, do you want me to call the community health centre?’ So that relationship and the information around the difference between the symptoms of the illness and what the illness actually is is very important, and what the medication does a lot of the times is to relieve the symptoms of the illness rather than treat the illness, so family, friends and loved ones all need to know that, that education around the illness particularly, but it also goes hand in glove with an education about what wellness is, and what recovery is, and how you can view that as a family unit, how you can view that with a spouse or de facto, and how you can work in relationships towards that healthy outcome – very important” – Consumer

“My wife was diagnosed ten years ago, she first disappeared.... Back then I knew nothing about it and it had to be an emotional and physically draining and mentally draining learning curve and there wasn't enough education or pathways for how to care for the consumer but also I have three young children, my youngest is three and my eldest is ten, so I did [have] a nervous breakdown, but I was strong enough to pick myself up and continue. I am priority number one and if I don't survive, the rest of my family suffers, so I put myself there. There is also a pathway to care for the consumer but there is little care and consideration for carers” – Carer

Tensions between consumers and carers were touched on a number of times by carers. An important point raised by carers and interviewees was that inclusion of family and carers should not be an automatic assumption.

“I dislike it when people always refer to the family worrying about the loved one. Well sometimes they don't love the person with mental illness, and the person with mental illness doesn't love them. I think we always make the assumption that family is always lovely,

supportive, kind...we mustn't make any assumptions. I think a bit of knowledge about family dynamics would help" – Interviewee 1

Peer workforce

Consultation participants and interviewees discussed the importance of respect and recognition for the role of peer workers, and that workers need to acknowledge the value of lived experience. In addition, consultation groups and interviews identified that workers need an understanding of carer peer workers.

Findings from consultations and interviews are supported by the literature which views the person experiencing mental illness, their families, significant others and supporting peers as key participants in the coordinating service team along with service providers.^{74 75 76}

Evidence shows that the different cultural values and expectations of different population groups will influence whom a person wishes to be involved from among their families, friends and other supports, both formal and informal. For some it will be culturally appropriate for family and/or community elders or leaders to be involved in the coordinating service team.⁷⁷

In instances where a person's illness has resulted in isolation from family and friends, the literature also highlights the importance of involving a peer worker in the coordinating service team if the consumer so wishes.^{78 79 80 81}

Knowledge of local services and resources

One of the key competencies identified by all three consultation groups and interviewees was the need for good local knowledge about the services available, and the ability to find them. Workers need not only an awareness of local services, but also an understanding of what they do and how they operate.

"One of the conferences I went to, they swapped someone from a community team and put them in the acute ward and put an acute ward member into the community and when they went back to their regular jobs they were much better at their jobs...They need to know the actual reality of it, not just the theory...because the reality does not match the theory and they come out of their training with heaps of theory of how it should be but that is not the reality"
– Carer

"All of the different professions and organisations have to have clear understandings of what each other does" – Consumer

"You have to have someone who understands how Centrelink works to be able to cut through" – Service Provider

"There is also a need as a worker to be informed of all the services within the area because access to services might be a problem" – Service provider

"It is about the GPs not being afraid to say, 'I want to know a bit more about how mental health programs work'" – Consumer

Knowledge of resources and how to make the most of them was identified as critical, alongside an understanding of processes at the systems levels, for example, what happens when someone goes to the emergency department, what is involved in CTOs, what funding is available and the limitations associated with this.

“There is opportunity for further training with the GPs...the GPs need more education as to the raft of things that are available as support from a training perspective” – Consumer

“I am not so sure that mental health [service providers] are really aware of just how changed the service system is and I am not sure that is seen, so for example, the Commonwealth is funding services but...some of our long-term practitioners are unaware that these things are out there” – Service provider

“You need to understand the network of services so that you know at which level [of] that network you need to enter in order to get your outcome” – Interviewee 1

“Back to...the left arm not knowing what the right arm is doing outside the hospitals...At one of these days on ‘understanding mental illness’ I was there with about twenty organisations, most of which except for a couple of police officers were to do with an organisation that was involved with people with mental illness across a whole gambit of situations. Would you believe most of them did not know the people next to them, what they did or that they existed? That is the point I am making...Now these were the organisations themselves who were not aware and did not have liaison points of contact of other organisations within their own regional area” – Consumer

Knowledge and compliance with legislation, relevant standards, policies and evidence based/best practice standards

Familiarity with the law was discussed in terms of knowing consumer and carer rights, being able to inform consumers and carers of their rights and complying with standards of care. Such knowledge was identified as lacking and needed by all workers. Likewise, working to a code of ethics and standards of practice was identified as important by service providers and one carer.

Only consumers and interviewees emphasised the importance of working within a rights framework. They proposed that all providers need a minimum understanding of consumer rights in a variety of areas, such as the workplace, not just in direct practice. Carers also discussed carer rights in particular, including the difficulty they experience with the nominated carer forms which can be easily revoked so they have *“nothing to stand on, no way to get information”* – Carer.

Interviewees emphasised the importance of workers having knowledge of government policy and legislation. The *NSW Mental Health Act 2007* was mentioned in particular.

“More importantly, understanding what government policies are in that area” – Interviewee 1

*“Around the Mental Health Act, do you think it is important that people across the board have a good understanding of those issues?
Can I shout ‘yes’? That is worth shouting. Yes, it is really important. Look, even doctors...it is even at that level there is a lack of understanding” – Interviewee 7*

Participants also identified the necessity for an understanding of the balance between duty of care and dignity of risk in recovery-oriented practice, and this was identified as one of the most challenging areas in the service system.

“But there is also the duty of care. The legal balance, the human rights and the duty of care is always the trickiest. I think it must be one of the most difficult areas in all of our society at the moment, that sort of fine line between duty of care and the right of risk too, dignity of risk” – Carer

A parallel discussion around 'risk' is occurring as a part of the *NSW Mental Health Act 2007* review. The discussion paper states that *"historically, the way that mental health systems have tried to reduce and avoid the risk of serious harm can lead to considerable restrictions on people's lives and opportunities"*.⁸² One question is whether NSW will adopt an approach similar to the United Kingdom where risk is reframed through the lens of safety, with a more inclusive and holistic approach proposed to be a more mature and productive re-conceptualisation.

Effective use of information

"Continuation of services, I mean all I hear, even as I mutter, 'Refer on', I think, 'Oh, that poor person has to go and tell their whole story all over again!'" – Service provider

Sharing and managing information

Sharing information was identified as a key characteristic necessary for effective coordination. Participants talked at length about their difficulties gaining access to information from other service providers, consumers and carers or significant others. Likewise, it was noted that workers not only have the responsibility to provide access to information, but to proactively share it with the appropriate people in the appropriate way. This involves an attitude – a willingness to share, alongside an interest in what information already exists.

Managing information effectively was considered by interviewees as necessary to support the process of sharing information. Consultation participants noted that information management and documentation should be considered the responsibility of the service provider, not of the carer as is often the case, e.g. keeping records of medication or general notes pertinent to each individual.

"I just had a complaint about a person whose wife was treated with Clozapine in 2005 and started to get the symptoms of Clozapine toxicity syndrome where the head is dropped to the chest and they can't move. He went to see a private psychiatrist who was so appalled he phoned the hospital and said she is going to die unless you take her off the medication so they took her off the medication... The alternative treatment is a pill and they are now telling him they can't sit there and make sure she will take the pill each day so they want to go back to the depot injections and they can't find any record of her previous symptoms, of the conversation with the private psychiatrist which would say, 'This person is going to die if they go back to this modality' – now what can he do about it? He can't go to the Tribunal..."

It is noted in the literature that service planning processes and documentation enable efficient and accurate communication between members of the service team.⁸³

Confidentiality and privacy issues

One interviewee noted that it is important to be mindful that *"some consumers don't like it when others talk to each other"* – Interviewee 1.

Service providers and interviewees discussed the issue of confidentiality, and consensus was reached that, with the consumer's permission, there was no reason why more information shouldn't be shared. It was noted on several occasions that workers often 'hide' behind the concept of confidentiality and privacy which creates unnecessary barriers to coordinated care.

"It is a complicated space. We hear that our member agencies don't get any access to any information; they are lucky if they get access to discharge plans let alone risk assessments...In theory, with the person's permission there should be a lot more information sharing but it just doesn't happen" – Service provider

One interviewee spoke about their belief that the Tribunal should have a role in ruling about issues associated with information sharing.

Educating consumers and carers

Sharing information is also about educating consumers and carers, and transferring knowledge from the worker to the consumer and their support network.

"The education, for example, things like what is actually physically happening compared to what is psychologically happening; you are suffering an illness but it has an effect on your psychology" – Consumer

"Some of the skills you need...is to have an understanding of adult learning and how adults learn in the first place, the kind of environment adults need to be able to learn" – Service provider

"If you are not educating a consumer to be passionate about their own life, they are not on a recovery journey. They may be in recovery but they may not be on a recovery journey" – Consumer

Interviewees stressed the invaluable contribution the consumer and carer voice makes to worker training and education.

Informed choices and supported decision making

Sharing information is also about facilitating informed decision making, and supporting decision making. Service providers expressed concern about using the term 'supported decision making', preferring the term 'informed decision making'.

Regardless of the language used, the underlying message was the importance of recognising that consumers are capable of making their own decisions and that it is the service provider's responsibility to provide adequate information and support to allow consumers to make informed and supported decisions. A skill also exists around supporting people in not making decisions at inappropriate times.

"Also, I think attempting to engage the person rather than going straight away to the compulsory part will reduce resistance and get better compliance, because you will never get as good compliance without cooperation...Something that is really clear to me is that the Tribunal should be able to make a ruling about this; a person requires treatment, they should not be restricted to only make the ruling that a person needs involuntary treatment, because that is all they can do at the moment. A lot of people see that as their ticket to treatment, and what we say is people should have a ticket stamped by the MHRT but that shouldn't be in circumstances that is involuntary because that can change at the drop of a pin - someone can get insight, someone could be spoken to nicely. They should be saying, 'Does this person have a psychiatric illness? Does this person require treatment?' and then the extent to which this treatment can be involuntary" – Interviewee 3

"I was working with a riverboat captain...and I said, 'Look, you are on your boat; you are in charge; you, steering it down a river. I will be here and I don't want to crash, you know, I will see, listen – there is a shoal over there, so I just thought I would let you know, and you are going to do whatever it is that you are going to do but you have the information! And I am not going to mother you.' That kind of explanation is – he understands it because it is what he does and you can equate that to mothers, anything" – Service provider

The need for flexibility in this area is particularly important when considering how to best support people who feel acutely unwell, lack decision making 'capacity', or are limited by their status under the *NSW Mental Health Act 2007*. During such challenging times, more support may be needed to provide people with every opportunity to contribute to decisions about their own care, for example through peer support and advocacy, stepped care or supported decision making. As highlighted in the introduction, the review of the *NSW Mental Health Act 2007* involves discussion around whether a shift should be made from a focus on substituted decision making to supported decision making, which may mean that a person with mental illness is:

- Consulted about decisions relating to their mental illness
- Supported to make decisions, including in developing a treatment plan
- Provided with information and support to exercise their rights⁸⁴

Communication skills

Critical to sharing information, educating and assisting with informed decision making is ensuring the way in which the information is communicated is appropriate to the situation and person, including through non-verbal communication.

Additional communication skills identified include:

- Explanations that are individually tailored, in the right format at the right time
- Motivational interviewing and knowing how to ask the right questions
- Strengths-based language and approach
- Appropriate language use with consumers and carers
- Appropriate language use with service providers from different disciplines and across services and sectors.

In the service provider consultations considerable emphasis was placed on workers being able to speak each other's language, or being able to develop a shared language, to communicate effectively and ensure the message is being heard.

"We need to understand each other's language. You need to understand the language of clinicians because sometimes when you try to advocate if you don't understand the language it falls on deaf ears. Just as you need to have an understanding of the language of someone working in housing and the policies within that organisation, and it is the same with every person that you work with" – Service provider

In addition, a skill exists around being flexible to communicate in the language that a consumer or carer is using.

"One of the interesting things I encountered when I was first trying to deal with the health service was that I had to learn to change my approach, to change my language, to change my facial expression if I wanted to interact effectively with senior health staff. I had to do it calmly I could not show emotion I had to use the language they were comfortable with. I was nurturing them into a comfort zone rather than the other way around, because when I got upset or annoyed I became the hysterical mother and nothing was heard" – Carer

It is noted in the literature that coordinated care requires collaborative and interdisciplinary practice. Traditionally, however, each discipline involves separate education and training, resulting in interdisciplinary practice being frequently discussed but infrequently taught or practiced, and many mental health workers continue to struggle with the idea.⁸⁵ Reasons for this include different language, jargon and communication about appropriate service responses that can lead to misunderstanding, conflict and distrust.⁸⁶ It is through effective communication strategies that cohesion, the sharing of expertise and knowledge, collaborative practice and integrated service delivery is promoted.⁸⁷

Relationships and ways of working with people

"I suppose in the first place forming a relationship with the person...mutual trust, respect and cooperation between them" – Interviewee 6

All consultation groups and interviewees discussed the importance of interpersonal skills, including the ability to engage and to build rapport and trust. It was identified that there is skill in being able to just sit comfortably with a person, sometimes in silence, especially when they are in distress (in other words, to be able to sit with the pain and not feel the need to make an intervention). Interviewees also discussed the skill of building relationships over time, and in recognising when you may be unable to connect with a particular person and ought to refer them on to someone else. The positive impact of relationships and the importance to consumer engagement was again highlighted.

Boundaries were discussed as an important aspect in building relationships in a recovery-oriented way, and in engaging with people on a human and individual level. Service providers and interviewees identified that boundaries can be challenging for workers, often leading to confusion around what can be expected from a service and a worker by consumers.

Carers noted that workers must also be trauma-informed, and be able to implement trauma informed care into practice.

Finally, interviewees identified the importance of networking skills and the ability to build relationships with other service providers.

"I think it is partly knowing what is out there, and I guess actually having the interpersonal networks as well so it is not just phone numbers and service names but it is individuals and building better networks across those people" – Interviewee 5

The MHCC Care Coordination Literature Review and Discussion Paper identified service coordination as relational and requiring strong working relationships between services users and their families, supporters, peers and communities, mental health workers, service provider agencies, funders and policymakers.

For service coordination to be effective, sustained partnerships between practitioners, service providers and service users are necessary.^{88 89 90 91} The literature suggests that direct engagement including team meetings, conferences and shared learning opportunities will encourage professional relationships among staff.^{92 93 94}

A consistent finding in the literature is the importance of quality relationships of consumers with workers. Consumers have asked that providers be aware of their individual qualities including age, gender, cultural background, stage of life and particular circumstances. They have asked that providers take interest in and listen to their values, preferences, hopes and

goals. The importance of rapport, trust, empathy, respect and being listened to cannot be overemphasised.^{95 96 97}

Trauma Informed Care and Practice (TICP) needs to be integrated into recovery practices, as can be seen in the *National Recovery-Oriented Mental Health Practice Framework* and *Recovery Oriented Service Self-Assessment Tool (ROSSAT)*. TICP is based on an understanding of the physical, psychological and social impacts of trauma on a large number of people who engage with a diversity of health and human services. TICP is a strengths-based approach that recognises the vulnerabilities and ‘triggers’ that trauma survivors may experience and emphasises safety for both providers and survivors. It creates opportunities for survivors to rebuild a sense of control and empowerment, and fosters organisational cultures that are personal, holistic, creative, open, and therapeutic.⁹⁸

Teamwork and collaboration skills

“We have to learn how to play with each other’s toys because we don’t know how to do that either, whether it is organisations or individuals...you need to be trained in how to actually collaborate with others!” – Service provider

“I think there is a lot of skill involved in care coordination. I think it is sort of one of those aerosol [throw out] terms that everyone is expected to know what it means and know how it is done but just to work alone, that takes skill, but to work with other people takes a lot of skill and to work with different people, different organisations with philosophies, different backgrounds” - Interviewee 9

It was emphasised that workers need to break down service silos and start working with all those involved in care – all services and sectors need to be talking. Working cooperatively was characterised as a direct response to the need to be holistic and an acknowledgement that one person or service cannot manage all the various needs a person might have. Associated with this is the acknowledgement that other people are involved in care, and are necessary to provide particular skills and contributions.

“Valuing other people’s and services’ input, and valuing others’ input, expertise and role and what others have to offer and the attitude of not going it alone, not thinking that all the person needs is us – so seeing the importance of other services. Open to working in partnerships and valuing partnerships” – Interviewee 9

It was identified that often, due to lack of communication, it is assumed that someone else is doing the job and this is how people fall through the cracks, or how additional pressure is placed on consumers, carers and significant others. A crucial part of working together was identified as the clarification of roles and responsibilities, which enables both the gaps and duplication in care to be minimised.

Again, it was emphasised that consumers and carers must be viewed as a critical part of the care team.

There is increasing recognition of the need to delineate sector roles and responsibilities, particularly for public and community sector provision of community based services across all domains of practice - in particular, roles and responsibilities during transfer of care in shared care. The role of CMOs in medication management, compliance, breaches, admission and discharge from hospital is also unclear.^{99 100}

Some models of role delineation have been developed within local areas, e.g. Hunter New England Health Services¹⁰¹. This model divides responsibilities into clinical, non-clinical and shared roles for different stages of support including triage and hospitalisation, assessments,

CTO and medication management, review, information and education, rehabilitation and recovery, psychosocial support and exit and transitioning from hospital. While this model has been reviewed more recently following consultation with consumers and carers, MHCC is concerned that it represents a 'one size fits all' approach and separates roles according to sectors rather than integrating them.¹⁰² MHCC thinks a sector-wide approach should be taken and that delineations need to be more flexible than provided in the team model.¹⁰³ In addition, NSW CAG and MHCC advocate that another role be included in the document outlining consumer responsibilities.

Service providers need to work together, be on the same page and operate transparently. Similarly it is not just about telling, but about listening and developing relationships – it involves more than just team meetings and referrals.

A number of team-related skills were identified as important to service coordination including:

- Transparency
- Group decision making
- Conflict resolution
- Negotiation and compromise
- Organised and methodical approach
- Proactive approach
- Self-reflection
- Collaboration

The findings from the consultations and interviews are reflected in a number of previous studies, as reported in the *MHCC Care Coordination Literature Review and Discussion Paper*. Firstly, it is recognised that workforce training is required in interdisciplinary practice and sharing care.^{104 105 106} In Glasby et al. (2008), the researchers discussed the importance of team building and partnership strategies to coordinated care, which requires commitment to shared underpinning ideals of cooperative and coordinated practice. Rossen et al.(2008) also describe some key skills as follows:

“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 bias”

Interdisciplinary team members need to understand group dynamics. 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 consumers and families.¹⁰⁷

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 emphasised 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.

Recently, the Inner South East Mental Health Alliance (ISEMHA) established a Collaborative Interagency Culture and Leadership Program to encourage collaborative practice. ISEMHA found that in order to work collaboratively, there must be a shared understanding of what this means, the stages involved, leadership appropriate to collaborative scenarios and so on. Six categories were identified as important to building collaborative interagency teams, namely:

- sees the bigger picture
- outcome-focused
- self-aware
- communicator
- collaborative leader, and
- collaborative team player.

It is possible that this framework could be incorporated into the development of collaborative training for VET qualifications.¹⁰⁸

Key worker

There was general agreement that ‘an individual’ was required to assist in the coordination process to:

- Create and follow up action plans
- Keep workers and services accountable
- Manage meetings
- Assist in developing role responsibilities
- Ensure that the person is getting appropriate referrals and access to services or available resources

While some participants across all groups spoke about the lack of care coordinators, those who had experience with a ‘case manager’ were largely positive about the impact it had on coordination of their care. It was noted, however, that the term ‘case manager’ is not the preferred one for this role.

This key worker role was described as entailing many functions – to act as a leader, champion, project manager, coordinator. The key worker was described as someone who would push, organise, advocate, motivate and educate. The role was largely seen as building capacity for the consumer to coordinate and make their own decisions. Once again, this points to the differences that exist between a care coordinator and the role that is typically referred to as ‘case manager’.

Significant discussion surrounded the fact that while an individual care coordinator is important, they may not be sufficient. It is not necessarily about having the same one person stand beside you and be your individual ‘coordinator’, but about each and every service provider ‘coaching’ the individual to support them on their recovery journey.

“I honestly don’t think it needs to be one person for the rest of your life” – Consumer

Participants proposed that the key coordinator could be anyone, not just a service provider. It could be a family member, a friend, a peer worker or an advocate who is nominated by the consumer.

A lynch pin within the service coordination team framework identified in the literature is that of a service or care coordinator who assumes a leadership role.¹⁰⁹ However, it is also recognised that by itself, a coordinator “cannot alter biases and shortages in the delivery system”.^{110 111}

Similar to the above findings, the role has been described in the literature as including: the collaborative development of a care plan with each individual, 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, colleagues and service partners as necessary.¹¹² It is consistently reported that coordination occurs more effectively when there is a key person whose role it is to identify the services required, and facilitate timely, ongoing and shared care. A key coordinator requires the skills to practice both as a care coordinator to individual consumers as well as the authority to ensure that care plans are implemented¹¹³. Evidence shows that the level of worker authority ultimately determines how effective a coordinator can be.

Management role

“...which kind of leads on to the fact that if this is what you want in your baselines workers, then the next step would be management training needs to be something else as well” – Service Provider

Although the management role was not a focus of the current consultations and interviews, discussion of this role occurred in the service provider consultations.

In particular, it was discussed that a worker at the management level will need to:

- Act as a coach for the workforce
- Drive a culture of collaboration within the organisation
- Build capacity to reach out to the community
- Engage other workers and services in a partnership
- Develop a shared vision and values
- Ensure workers are receiving appropriate supervision
- Refine HR and values-based recruitment processes to employ workers with appropriate attitudes and commitment to collaboration
- Embed service coordination as a responsibility within all job descriptions
- Develop solid business models for the organisation.

A number of these findings mirror the literature, which include competencies such as:

- Encourage consumer participation and advocacy
- Develop and communicate shared goals and commitment to a collaborative culture^{114 115 116}
- Develop shared records and information systems, standardise documents and create templates for use between services^{117 118 119}
- Develop shared frameworks, guidelines and protocols to improve discharge and referral pathways or transfer of care, information sharing and clarity on responsibilities and accountabilities^{120 121 122 123}
- Explore co-location opportunities¹²⁴ and back of office rationalisation
- Conduct research and evaluation on services and programs
- Form service agreements, e.g. MOUs
- Improve data collection and outcome measuring

- Promote the use of flexible organisational structures that encourage team work and collaborative practice^{125 126}
- Shared safety and quality assurance processes¹²⁷

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

Medication and mental health, illness and diagnosis

An additional theme arose from the targeted interviews that was absent in the consumer, carer and service provider consultations concerning the need for all workers to have a basic understanding of mental illness, symptoms, diagnoses and medication, side effects and associated information including alternative interventions.

“We also have to recognise that there are also quite rational reasons for people to reject their medication, for example, very significant side effects and minimal impact on the symptoms. It is not irrational to resist treatment in those circumstances and this is where the advocacy on the part of those people becomes very important” – Interviewee 3

“I think they need a pretty comprehensive knowledge of mental illness and its implications so that they can recognise where a person is at, diagnose symptoms. I think they need to know about the medication and side effects that people might have and reasons why they can be unhappy taking medications and how to help a person handle that or get the doctor to compromise or whatever is required, acting as an intermediary” – Interviewee 6

Similarities and Differences between Groups

General consensus was reached on a number of points, including the need for a holistic approach and working as a team, effective use of information, communication skills, knowledge of local services and resources, recovery and supporting self-directed care. See Appendix 6 for theme and word frequencies.

Themes discussed most frequently in each consultation group			
CONSUMERS <ul style="list-style-type: none"> Holistic practice Working as a team Attitudes Effective use of information Recovery Supporting self-directed care Communication skills, appropriate explanations Consistent service delivery Consumer education Consumer rights Knowledge of local services and resources Meaningful referral and transition support Ongoing support and access 	CARERS <ul style="list-style-type: none"> Holistic practice Working as a team Effective use of information Access and eligibility Consistent service delivery Inclusion and support of carers and family, and carer rights Knowledge of legislation, standards 	WORKERS <ul style="list-style-type: none"> Holistic practice Working as a team Attitudes Effective use of information Knowledge of local services and resources Recovery Supporting self-directed care Communication skills, effective use of language Assessment and planning skills Key worker 	INTERVIEWEES <ul style="list-style-type: none"> Holistic practice Working as a team Attitudes Knowledge of local services and resources Recovery Supporting self-directed care Communication skills
Themes that were discussed largely by particular consultation groups			
CONSUMERS <ul style="list-style-type: none"> Consumer rights Education for consumers, and importance of explanation Informed choice Meaningful referral and supporting transitions Ongoing support and access 	CARERS <ul style="list-style-type: none"> Access and eligibility Carer rights Inclusion of family and carers Knowledge of legislations and standards 	WORKERS <ul style="list-style-type: none"> Assessment and planning skills Effective use of language Meaningful referrals Evaluation and quality assurance 	CONSUMERS AND CARERS <ul style="list-style-type: none"> Consistent service delivery Early intervention CONSUMERS AND WORKERS <ul style="list-style-type: none"> Communication skills Need to prioritise care Recovery Supporting self-directed care

Support Facilitators and Partners in Recovery

The *Partners in Recovery (PIR) Fact Sheet, Information Paper and Program Guidelines* provide information on the PIR initiative, how it is expected to operate and how to apply for funding. PIR aims to facilitate coordination of and collaboration between multiple sectors, services and supports to better assist people experiencing severe and persistent mental illness with multiple needs. PIR will be delivered by 'suitably placed and experienced' non-government organisations across Medicare Local geographic regions. PIR Support Facilitators will be engaged by the PIRO to undertake day to day tasks in supporting the role of the PIRO and these Support Facilitators will be 'appropriately skilled and experienced individuals'. No further information is provided on whom this might include, and what the requirements might be in terms of qualifications, training or experience. Below is a comparison of the qualities identified by the PIR guidelines as important for Support Facilitators in comparison to the themes that emerged from the current MHCC consultations.

PIR Criteria for Support Facilitators	MHCC Consultation findings
<ul style="list-style-type: none"> Encourage a recovery-orientated culture 	Recovery approach
	Holistic practice
	Support self-directed care
<ul style="list-style-type: none"> Possess personal qualities such as humane concern, empathy with both the client's issues and service provider experience, imagination, hope and optimism. 	Attitudes
<ul style="list-style-type: none"> Analyse and formulate assessments and plans 	Continuity of care
	Inclusion and support of carers
<ul style="list-style-type: none"> Share experiences and information 	Effective use of information
<ul style="list-style-type: none"> Have strong communication and negotiation skills 	Communication skills
<ul style="list-style-type: none"> Have experience with and understanding of clinical/health and/or experience welfare service and support systems Relevant expertise and knowledge to equip them to understand and be the bridge between Commonwealth, state/territory and local services and supports An understanding of what services are in the region and who needs to be connected with whom to successfully meet the objectives of PIR An understanding of the region's demographics and number of people within the PIR target group in the region 	Knowledge of local services and resources
	Knowledge and compliance with legislation, standards, policies, evidence-based/best practice approaches
<ul style="list-style-type: none"> Capacity to engage people who have often been difficult to work with Build and maintain effective relationships and partnerships and have strong networking abilities 	Relationships and ways of working with people
	Teamwork and collaboration
<ul style="list-style-type: none"> Be confident in the appropriate use of authority 	Individual role
	Management role
<ul style="list-style-type: none"> Have an understanding of mental health issues and/or experience working with people with severe mental illness 	Mental illness and medication

It is clear that a number of critical characteristics have been overlooked including:

- Holistic practice;
- Support for self-directed care;
- Inclusion and support of carers and their needs;
- Knowledge of and compliance with legislation, standards, policies, and evidence-based/best practice approaches;
- Teamwork and collaboration; and
- Management skills.

Of note is the fact that what is known about the proposed PIR evaluation framework does not currently include workforce and as such does not recognise the critical importance of practice skills to the successful coordination of services and the PIR initiative.

Comparison to Findings in a Similar Australian Study

A study conducted by Lawn et al. (2009)¹²⁸ investigated consumer and carer perspectives on the skills that primary health care professionals need to provide effective self-management support for people with chronic conditions. This research was linked to a previous body of work by Battersby et al. (2008)¹²⁹ which involved an extensive audit of training organisations, focus groups and interviews with the primary health care workforce. While the chronic conditions considered did not specifically include mental health, mental health certainly qualifies as a chronic condition for some people and as such the studies are comparable. The findings from these projects are presented below in comparison to the themes arising from the MHCC consults.

Audit of PHC Workforce (Battersby et al. 2008)	Consumers and Carers (Lawn et al. 2009)	MHCC Consultation Themes (2012)
	<ul style="list-style-type: none"> • Collaboration with consumers and acknowledging their self-management role • Identifying consumers' strengths and supporting self-efficacy • Understanding stages of change and consumer motivation or perceived lack of it 	Recovery approach and support for self-directed care
<ul style="list-style-type: none"> • Health promotion approaches • Psychosocial skills • Cultural awareness/interpreter service utilisation 	<ul style="list-style-type: none"> • Understanding the person's need holistically, including psychosocial impacts and environmental influences • Cultural awareness 	Holistic practice
	<ul style="list-style-type: none"> • Valuing the chronically ill person's experiences and expertise 	Attitudes
<ul style="list-style-type: none"> • Assessment of health risk factors • Assessment of self-management capacity • Conducting practice-based research/quality improvement framework • Structured problem solving • Goal setting and attainment 	<ul style="list-style-type: none"> • Assessment of consumers' needs • Understanding problems and priorities from the consumer's perspective • Involving consumers and carers more in the planning, delivery, evaluation and accreditation of training • Helping consumers navigate the system • Goal setting 	Continuity of care

		Inclusion and support of carers
<ul style="list-style-type: none"> • Use of electronic (or other) recall systems 	<ul style="list-style-type: none"> • More sharing of information between service providers and services 	Effective use of information
<ul style="list-style-type: none"> • Communication skills (including awareness raising and engagement) • Motivational interviewing 	<ul style="list-style-type: none"> • Interviewing skills • Communication skills • Raising issues with consumers ('learning how to ask') 	Communication skills
<ul style="list-style-type: none"> • Awareness of community resources 	<ul style="list-style-type: none"> • Understanding how to use community resources more effectively • Skills in supporting new technologies 	Knowledge of local services and resources
<ul style="list-style-type: none"> • Use of evidence-based guidelines 		Knowledge and compliance with legislation, standards, policies, evidence-based/best practice approaches
	<ul style="list-style-type: none"> • Developing rapport 	Relationships and ways of working with people
<ul style="list-style-type: none"> • Working in multidisciplinary teams • Collaborative problem definition • Use of peer support • Collaborative care planning 	<ul style="list-style-type: none"> • More collaboration, cooperation, teamwork and sharing of information between service providers and services • Valuing peer support services and using them effectively as an adjunct to health services • Collaboration with consumers and acknowledging their self-management role 	Teamwork and collaboration
		Individual role
<ul style="list-style-type: none"> • Organisational change techniques • Models of health behaviour change 		Management role

There is a strong alignment between the MHCC consultation and interview findings and the results of the Lawn et al. (2009) study on consumer and carer perspectives. It appears that the current study has built on the prior study and captured additional details. This may reflect the fact that the current study involved a larger and potentially more representative sample.

However, there appears to be significant differences to primary health care service provider perspectives of self-management support skills, notably a lack of discussion around:

- Recovery and supporting self-directed care (only assessment of self-management was reported);
- Attitudes;
- Including and supporting consumers and carers;
- Effective use of information in regards to information sharing; and
- Relationships and ways of working with people.

It appears that overall, the primary health care service provider perspectives aligned better with the 'managed care' end of the spectrum as opposed to the consumer, carer and largely

CMO service provider perspectives reported in the Lawn et al. (2009) and current MHCC study. This conclusion mirrors that made by Lawn et al. (2009) on the discrepancy in findings (p. 42).

Targeted Interviews: Additional Findings

As discussed in the methodology, the targeted interviews were conducted to ensure that a diversity of people from different disciplines, sectors, and roles were able to provide input on the key characteristics and competencies for effective coordination. In addition, the interviewees were asked to comment on a number of specific issues relevant to the implementation of service coordination as a practice skill.

Barriers to service coordination at the practice level

The main barriers to or gaps in service coordination identified by interviewees were:

- Lack of resources
- Lack of time
- A lack of recognition that service coordination takes time and skill
- Job descriptions and funding formulas that don't recognise service coordination as a practice
- Poor record keeping
- Caseloads that are too large
- A lack of clarity about who is responsible for coordinating care
- Ineffective relationships between 'clinical' and 'non-clinical' services
- Exclusion of General Practitioners in service coordination
- A gap between hospital and community based services
- Misperceptions about recovery
- Lack of communication and ability to speak the same language
- Lack of awareness
- Lack of appreciation for what other services contribute
- Obstructive approaches to confidentiality and privacy specific to the mental health sector
- Embedded culture and perceptions regarding working with CMOs

One of the biggest barriers discussed across consultation groups and in the interviews was the lack of funding and acknowledgement of collaboration, and therefore the lack of incentive.

"That is actually one of the current gaps in most of the funding processes; there is funding for insufficient client contact, but there isn't funding to make partnerships, collaborate, do the interagency stuff, network, and that is time consuming" – Carer

"One of the barriers to this kind of thing is they need to find a mechanism for still funding things competitively for bringing the best practice across states, and to be aware that the competitive funding is what is actually preventing all of these services from coordinating – it is a key barrier to all of this practice" – Consumer

"It is basically billable hours, or we want it to be...but who pays you?" – Service provider

"Treat one aspect of their life to death and address that completely and not worry about anything else. That is what you get when you design services that way to be very focussed on a particular input. So I think the other thing is that organisations need to be specifically made to focus on the coordination role as a key performance indicator for them; not just how their

particular element goes but whether it fitted into the others as well. I think they have to be obliged to pay attention to it and rewarded for it with funding and other things” – Interviewee 3

“Our job descriptions, funding formulas, you know, they were premised almost on stand-alone workers, stand-alone services as against, ‘OK, if we are going to work in a collaborative, coordinated way, then what does it involve and how much time does all of that take? How much time does that involve? What sort of training is involved? How do you keep it going?’ Whereas most direct service positions there may be something about ‘collaborate with’ but it is probably not systematically developed through so it is almost starting again so that, OK, if care coordination is part of everyone in the direct service role, what should a job description look like? And then the funding formulas – it has just got to have implications” – Interviewee 9

Many of these barriers to service coordination mirror challenges that have been reported in the existing literature, including:

- Role delineation between workers¹³⁰
- Lack of cross-sectoral knowledge¹³¹
- Difficulty managing workloads¹³²
- Time constraints, resources and changes to work practices^{133 134 135}
- Training needs in interdisciplinary collaboration¹³⁶
- Lack of mutual regard and recognition of experience¹³⁷
- Little support for change^{138 139 140}
- ‘Hierarchies’ between professions and sectors^{141 142}
- Poor conditions, pay, workforce training and support
- Different thinking between the recovery approach and the medical model and different disciplines.^{143 144 145 146}

The most common and crucial area for change is identified as workforce attitudes: towards clients, towards other service providers and towards approaches to care.

What is being done well

It was noted by interviewees that service provision is varied and inconsistent, and as such it was difficult to make generalisations.

“Like most things in NSW there is a wide continuum and some are doing a really smashing job and other places are really terrible” – Interviewee 3

It was identified that service providers:

- Are generally well intentioned and motivated
- Do their best to listen
- Can be quite proactive in *some* instances

Workers in community organisations were praised for:

- The ability to connect with the community
- Spending time with people and implementing recovery-oriented practice
- Understanding what resources are there and how to get the most out of them to best support consumers
- The ability to act swiftly and problem solve to get good results

One interviewee acknowledged that the introduction of mental health care plans and increased access to psychological services, including the Headspace program, has made a significant difference. However there was room for improvement in many areas, including the ability to work with people who have complex needs.

Research investigating consumer opinions and experiences of service delivery has reported both positive and negative experiences. Consumers have reported a noticeable shift towards more person-centred care, with an increasing understanding in the workforce of the need to consult and collaborate with consumers, carers and significant others. However, current practice generally fails to support self-directed care, and there are significant differences in experience across workers from different disciplines and specialisations.^{147 148}

The role of culture

“Culture eats strategy for breakfast...The culture of the organisation will undermine many attempts to change” – Interviewee 7

All interviewees who were asked about the importance of culture provided clear feedback that it is critical to effective service coordination. It was explained that appropriate attitudes and interdisciplinary practice must be demonstrated, and embedded in an organisational culture, and that there must be an inherent appreciation for the individual, *their* life and *their* recovery. Two interviewees also identified the need for services to be flexible, outward-facing and interested in making links externally.

“An introverted, inward-looking organisation is just not going to be able to do care coordination, because they need to...not just understand, but be committed to the importance of care coordination” - Interviewee 9

The importance of culture in shaping attitude was also discussed.

*“Does training change attitude?
What about for things like mutual regard or interdisciplinary practice – is that concrete enough?
I think it has to be demonstrated rather than taught”
– Interviewee 7*

Areas of priority for training

There was an interesting spread of issues that were considered a priority which may reflect the differing roles and sectors the key informants came from. Priority areas included:

- Cultural and socio-economic awareness
- Person-centred principles
- Reflective practice
- Understanding the impact and limitations of support
- Recovery and recovery-oriented practice
- Knowledge of the system and processes
- Ability to navigate the system and use resources effectively
- Understanding of CTOs
- Being trauma informed
- Working with people who have dual diagnoses and complex needs
- Working in a human rights framework

- Respect for consumers
- Communication and sharing information

In the literature consumers and carers also propose that workers need:

- Improved communication and listening skills, and ability to ask consumers about their views and perspectives.
- Better capacity for collaboration with consumers, carers and interdisciplinary practice
- Greater awareness of local services and resources
- A shift in focus from deficits to strengths^{149 150}

Where training should occur

There was general consensus that training needs to occur at a number of points across a range of areas including:

- Formal training and education;
- Work placement training;
- Inductions in the workplace; and
- Professional development.

“I think certainly [training] on the job is imperative but I think there is a good capacity for when you are doing your base level training, wherever it is you learn your particular competencies, there should be something in that as well” – Interviewee 4

“I think it needs to be in all of the undergraduate or post-secondary training and then there needs to be induction, so every organisation says to a new member of staff, ‘We value care coordination, we see it as part of our bread and butter’, there is some training provided and then after that professional development and in an ongoing way it is revisited” - Interviewee 9

These stages of training were considered necessary so workers get trained in the baseline theory and gain appropriate knowledge, see service coordination in practice and receive on the job training, are oriented to the culture of the organisation and expectations for collaborative care and receive ongoing training throughout the span of a career to remain up to date with evidence based/best practice approaches.

The above aligns well with the identified key workforce development tasks and priorities required to assist the sector achieve effective service coordination outlined in MHCC’s *Care Coordination Literature Review and Discussion Paper* (2011) including:

- 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 skills embedded in relevant curricula; and,
- Workforce planning, recruitment and retention strategy.

Who should have the competencies

There was a strong consensus among interviewees that all workers should have competencies to provide effective service coordination.

“All the people that are working in the field” – Interviewee 6

“I think everybody when you are working with people, and if we are just limiting to people with mental illness, anyone who is working with them needs to have these skills” – Interviewee 8

“The only thing that I would emphasise is you see care coordination as a practice skill, something as the norm, not an add-on, not a luxury” - Interviewee 9

“I think workers in general” – Interviewee 10

Only one person said that they thought it was only needed for someone working in a service coordination role, and this person also explained their apprehension about developing more ‘mandatory training’:

“Anyone who is in the care coordination role. Again that is starting to sound like more mandatory training. This is a problem. I was involved in [date] when we rolled out [a training package] and we were told it was mandatory and then when I went back to my normal job I rang up HR and said, ‘Just wanting to talk to you about mandatory training,’ and HR said, ‘Well, mandatory– it is a fluid concept, so you know we have rolled out all of this training which is supposedly mandatory and then the local area or LHD have to decide which is most mandatory and make a decision, a risk management decision, on what do we have to give people, what can we avoid tying them up in more training because if push comes to shove and there is a negative outcome the department goes, ‘Well, hang on, they were supposed to be trained in this, but they were also meant to be trained in a hundred other things, and so each of the areas have had to make those decisions about what can be avoided” – Interviewee 7

Whose role it is to coordinate care

“I find it hard to get why people don’t get that the normal practice is to work in coordination with others whether it is within a team, within a service, within the sector or across sectors. I find it really hard to get why people don’t get that. So I may not be that helpful on this but we need to get to a point where care coordination is not seen as something that a specially designated person does, or a specially designated organisation does except where there is a programmatic need for that to happen but that it is seen as a responsibility of every single practitioner. Who do I coordinate with? Who do you want me to coordinate with? Who do you not want me to coordinate with? And if we must then, we have to talk it through, so just getting to that point where it is accepted and so that flows back to training, and either at the university or TAFE level that needs to be in there as a practice skill” - Interviewee 9

There were differing responses and ideas around whose role it is to coordinate care. There was some discussion about who was currently given responsibility to coordinate care by default, usually CMOs, carers, and social workers. Interviewees discussed the importance of a ‘case manager’ role, and the fact that case management is not being conducted adequately.

One interviewee explained that they thought the role should exist in the public sector, but most others said that a service coordination role should exist in the community managed sector. Two interviewees emphasised that this role or decision needed to rest with the consumer.

“I have got to answer that it is very clearly the consumer’s role. I will qualify that because depending on degree of disablement and so on there are different levels of how much of your own care you can coordinate” – Interviewee 4

“I think it is different for different people and realistically the consumer should be at the centre of their own care, should be the one deciding who that might be. I think there is some people who would like their family members to do that role, and there are some families who would like to do that role as well, but often I think it ends up being the family by default”
– Interviewee 2

Another person explained why this question is less than straightforward. Change may occur at different points due to the dynamic nature of mental health. Overall however, it was identified that service coordination competencies should not be identified as the responsibility of one discipline, or one person in a particular role only.

“I think they can be done by all disciplines” – Interviewee 6

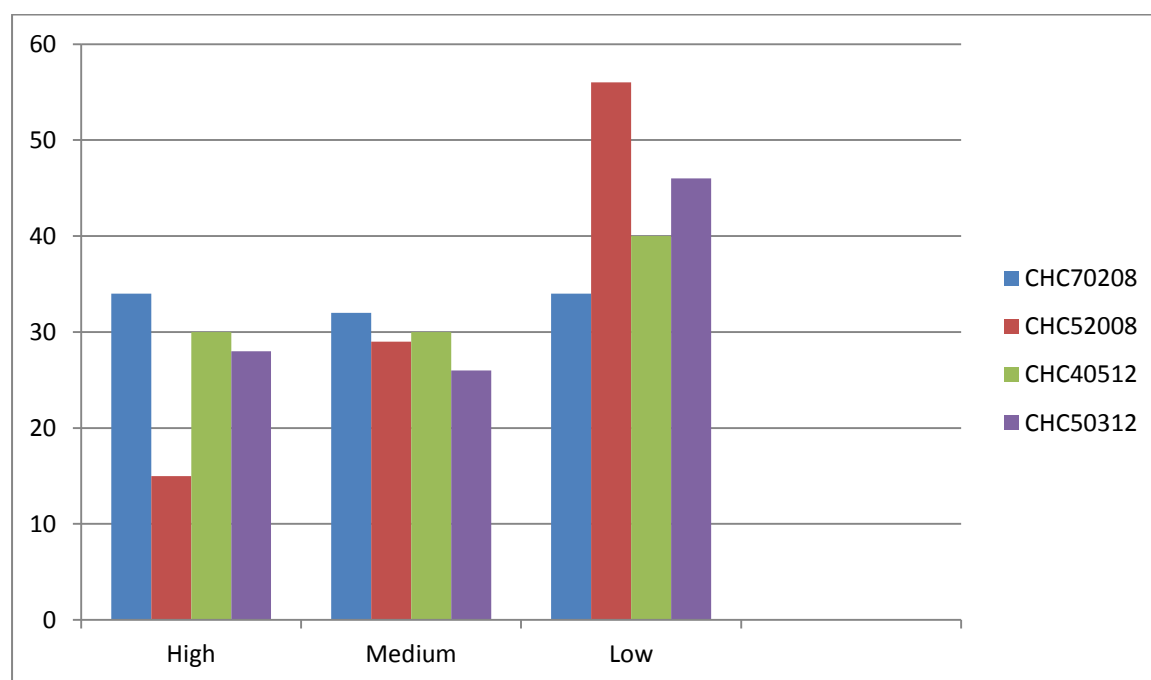
“I would like to think that everyone practices care coordination so that everyone, every practitioner, is thinking, ‘Who do I need to coordinate with?’ and they also talk with the person about, ‘Well, I am in this working relationship that we have got, who else do we need to involve and who do you want me to coordinate with and why?’ so that everyone operates in that way” – Interviewee 9

QUALIFICATION ANALYSIS



5. QUALIFICATION ANALYSIS

As discussed in the methodology section, 'What We Did', the units of competency related to service coordination in each qualification were analysed against the key themes identified by the first investigator from the consultations. Competency units were rated as low, medium and high according to the extent to which they addressed each theme, and these ratings were amalgamated to provide an overall picture of how well the qualifications address the key competencies required for effective service coordination. The results of the qualification analysis are presented below in Graph 1.



Graph 1. Percentage of high, medium and low ratings per qualification

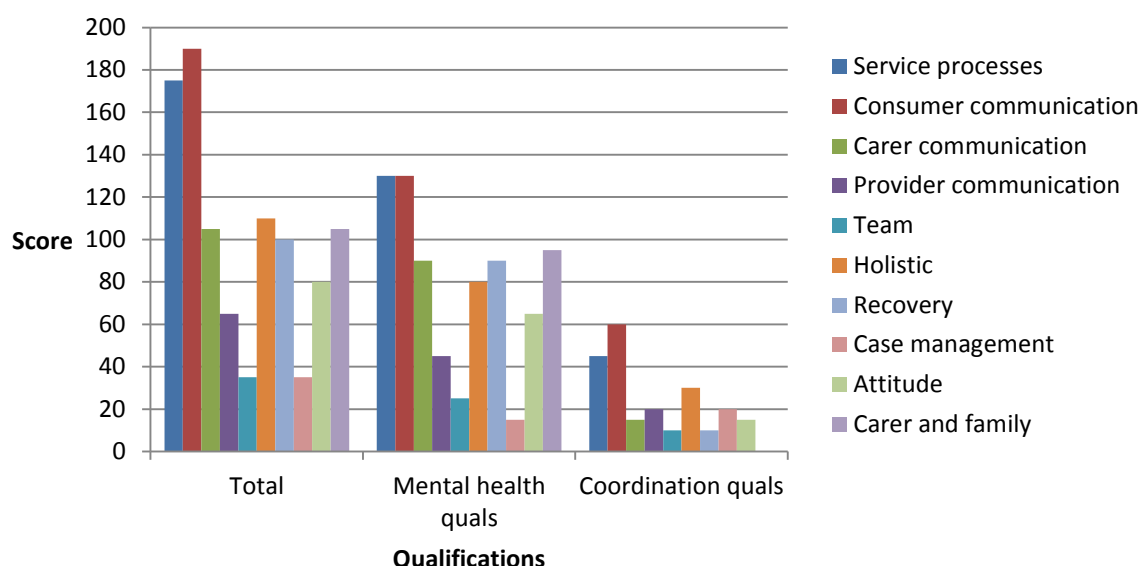
It is clear that an amalgamation of ratings resulted in a fairly even spread of low, medium and high content of key themes. As such, an overall conclusion can be made that while the qualifications listed are addressing key competencies identified by the MHCC consultations to a medium and high level, there is still a lot of room for improvement.

It must be noted that while the ratings in the CHC70208 Vocational Graduate Certificate in Community Service (Client assessment and case management) and the CHC40512 Certificate IV in Mental Health have a fairly even distribution of low, medium and high ratings across all units of competency, the CHC52008 Diploma of Community Services (Case management) and CHC50312 Diploma of Community Services (Mental Health) each have two units of competency that received a very low rating. This rating had a significant impact on the overall rating of the qualification. The units of competency that received these low ratings were:

- CHCCW503A Working intensively with clients; and
- CHCCS504B Provide services to clients with complex needs.

A full record of the ratings is included in Appendix 8.

The amalgamation of rankings across all of the qualifications, the mental health qualifications and the coordination-related qualifications produced some interesting results. Service provision processes and communication with consumers were most represented in the content, with quite a difference between the level in the two mental health qualifications and the two service coordination qualifications. Communication with carers and with service providers, operating as a team, holistic service provision, the recovery process, service provider attitude and the needs of carers and families are also more significantly represented in the mental health qualifications.



Graph 2: Score for mental health, service coordination and all qualifications against key themes

While it was found that many of the competencies identified in the consultations were included in the units of competency of the existing qualifications, a number of the key categories were lacking and in need of additional competencies in order to equip the workforce for effective service coordination.

Specific competencies identified as gaps included:

- Recovery-oriented service provision
 - Ability to work in a recovery-oriented way with consumers who have challenging behaviours or are involuntary; ability to balance dignity of risk, duty of care and 'harm'
- Supporting self-directed care
 - Understand the managed care to self-directed care continuum; how to engage, coach, motivate and empower consumers; negotiation and advocacy skills
- Providing continuous care
 - Early intervention; needs assessment; planning; monitoring; follow up; support transitions; understand importance of and how to plan to stay well; solution focus; negotiation and mediation skills; prioritising elements of care
- Inclusion and supporting of carers and significant others
- Knowledge of services and resources
 - Understand processes and systems in place; awareness of resources and initiatives; knowing the full range of options across the human services sectors; investigation skills and ability to access/locate information
- Effective use of information

- Identify who needs information and proactively provide it; identify how an individual best learns/receives information; manage administrative tasks; information management; facilitate and support informed decision making/supported decision making
- Communication skills
 - Ability to individually tailor explanations and identify what information is appropriate at what time; motivational interviewing; strengths-based language
- Relationships and ways of working
 - Trauma informed; ability to engage with people; ability to respond to complex situations; networking skills
- Teamwork and collaboration skills
 - Understand team and group dynamics; work with others who have different backgrounds, perspectives and approaches; negotiate multiple perspectives; clearly identify roles and responsibilities; work transparently; compromise and mediation skills.

Please see the full list in Appendix 5.

CONCLUSIONS AND RECOMMENDATIONS



6. CONCLUSION AND RECOMMENDATIONS

The key driver for this consultation and report is to progress the MHCC *Service Coordination Strategy* in response to Recommendations 3 and 5 of MHCC's 2010 *Sector Mapping Project*. Phase 1 of the *Service Coordination Strategy* project included the *Care Coordination Literature Review and Discussion Paper* written by Dr Leanne Craze, and Regional Forum consultations, which clearly identified that service coordination is a practice skill, and that no existing literature reviews included consumer and carer perspectives on what is required for effective service coordination to occur.

This paper presents findings from consultations and targeted interviews on consumer, carer and service provider perspectives of the key characteristics and competencies required (including knowledge, skills and attitudes) to provide effective service coordination.

The key messages that were expressed by consumers, carers, service providers and interviewees around effective service coordination include the need for workers to:

- Practice in way that is recovery-oriented, holistic, and supportive of self-directed care
- Embrace recovery-oriented, holistic, respectful and collaborative attitudes to underpin all aspects of service provision
- Provide continuity of care including access, early intervention, consistency, assessment and planning, ongoing support, re-access and follow up, evaluation and quality improvement and meaningful referral and supported transitions in a way that is consistent with recovery-oriented and holistic practice
- Inclusive and supportive of carers and significant others
- Have knowledge of local services and resources and legislation, standards, policies and evidence based/best practice approaches
- Use information effectively including sharing and managing information, understanding confidentiality and privacy issues, educate consumers and carers, and support informed decision making and supported decision making
- Have good communication skills including strengths-based and individually tailored language
- Have skills to build and develop relationships with consumers, carers and other service providers
- Work collaboratively in a team

The following conclusions have emerged from the findings in respect to the broader context of a *Service Coordination Strategy*:

- While a key role is important to service coordination, the skills set required to undertake this task are not exclusive to a particular role – all service providers need to be practicing coordination and collaboration across the human services system.
- All consumers should experience continuity of care and coordinated service delivery. It should not be an exclusive practice for those with severe and persistent conditions identified as those most in need.
- Approximately sixty-seven per cent of the existing VET qualifications incorporate service coordination competencies to a medium or high level, however there is still room for improvement.

- Given that there is reasonable coverage of many of the competencies identified as necessary for effective service coordination in the VET qualifications, consideration should be paid to the level at which care coordination is addressed in human service university curriculums and the medical and allied health fields.
- 'Service coordination' related VET qualifications are currently lacking in the competencies identified by consumers, carers and services providers as required for effective service coordination, more so than 'mental health' related VET qualifications.
- Service coordination competencies identified as a 'gap' in existing VET qualifications must be promoted and embedded in nationally recognised qualifications.
- The current activities of the CS&HISC need to have synergy with the PIR initiative to ensure that the workforce capabilities required to implement the PIR initiative are supported by nationally accredited qualifications. The availability of the information provided through this consultation process has the capacity to inform this development.
- Service coordination education and training needs to be embedded in formal education, work placement, workplace inductions and professional development.
- A number of additional factors are critical to service coordination including culture, acknowledgement of a management and key worker role, quality improvement and ongoing evaluation and funding that reflects the time and effort required to coordinate services.

The findings from this investigation will inform recommendations on education and training necessary to achieve improved continuity of care and to support self-directed care. In addition, the findings provide recommendations for Phase 3 of the MHCC *Service Coordination Strategy*.

Recommendations

1. Disseminate and promote the findings from Phase 2 of the MHCC *Service Coordination Strategy* by:
 - a. Convening a forum in the first half of 2013 to present the findings and conduct further consultations; and
 - b. Producing a brief promotional piece to promote better awareness and understanding of service coordination, including an understanding of service coordination as a practice skill.
2. Promote the inclusion of service coordination competencies in the mental health qualifications being reviewed by the Community Services and Health Industry Skills Council (CS&HISC) to:
 - a. Build workforce capacity to provide effective service coordination in the mental health sector; and
 - b. Ensure mental health workforce capabilities required to successfully deliver the objectives of the PIR initiative are supported by nationally accredited qualifications.
3. Develop and promote additional training incorporating the essential skills required for effective service coordination including:

- a. A Certificate IV level unit of competence and/or a service coordination skill-set;
 - b. An additional higher level unit of competence incorporating the essential service coordination skills required for more advanced practitioners and team leaders/frontline managers; and
 - c. A short course based on the units of competence to be offered in the Professional Development Series through MHCC Learning and Development.
4. Advocate for greater inclusion of service coordination competencies in mental health university training curriculums including: psychiatry, psychology, social work, nursing, and occupational therapy.
5. Use the findings from consultations to inform and influence the implementation and development of the PIR program including:
 - a. Capacity building resources for Partners in Recovery Organisations (PIROs); and
 - b. Advocacy for the inclusion of workforce measures in the PIR evaluation.
6. Correspond with the CS&HISC regarding the investigation and findings to inform the development of the Environmental Scan 2013.
7. Advocate for consideration of service coordination as a critical part of practice, not an exclusive separate role, at the State and Commonwealth level in:
 - a. The planning of service delivery and roles, including the development of benchmarks, care packages, the allocation of resources and funding models (e.g. MHCC Sector Benchmarking Project, National Mental Health Service Planning Framework, Activity-Based Funding, etc.);
 - b. The collection of data on current service delivery and workforce activity (e.g. MHCC *Data Management Strategy*).
8. Use findings from the consultations with consumers, carers and service providers to inform progress on Objective 4.2.2 of the *National Mental Health Workforce Strategy and Plan* to promote shared care, service coordination and cooperation across the government, non-government and private sectors.
9. Pursue resources for Phase 3 of the MHCC *Service Coordination Strategy*, and commence service coordination pilots in urban, regional and rural areas. It is likely the Hunter region will be targeted given that it has been identified as the NSW location for the National Disability Insurance Scheme (NDIS) roll-out.

APPENDICES



7. APPENDICES

Appendix 1

Key Informant Interview Schedule

Overview

1. Briefly, can you tell me about where you work and what it is that you do?
2. What do you think it would 'look like' for a consumer to receive good care coordination?
3. What do you think the relationship is between care coordination, and the continuum between managed care and self-directed care?
4. Whose role do you think it is to coordinate care?

Competencies

5. What are the competencies that service providers need to be able to achieve this outcome (discussed prior)? Including:
 - Attitudes?
 - Knowledge?
 - Skills?
6. What do you think service providers are currently doing well in terms of these competencies?
7. What care coordination competencies should be included in education and training as a matter of priority?

In practice

8. What do you think the barriers are to the delivery of care coordination at the practice level?
9. How important do you think the culture of an organisation is to achieving these outcomes?
10. Where, if anywhere, do you think care coordination education and training should occur?
11. Who do you think needs to have these competencies?

Conclusion

12. Summing up.

Competencies Reviewed

CHC70208 Vocational Graduate Certificate in Community Services (Client assessment and case management)	<ul style="list-style-type: none"> • CHCAD504B Provide advocacy and representation services (e) • CHCCM701B Undertake advanced client assessment (e) • CHCCM702B Implement goal directed care planning (e) • CHCCM703A Apply effective case management practice (e) • CHCCM705C Work effectively with carers and families in complex situations (e)
CHC52008 Diploma of Community Services (Case management)	<ul style="list-style-type: none"> • CHCAD504B Provide advocacy and representation services (c) • CHCCM503C Develop, facilitate and monitor all aspects of case management (c) • CHCCM504D Promote high quality case management (c) • CHCCS416B Assess and provide services for clients with complex needs (c) • CHCCW503A Work intensively with clients (c) • CHCICS406B Support client self-management (c) • CHCMH402B Apply understanding of mental health issues and recovery processes (e) • CHCMH411A Work with people with mental health issues (e)
CHC40512 Certificate IV in Mental Health	<ul style="list-style-type: none"> • CHCMH401A Work effectively in mental health settings (c) • CHCMH402B Apply understanding of mental health issues and recovery processes (c) • CHCMH403A Establish and maintain communication and relationships to support the recovery process (c) • CHCMH404B Conduct assessment and planning as part of the recovery process (c) • CHCMH405A Work collaboratively to support recovery process (c) • CHCMH408B Provide interventions to meet the needs of consumers with mental health and AOD issues (e) • CHCMH409A Facilitate consumer, family and carer participation in the recovery process (e) • CHCMH411A Work with people with mental health issues (e)
CHC50312 Diploma of Community Services (Mental Health)	<ul style="list-style-type: none"> • CHCMH501B Provide advanced support to facilitate recovery (c) • CHCCS504B Provide services to clients with complex needs (c) • CHCCW503A Working intensively with clients (c) • CHCMH401A Work effectively in mental health settings (c) • CHCMH402B Apply understanding of mental health issues and recovery processes (c) • CHCMH409A Facilitate consumer, family and carer participation in the recovery process (c) • CHCMH501A Provide advanced supports to facilitate recovery • CHCCM501A Coordinate complex case requirements (e) • CHCMH405A Work collaboratively to support recovery process (e)

Summary of Consultation Themes

1. Recovery-oriented
 - a. Understand what recovery is
 - b. Know how to implement recovery and work within a recovery framework
2. Holistic
 - a. See people as a whole including their mental, physical and social needs
 - b. See people in the context of their lives/environment including support networks
 - c. Cultural sensitivity and understanding the social determinants of health
 - d. Ability to support people who have multiple and complex needs
3. Support and maximise self-directed care
4. Attitudes
5. Provide continuous care
 - a. Access
 - b. Consistency
 - c. Early intervention
 - d. Assessment and planning
 - e. Review and monitoring
 - f. Ongoing support, re-access and follow up
 - g. Evaluation and quality
 - h. Meaningful referral and supporting transitions between services
6. Inclusive and supportive of carers and significant others
7. Knowledge of local services and resources
8. Knowledge of compliance with legislation, standards, and evidence based/best practice
 - a. Consumer and carer rights
 - b. Understanding of balance between duty of care and dignity of risk
9. Effective use of information
 - a. Shared access to information
 - b. Information management
 - c. Confidentiality issues
 - d. Consumer and carer education
 - e. Informed decision-making/ supported decision-making
10. Communication skills
 - a. General communication skills
 - b. Ability to make appropriate and individually tailored explanations
 - c. Motivational and strengths-based communication
 - d. Effective use of language
11. Teamwork and collaboration skills
12. Relationships and ways of working with people
 - a. Relational / interpersonal skills – rapport, trust and engagement
 - b. Trauma informed practice
 - c. Boundaries
13. Individual role
14. Management role
 - a. A coach for the workforce
 - b. Reaching out to the community
 - c. Develop shared visions and values
 - d. HR and recruitment

Summary of Interview Themes

1. Recovery-oriented
 - a. Understand what recovery is
 - b. Know how to implement recovery and work within a recovery framework
2. Holistic
 - a. See people as a whole including their mental, physical and social needs
 - b. See people in the context of their lives / environment including support networks
 - c. Cultural sensitivity and understanding the social determinants of health
 - d. Understanding of AOD, criminal involvement, trauma, cognitive and other disability and their interrelations with mental health
 - e. Ability to support people who have multiple and complex needs
3. Support and maximise self-directed care
4. Attitudes
 - a. Respect for consumers and other service providers and their expertise
 - b. A human rights perspective
 - c. Collaborative attitudes
 - d. Patient, flexible and passionate
 - e. Non-judgmental and self-reflective
5. Provide continuous care
 - a. Access
 - b. Consistency
 - c. Assessment, planning, review, follow up and referral
 - d. Evaluation and quality assurance
6. Inclusive and supportive of carers and significant others
7. Knowledge of local services and resources, policies and legislation
8. Effective use of information
 - a. Shared access to information
 - b. Information management
 - c. Confidentiality issues
 - d. Consumer and carer education
9. Communication skills
 - a. General communication skills
 - b. Ability to make appropriate and individually tailored explanations
 - c. Effective use of language
10. Teamwork and collaboration skills
11. Relationships and ways of working with people
 - a. Relational / interpersonal skills
 - b. Boundaries
12. Key worker
13. Medication and mental illness / diagnosis

Summary of Competencies

Bold = identified as a gap in current VET mental health and service coordination qualifications

Bold underlined = a higher order skill for a qualification above the Certificate IV level

CHARACTERISTIC	KNOWLEDGE	SKILLS	ATTITUDES
Recovery	<ul style="list-style-type: none"> Understand recovery (consumer and carer) and the full life cycle Understanding that most things are not black or white and must be tailored to the individual Understanding power differential between worker and consumer Impact of own belief system on values 	<ul style="list-style-type: none"> Implement a recovery approach Strengths-based skills Ability to work in a recovery-oriented way with consumers who have challenging behaviours including those who have been scheduled and are involuntarily accessing services Ability to balance dignity of risk, duty of care and 'harm' under the Act Ability to apply boundaries that are appropriate to recovery-oriented service delivery Ability to self-reflect on practice 	<ul style="list-style-type: none"> Respect for consumers as equals and experts in their own care Respect for service providers in different services, sectors and disciplines Recovery-oriented Holistic Aware of own and others' humanity and individuality Passionate Dynamic Flexible Courteous Open-minded and non-judgmental Self-reflective – willingness to look at self Collaborative Willing to take direction from consumer Commitment to continue learning as a worker and to improve one's recovery-oriented skills over time
Holistic (A subset of recovery)	<ul style="list-style-type: none"> Awareness of relationships between physical and mental issues, developmental and cognitive disability, AOD, criminal justice issues, cultural, social and economic diversity, impact of interpersonal trauma Awareness of the social determinants of health 	<ul style="list-style-type: none"> Holistic, person-centred practice Work with people with complex needs Cultural sensitivity Tailor services to accommodate age, gender, socio-economic background, and cultural diversity including people of Aboriginal and Torres Strait Islander background Ask about consumer support networks and living environment 	
Self-directed care (A subset of recovery)	<ul style="list-style-type: none"> Understand the managed care to self-directed care continuum, and know how and when to take more responsibility for care and when to hand it back to the consumer Understand advocacy – what it is and isn't, and its importance to consumers where it is appropriate 	<ul style="list-style-type: none"> Include and maximise consumer choice and participation at every step of the process Be sensitive to individual needs in terms of level of support Ability to coach and motivate where appropriate Negotiation skills Engage with consumers, empower them to be autonomous, make decisions, and mobilise them to take 	

CHARACTERISTIC	KNOWLEDGE	SKILLS	ATTITUDES
		control <ul style="list-style-type: none"> Educate consumers to value themselves, have hope and set goals Teaching and education skills Advocacy skills Listening skills 'Align' with individual clients and take direction from them Support and encourage consumers to understand the value of the recovery approach and self-direction 	
Continuous care (including access, consistency, assessment, early intervention, planning, ongoing support, re-access, evaluation and quality assurance, meaningful referral and supporting transitions)	<ul style="list-style-type: none"> <u>Awareness of history of other programs initiatives – successes and lessons learnt</u> Early intervention Maslow's hierarchy of needs Understand long-term ongoing needs to maintain wellness and the importance of planning to stay well, not just rehabilitate Understand best practice standards, <u>evaluation and quality assurance methods and outcomes</u> Understand 'well' means different things to different people How to set appropriate goals and milestones Understand it is the worker's responsibility to close the gaps between services Understand the differences across geographical areas Knowledge to effectively refer to a diversity of services 	<ul style="list-style-type: none"> Connect geographically and share knowledge, experience and learning opportunities Ensure standards of care Early intervention skills Conduct holistic and recovery-oriented, strengths-based assessment processes Conduct regular assessment reviews Provide ongoing support and follow up Solution focussed skills Plan in partnership with the consumer Prioritise elements of care, i.e. needs and actions Active listening skills Needs identification Negotiation and mediation skills Evaluate level of service needs required Use of recovery-oriented, strengths-based language Sensitive post-service follow up <u>Include consumers within organisational policy and program development</u> Include consumers and carers in service delivery evaluation Include consumers and carers in decision- making processes Work with and keep connected to referees 	<ul style="list-style-type: none"> Respect for consumer and carer lived experience Respect client satisfaction as valid outcome measure Willingly engage in self-evaluation surrounding ROP Reject the 'tick and flick' culture of referrals; never abrogate responsibility Willingness to refer on Supportive of service re-engagement where necessary as a part of a recovery journey; not necessarily relapse Not make assumptions regarding people's needs Person-centred

CHARACTERISTIC	KNOWLEDGE	SKILLS	ATTITUDES
		<ul style="list-style-type: none"> • <u>Implement feedback loop across services</u> • Plan and support transition processes • Referrals that meet consumer's needs • Discuss service capacity to meet needs with consumer • Discuss with the consumer possible pathways to recovery, limits of service capacity and when exit might be appropriate • <u>Skills to evaluate processes</u> • <u>Skills to evaluate outcomes</u> • Advocacy skills, and understanding boundaries of advocacy role • <u>Organisational development, change management skills</u> 	
Inclusive of carers and significant others ('Carers/families' includes significant others where appropriate)	<ul style="list-style-type: none"> • Acknowledge importance of carers/families • Understand carer/family support needs • How to support carers/families and where to refer • Understand potential tension between consumer and carer rights and perspectives • Understand 'toxic families' and that family engagement is not a given • Understand issues concerning confidentiality and privacy • Understand alternative supports for consumers other than families, e.g. peer workers and advocates 	<ul style="list-style-type: none"> • Include carers/family as part of the care team where appropriate • Identify who else exists in the support network ('hidden carers') • Promote the involvement of a carer/significant other or consumer advocate • Inform and provide resources for carers/families • Identify carer needs and provide referrals where appropriate • Have strategies to balance potential consumer and carer tensions 	<ul style="list-style-type: none"> • Respectful of role carers/families often play in a consumer's life • Acknowledge carers/families as an important information and support resource • Acknowledge importance of peer workforce • Be open to who the consumer wants to involve in their care
Knowledge of services and resources	<ul style="list-style-type: none"> • Awareness of service types available in the local community • Understanding availability and limitations of services • Understanding different worker roles and responsibilities • Knowledge of other services and target groups • Understand the way social supports 	<ul style="list-style-type: none"> • Investigation skills and how to access information • Curious inquiry – maintaining currency around organisations for referrals • <u>Understand and advocate the central role of community based service delivery / CMOs</u> 	<ul style="list-style-type: none"> • See self as one part of a larger, interconnected system • Respect for the CMO sector as central to service delivery

CHARACTERISTIC	KNOWLEDGE	SKILLS	ATTITUDES
	<p>promote better outcomes</p> <ul style="list-style-type: none"> • <u>Understanding of processes and systems in place</u> • Knowledge of policies, e.g. MOUs • Awareness of resources and initiatives; know the full range of options across human service sectors 		
Knowledge of legislation, standards and evidence based/best practice	<ul style="list-style-type: none"> • Full understanding of consumer and carer rights, obligations • Knowledge of relevant legislation • Understand legislative process and bodies such as the Mental Health Review Tribunal and Guardianship Tribunal • Aware of mental health policy guidelines and standards • Aware of complaints processes • <u>Knowledge of consumer and carer driven research</u> • Understand the concept of capacity 	<ul style="list-style-type: none"> • Explain rights to consumers and carers • <u>Work within a human rights framework</u> • Comply with policy directives and practice standards • Implement and foster evidence based/best practice standards 	<ul style="list-style-type: none"> • Every worker has responsibility to have a broad understanding of the legislation and standards • Every worker must be fully aware and accepting of organisational and industry policy directives
Effective use of information	<ul style="list-style-type: none"> • Understand confidentiality and privacy issues • Knowledge of alternative interventions and options available • Understand diversity of adult learning needs 	<ul style="list-style-type: none"> • Identify who might require information and proactively provide them with what they might need • Ability to use IT technology • Ability to communicate information • Identify how individual best learns / receives information • Manage necessary administrative tasks, e.g. consumer notes and effective information management • <u>Comprehensive, accurate report writing</u> • <u>Ability to disseminate information to colleagues, consumers and carers</u> • Facilitate and support informed decision-making 	<ul style="list-style-type: none"> • Willingness to share information with all appropriate parties • Acknowledgement of responsibility to provide relevant information where/when appropriate • Respect a consumer's right to make informed decisions • Determination to follow up despite challenging circumstances
Communication skills	<ul style="list-style-type: none"> • Know the language of different service providers and agencies to be able to communicate effectively 	<ul style="list-style-type: none"> • Communication skills • Ability to tailor explanations • Ability to identify what information is 	<ul style="list-style-type: none"> • Use of strengths vs. deficits approach • Willingness to listen

CHARACTERISTIC	KNOWLEDGE	SKILLS	ATTITUDES
		appropriate at what point in time <ul style="list-style-type: none"> Ability to ask consumer what they want, and listen to the answer Strengths-based communication Ability to verify that one has understood and been understood Ability to present information in different formats and to use a suite of communication tools Motivational interviewing <u>Ability to use vocabularies across disciplines/sectors/systems</u> Active listening skills Ability to check in Ability to communicate genuine empathy 	<ul style="list-style-type: none"> Not make assumptions
Relationships and ways of working	<ul style="list-style-type: none"> Understand power dynamics, boundaries and meaning in recovery oriented-practice Be trauma informed Awareness of potential worker / consumer mismatch Understand the importance of lived experience 	<ul style="list-style-type: none"> Ability to build rapport and trust Ability to make people feel comfortable and valued Ability to engage with people displaying challenging behaviours Interpersonal / relational skills and emotional intelligence Ability to implement trauma informed practices Ability to just sit with a consumer, and know when to provide an intervention Work within ROP professional boundaries Build consumer / carer and service relationships over time Respond to complex situations, e.g. risk Networking skills <u>Ability to develop networking processes</u> 	<ul style="list-style-type: none"> Respect Self-reflective Appreciate human diversity Self-care
Teamwork and collaboration skills	<ul style="list-style-type: none"> Understand team roles Understand teamwork processes and group dynamics <u>Understand how to maintain teams over time</u> Understand how better outcomes are 	<ul style="list-style-type: none"> Ability to work with others who have different backgrounds, perspectives and practice approaches / disciplines Ability to share and negotiate multiple perspectives Ability to clearly identify working roles 	<ul style="list-style-type: none"> Willingness to work collaboratively Respectful of contributions from other workers / services / sectors Open to necessity for

CHARACTERISTIC	KNOWLEDGE	SKILLS	ATTITUDES
	achieved by working collaboratively	and responsibilities <ul style="list-style-type: none"> Networking skills Partnership and cross-professional relationship-building skills Communication skills Ability to collaborate Ability to define common goals with the consumer and care team Listening skills Ability to work transparently Team based decision-making processes Ability to compromise and mediate <u>Conflict resolution</u> Organised and methodical 	multiplicity of skills in the care team <ul style="list-style-type: none"> Prioritise the person, not the program Be prepared to refer someone on or involve an additional person in the care team when required Be flexible Be proactive Innovative and creative Self-reflective
Medication and mental illness	<ul style="list-style-type: none"> Knowledge of medication and strategies to manage side effects Understand common reasons for not taking medications and alternative options available Understand when to propose a medication review Understand that medication may need to be adjusted prior to known stressful or triggering times Know consumer medication, and existing or potential physical health issues Understand mental illness/symptoms and DSM diagnoses and presentations 	<ul style="list-style-type: none"> Inform consumers and carers about medications, their side effects and other possible implications Stay informed and be conscious of complex relationship between mental and physical health and medication Ability to advocate for consumers concerning medication where appropriate Ability to identify and recognise symptoms and changes over time 	<ul style="list-style-type: none"> Recovery-oriented attitudes
<u>Key worker</u>	<ul style="list-style-type: none"> Understand the differences between care coordination and 'case management' Have comprehensive knowledge of the system and service types Know how to navigate the system and get the best out of resources Understand group dynamics in 	<ul style="list-style-type: none"> Ability to monitor and follow up Verbal and written communication skills <u>Ability to orchestrate services as needed</u> <u>Leadership skills</u> Ability to drive outcomes Advanced assessment and planning - understand what is needed and pulling a 	<ul style="list-style-type: none"> See each consumer as a person, not a 'case' Confident Assertive View CMO perspectives as equal in value

CHARACTERISTIC	KNOWLEDGE	SKILLS	ATTITUDES
	teams <ul style="list-style-type: none"> • <u>Have knowledge about accountability frameworks</u> • Understand advocacy – what it is and isn't 	team together <ul style="list-style-type: none"> • <u>Project management</u> • Facilitate access to services • <u>Manage meetings and groups of people</u> • <u>Ability to hold people accountable</u> • Organisational skills • <u>Challenge group language and processes</u> • Support self-directed care • Assist consumers to build capacity • Coaching skills • <u>Ability to present to bodies such as the MHRT and provide a clear overview of a person's experience</u> • <u>Act as a champion for culture within an organisation</u> 	
Management-level worker	<ul style="list-style-type: none"> • <u>Knowledge of services, sectors, disciplines, successful initiatives, models at a high level</u> • <u>Financial literacy</u> • <u>Understand organisational culture</u> • <u>Understand inclusive business practices</u> • <u>Current knowledge about current evidence based/best practice standards</u> 	<ul style="list-style-type: none"> • <u>Coaching skills for the workforce</u> • <u>Engage the community</u> • <u>Build service capacity</u> • <u>Develop professional networks</u> • <u>Negotiate and mediate services</u> • <u>Problem solving skills</u> • <u>Accountability</u> • <u>Develop shared visions and values</u> • <u>Build collaborative culture into the service and expectation of staff</u> • <u>Define staff roles</u> • <u>Ensure workforce have appropriate attitudes and clear understanding of their roles through HR, recruitment and job descriptions</u> • <u>Implement evidence base/best practice into service</u> • <u>Advocacy skills</u> 	<ul style="list-style-type: none"> • Leadership • Clarity of vision for long term • Supportive of staff • Be accessible to staff • Model practice philosophy

Theme Frequencies

The colour coding represents whether the themes were discussed a medium, high or very high amount by each group according to the thematic analysis conducted in NVIVO.

Low	
Medium	
High	

THEMES	Carers	Consumers	Workers	Interviewees
Attitudes				
Communication skills				
Access and eligibility				
Assessment and planning				
Consistency				
Early intervention				
Evaluation and quality assurance				
Meaningful referral and supporting transitions				
Ongoing support and access				
Holistic				
Inclusive of family and carers				
Individual role				
Effective use of information				
Knowledge of legislation, standards and best practice				
Rights				
Knowledge of local services and resources				
Management training				
Peer workforce				
Recovery				
Relationships				
Supporting self-directed care				
Working collaboratively				

Word Frequencies

The table below contains a count of the number of times each of the key words was said by each of the groups. The highlighted cells indicate when one or two groups have used the key word significantly more frequently in comparison to another group.

Theme	Carer	Consumer	Worker	Interviewees
Recovery	12	50	33	85
Holistic	7	17	11	15
Whole	17	37	28	22
Respect	11	6	4	15
Access	17	6	4	12
Early	6	6	0	3
Intervention	7	6	0	5
Assessment	0	0	22	16
Plan	6	0	3	20
Planning	3	0	8	10
Quality	0	3	27	7
Refer	0	3	5	5
Referral	0	3	9	12
Transitions	0	10	2	0
Carers	19	7	3	35
Carer	33	1	12	17
Family	19	7	3	36
Peer	4	2	4	0
Consumer	18	31	5	69
Standards	0	0	13	3
Information	18	28	18	38
Informed	5	7	3	7
Communication	6	7	18	13
Talking	16	14	50	46
Strengths	0	0	15	10
Language	3	0	41	24
Relationship	0	6	3	23
Team	12	18	23	19
Together	4	13	28	19
Case	28	21	12	55
Competencies				
Know	40	46	42	112
Knowledge	9	17	11	37
Understand(ing)	7	15	27	62
Aware(ness)	3	8	2	19
Skill	7	0	27	39
Skills	15	22	64	73
Attitude	11	10	6	20
Attitudes	11	3	3	19

Existing Qualification Review Ratings

8a. Analysis of key themes in CHC70208 Vocational Graduate Certificate in Community Services (Client assessment and case management)

Theme	CHCAD504B Provide advocacy and representation services	CHCCM701B Undertake advanced client assessments	CHCCM702B Implement goal directed care planning	CHCCM703A Apply effective case management practice	CHCCM705C Work effectively with carers and families in complex situations
Service provision processes	M	H	H	H	M
Communication with consumer	M	H	H	H	L
Communication with carers	M	H	H	M	H
Communication with services	M	H	H	H	M
Operating as a team	L	L	M	M	L
Holistic approach	L	H	L	H	L
Recovery process	L	L	L	L	L
Case management	L	L	L	H	L
Service provider attitude	M	M	M	M	M
Carer and family requirements	L	H	M	M	H

8b. Analysis of key themes in CHC52008 Diploma of Community Services (Case management)

Theme	CHCAD504B Provide advocacy and representation services	CHCCM503C Develop, facilitate and monitor all aspects of case management	CHCCM504D Promote high quality case management	CHCCS416B Assess and provide services for clients with complex needs	CHCICS406B Support client self-management	CHCCW503A Work intensively with clients	CHCMH402B Apply understanding of mental health issues and recovery processes	CHCMH411B Work with people with mental health issues
Service provision processes	M	M	L	M	H	M	M	H
Communication with consumer	M	M	L	H	H	H	H	H
Communication with carers	M	L	L	L	L	L	H	L
Communication with services	M	L	L	M	M	L	M	L
Services operating as a team	L	L	L	M	L	L	M	L
Holistic approach	L	L	L	M	M	L	H	H
Recovery process	L	L	L	L	L	L	M	M
Case management	L	M	L	H	M	L	L	L
Service provider attitude	M	L	L	L	L	L	H	L
Carer and family requirements	L	M	L	L	L	L	M	L

8c. Analysis of the key themes in CHC40512 Certificate IV in Mental Health

Theme	CHCMH401A Work effectively in mental health settings	CHCMH402B Apply understanding of mental health issues and recovery	CHCMH403A Establish and maintain communication and relationships to support the recovery process	CHCMH404B Conduct assessment and planning as part of the recovery process	CHCMH405A Work collaboratively to support recovery process	CHCMH408B Provide interventions to meet the needs of consumers with mental health and AOD issues	CHCMH409A Facilitate consumer, family and carer participation in the recovery process	CHCMH411A Work with people with mental health issues
Service provision processes	H	M	M	H	M	H	H	H
Communication with consumer	M	H	H	M	H	H	H	H
Communication with carers	M	H	H	L	L	L	H	L
Communication with services	M	M	H	L	L	M	L	L
Services operating as a team	L	M	L	L	L	M	L	L
Holistic approach	H	H	L	H	L	M	L	H
Recovery process	M	M	M	H	H	M	M	M
Case management	L	L	L	L	L	L	L	L
Service provider attitude	H	H	L	M	M	L	M	L
Carer and family requirements	L	M	M	M	L	L	H	L

8d. Analysis of the key themes in CHC50312 Diploma of Community Services (Mental Health)

Theme	CHCMH501A Provide advanced support to facilitate recovery	CHCMH401A Work effectively in mental health settings	CHCMH402B Apply understanding of mental health issues and recovery processes	CHCMH403A Establish and maintain communication and relationships to support the recovery process	CHCMH404B Conduct assessment and planning as part of the recovery process	CHCCW503A Working intensively with clients	CHCCS504B Provide services to clients with complex needs	CHCCM501A Coordinate complex case requirements	CHCCM705C Work effectively with carers and families in complex situations
Service provision processes	H	H	M	M	H	M	M	M	M
Communication with consumer	H	M	H	H	M	H	H	L	L
Communication with carers	H	M	H	H	L	L	L	L	H
Communication with services	L	M	M	H	L	L	L	H	L
Services operating as a team	L	L	M	L	L	L	L	H	L
Holistic approach	L	H	H	L	H	L	L	L	M
Recovery process	H	M	M	M	H	L	L	L	L
Case management	L	L	L	L	L	L	L	H	M
Service provider attitude	M	H	H	L	M	L	L	L	L
Carer and family requirements	M	L	M	M	M	L	L	M	H

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8. REFERENCES

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