



Collaborative and coordinated care: An investigation of the enablers and barriers for adults who experience mental ill-health in Eastern Melbourne

EMHSCA CARE COORDINATION
RESEARCH SUMMARY

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Introduction

Collaborative and coordinated care and support for people who experience Mental ill-health (MIH) is listed as a key aim in numerous health and community service policy documents, beginning in Victoria with the 1st and 2nd National MH Plans in 1992 and 1998 respectively. This is where recognition was given to the need for partnership between Mental Health (MH) services and the Primary Health (PH) sector during the de-institutionalisation of MH care (Commonwealth Government 2001). Victoria's current 10-year MH plan also acknowledges the complexity of the service system and aims to support improved system integration to make accessing services easier and more streamlined (Victorian Government 2015). Localised cross-sector efforts to partner and improve MH service coordination have existed for more than a decade.

The Eastern Mental Health Service Coordination Alliance

The Eastern Mental Health Service Coordination Alliance (EMHSCA) is a more than 10-year partnership that aims to support MH service coordination, collaboration and system integration across the inner- and outer- eastern areas of Melbourne to improve outcomes for consumers, and with respect to the needs of carers (EMHSCA 2018b; Moreton 2018, p.18). An Australian study by King et al (2013, p.5) focussed on the key factors in sustaining MH networks and found that they require dedicated coordination roles with funding attached to enable their continuation. EMHSCA has a funded coordinator and includes stakeholders such as MH, AOD, homelessness & housing, family services, family violence services, Aboriginal services, community health services, and Centrelink and is supported by the member endorsed 'Shared care protocol' (EMHSCA 2018a; Moreton 2018).

The EMHSCA 'Shared care protocol' was developed in 2007 as an enabler to support effective shared care by addressing potential barriers to communication between health and community

services (2018a). An implementation strategy was developed and included an extensive annual file audit (2014-2017), partner and consumer surveys, and targeted workshops that have been delivered to staff across the region between 2011 and 2018 (EMHSCA 2018b). Barriers and solutions to CC have been collated from these workshops and are available for comparison with the current study data (EMHSCA 2017a). The current impacts of system reform on CC need to be understood if we are to preserve and improve upon the work of EMHSCA into the future.

The changing landscape

Service reforms have become the expectation for health and community services in the past decade. In 2013 the Victorian AOD sector reform occurred simultaneously with the community MH supports reform, causing significant disruption to consumers, families and service providers (Aspex consulting 2015; Tandem 2015; Vicserv 2014). Currently across Australia, the primary MH initiative known as 'stepped-care' promises a more staged, coordinated and accessible system of supports for people with high prevalence MH issues (Eastern Melbourne primary health network 2019) and this reform is occurring at the same time as the National Disability Insurance Scheme (NDIS) roll-out, inclusive of people with MH related psychosocial disabilities. Staff attrition is expected with each reform and formed relationships are lost. Consumers and carers are often caught in the middle trying to navigate the services, as worker changes necessitate the establishment of new and vital care connections, often with less experienced staff (Tandem 2015, p.8).

The NDIS provides the most significant reform of community MH services and is marked by disruption to collaborative care for people who experience MIH and co-occurring issues (Hancock et al 2018; MH Council of Australia 2013; MH Victoria 2018). With a shift away from block funding to a fee-for-service (FFS) model, the NDIS has necessitated a competitive community MH service environment to emerge (Green et al 2018; Office of Parliamentary Counsel 2013). The lower pricing for supports under NDIS have meant that pre-transition staff are leaving the sector and a new, less skilled workforce is emerging with limited capacity to attend care team and linkage meetings and cross-sector capacity building activities (Furst, Salinas-Perez & Salvador-Carulla 2018; Hancock et al 2018, p.9; Mavromaras et al 2018, pp.263-268; MH Victoria 2018, p.18).

This was confirmed locally by a 50% reduction in staff attendance at EMHSCA forums and meetings in 2018 (EMHSCA 2017c). Additionally, EMHSCA's annual Shared care file audit in 2017 showed a decline in collaborative practices as the NDIS rolled out across the region (EMHSCA 2016; 2017b). We need to understand why this occurred, and identify ways of preserving collaborative practices, as they are essential to ensure service access and safety issues are effectively managed (Hamilton & Elford 2009). A literature review was conducted to discover what is known about the enablers and barriers to CC and inform this study design.

Literature review

To examine this topic further and to identify relevant knowledge gaps, a targeted review was conducted sourcing published literature relevant to Care Coordination. A brief summary follows.

Definition of Care Coordination

It is a view commonly held by researchers that the concept of CC has been ill-defined and that this has resulted in poor translation to practice (Banfield et al 2012; Flatau et al 2013; Jones & Delaney 2014). In policy, the concepts attached to CC are complex and include; a person-centred approach, information sharing with a particular focus on confidentiality, networking and partnership, and knowledge transfer (Ehrlich et al 2009, p.626).

'Shared care', 'coordinated care', 'integrated care' and 'collaborative care' are used interchangeably throughout the literature, although pedantic definitions are arbitrarily applied by some, and 'collaborative care' may be seen as the precursor to 'coordinated care' (Holmwood, Groom &

Nicholson 2001, p.15; Jones & Delaney 2014; WHO 2016). For the purposes of this current study 'care coordination' (CC) is the preferred term in relation to practicalities of service delivery. The term 'collaboration' was commonly used by research participants to frame their experiences working with other providers at all levels and with consumers and carers. 'Service coordination' is also used in this study and is considered an overarching term used to describe partnership and working relationships between services to support people with multiple and complex needs (PCP Victoria 2012).

Limitations of previous studies

Among the extant literature it appears studies have focussed on two sectors, physical health and MH; or MH and AOD, rather than the broader range required to address more complex problems such as those targeted by service coordination efforts. Consumer and carer views were seldom sought, with service providers making up the majority of research participants. It was recommended by Banfield et al (2012, p.156) that consumers be included in future studies on the subject of CC.

Green et al's (2018, p.14) qualitative study examining the early impacts of NDIS on inter-service relationships recommended that further research will be required when the roll-out of the scheme has progressed. There is a demonstrated need to investigate strategies that can be used by organisations to preserve collaborative practices and partnerships in a reforming MH system (Green et al 2018, p.14).

Research aims

Given the above and the identified knowledge gaps, this study is an investigation of the enablers and barriers for service providers, consumers and carers to achieve collaborative and coordinated care. Specifically, it aims to extend understanding about what is required to connect the 'care team' and avoid preventable gaps in service provision. As such, this study will provide a multi-level, cross-sector perspective on collaborative and coordinated care and give voice to consumer and carer experiences. The ultimate goal is to provide impetus for effective systemic change, including improved funding models and supporting structures. As the research was conducted with study cohorts from EMHSCA member organisations, the results are to be presented to the alliance with the intention of informing future work across inner- and outer-eastern Melbourne. It is imperative that we create a joined-up service system of accessible and navigable supports to reduce the toll on consumers and their families.

Research questions

Accordingly, based on the need to understand the current situation arising out of multiple and simultaneous system reforms, and noticeable disruptions to collaborative work in the inner- and outer-eastern regions of Melbourne, the following questions guide this research:

1. What are the perceptions and experiences among a) health and community service staff, and b) their leaders, regarding the enablers and barriers to collaborative and coordinated care and support for people with MIH and cooccurring issues at this time?
2. What are the perceptions and experiences of MH consumers and carers in relation to collaboration with and between services?
3. What has changed, for better or for worse in the past year?
4. What perceived future changes are required to preserve and improve cross sectoral and collaborative practices and CC?

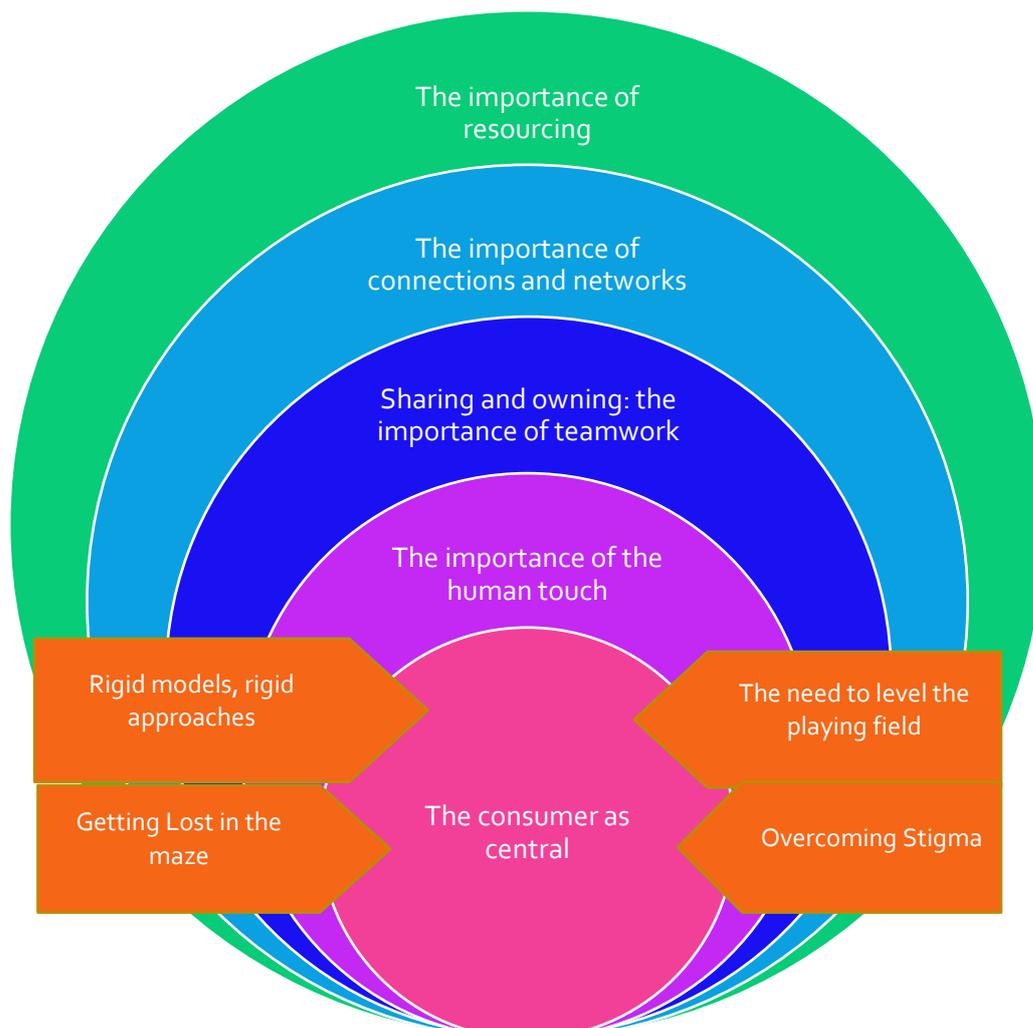
Methodology

A qualitative design was informed by a phenomenological approach. The sample included 59 participants in total, spanning 5 cohorts: Health and community service leaders (n=16); staff (n=19); Peer Support Workers (PSWs) (n=4); MH and AOD consumers (n=10); and MH and AOD carers (n=10). Thematic analysis from the subsequent 40 interviews and 7 focus groups was applied to data from each cohort and analysed for sub-themes. Data was analysed within and across cohorts, to identify overarching themes that describe the lived experience of current Care Coordination (CC) delivery. A summary of the results of this analysis follows.

Discussion of results

There were several consistent themes across all cohort data sets that inform what enables CC and collaboration: 1. The consumer as central; 2. the importance of the human touch; 3. sharing and owning: the importance of teamwork; 4. the importance of connections and networks; 5. the importance of resourcing. There were four key barriers identified that are eroding the quality of CC and collaboration: 1. Rigid models, rigid approaches; 2. Getting lost in the maze; 3. The need to level the playing field; and 4. Overcoming stigma. These themes and their relationship to each other are depicted in Figure 1 below.

Figure 1: Depiction of the key enablers and barriers to collaborative and coordinated care for people who experience MIH and co-occurring issues in the Eastern Metropolitan Region of Melbourne.



Enablers to collaborative and coordinated care

In a synthesis of CC literature, Ehrlich et al (2009) summarise their findings with the following 3 functions of coordinated services: 1. Continuity of care for consumers; 2. Care teams and knowledge sharing; 3. Integrated networks. The findings of the current study align with Ehrlich et al's (2009, pp. 622-626), and expand them to include description of the mechanisms by which consumers may be engaged as well as contemporary and contextual recommendations regarding resourcing and structural supports.

1. The consumer as central

The consumer as the centre of their care (as described in this paper's introduction) is a concept that is commonly understood within service coordination models and MH recovery frameworks (Commonwealth government 2013; PCP Victoria 2012, pp. 23-24). An understanding of this concept was conveyed by many of the staff and leader participants in this study. When the consumer is central to the work and they are well engaged it is their goals that guide the composition of the care team. From this study it was clear that a tailored approach for each individual is required if staff are going to engage consumers effectively.

2. The importance of the human touch

Many people accessing services have been traumatised at some time and the effects can be enduring (Marel et al 2016, p.113). Consumers said they need a gentler approach to care and less stimulating environments which will enable them to work with service providers. Being visited at home can reduce the barriers for people in accessing supports and enable relationships to develop that enable a team approach to care planning.

The value of having workers with a lived experience of MIH was mentioned multiple times by every cohort. Consumer participants outlined the value of the staff with lived experience, known as Peer Support Workers (PSWs), as having the ability to understand and empathise with people who are experiencing symptoms of MIH. It appeared from the data that consumers found it easier to trust PSWs, possibly because they felt they were understood. 'I know one (staff member) cares coz we talk. And she's been where I've been' (Participant 22).

3. Sharing and owning: the importance of teamwork

Flatua et al (2013, p.97) found that there was 'significant overlap' of consumer characteristics across service sectors and identified a need for improving inter-service communications. For the current study, staff and leader participants valued cross-sector work and described the utility of connecting consumer's supports as: the clarification of various roles and expectations; mutual respect; more creative problem solving; clear communication mechanisms; a sharing of any safety issues; and improved continuity of care for people. Care team meetings were seen to encourage a more holistic view of the consumer's situation and support person-centred care. Staff and leaders spoke about the importance of having just one care plan for the consumer to clarify responsibilities and show how all supports fit together to enable the person's goals. This is a key aim of the Service Coordination Framework outlined by PCP Victoria (2012, pp.22-23).

Consumers voiced that the coordination of supports is important to them, especially when they are experiencing exacerbations in MIH, as it lifts some of the burden of engagement at more challenging times. Rollins et al (2018, pp.8-9) asked consumers about how they manage co-occurring severe MIH and physical health issues and their views on CC and found that they viewed CC as convenient. Consumers appreciated friendly and knowledgeable staff and efficient communication between providers but said they would like more responsive communication from services at times (Rollins et al 2018, pp. 8-9). Flatua et al (2013, p.94) found similarly that consumers appreciated CC as it reduced confusion and the uncomfortable re-telling of their stories.

Carers described their desire to have their role acknowledged by staff and to have more open communication with the care team, which aligns with findings by Olasoji, Maude and McCauley (2017). In many cases the carer is the main person involved in the consumer's life and they carry the greatest burden of responsibility and knowledge in the care team, apart from the consumer themselves.

4. The importance of connections and networks

A strong theme emerging from the data across cohorts was of the need to build the knowledge and capacity of staff to work more collaboratively and to provide a high-quality service to consumers. Broadbent and Moxham (2014, p.232) demonstrated that it is easier for staff to interact across services and sectors when they are aware of the cultural differences and have some knowledge of the language required to reach a shared understanding of the consumer's needs. Network meetings and shared training provide useful opportunities to connect and educate staff for this purpose (Broadbent & Moxham 2014; Crotty, Henderson & Fuller 2012, p.216; King et al 2013).

The importance of the regional alliance in uniting services, sharing information and problem solving was outlined by many participants across staff and leader cohorts. Additionally, the importance of a personal relationship with other providers was highlighted and the view commonly held that effective coordination of supports is person dependent. This idea is supported by studies by Banfield and Forbes (2018), Crotty, Henderson & Fuller (2012), Green et al (2018), Groenkjaer et al (2017), and Overbeck, Davidsen and Kousgaard (2016) who all found there was a need for personal relationships to enable CC, with most identifying specific traits of staff that enhance relationship development.

According to Flatau et al (2013, p.96), modes of integrated care include internal provision of multiple services, and external collaborative partnerships. Recommendations regarding service integration included the need for 1. effective models of integration for people who have complex needs; 2. development of structural mechanisms within service networks to assist with sharing policy, protocols and care plan documents; 3. improved cross-sector communications and connectivity; and 4. governments should better meet the associated costs of these measures (Flatau et al 2013, p.97).

5. The importance of resourcing

The findings of this study support the need for a systematised suite of supports to simplify the journey for consumers and to enable staff to provide appropriate long-term planning and referrals. The current system is fragmented with no central point of navigation for people.

Several studies concluded that a well-resourced service system enables CC (Banfield et al 2012, p.156; Cranwell 2017; Groenkjaer et al 2017). Consumers report that when staff are busy and task focussed, they are not getting the person-centred support they need, and the human touch is lost. Services need to be flexible and tailored to the individual's needs to enable consumers to engage. Carers shared these perspectives and added that staff only seek to collaborate with carers when consumers are in crisis.

Staff and leaders reiterated the importance of being well resourced to provide responsive and coordinated services and said that when there are insufficient staff hours it is not possible to work as a care team across services. An important development to support CC would be the introduction of key performance indicators linked to collaboration. A number of studies conclude that outcome measures are required to evaluate various CC efforts (Banfield et al 2012; Ehrlich et al 2009; Flatau et al 2013; Frost et al 2017).

When staffing is stable the relationships built between services are preserved and can develop. Multiple sector reforms have seen significant staff attrition causing disruption to relationships that support CC (Frost et al 2019).

Barriers to Collaborative and Coordinated care

1. Rigid models, rigid approaches

A lack of staff time and resources was mentioned by the majority of participants as a key barrier to CC. Competing demands and a focus on risk management can mean staff cannot prioritise connections with other providers. Additionally, staff changes, and attrition were identified as barriers to collaborative and coordinated care. Staff talk about playing 'phone tag' due to limited hours of employment, or limited time working during weekdays. Many projects and programs are only funded for very short terms, leading to a substantially reduced capacity for service coordination.

Tight costing models and efficiencies under the NDIS mean reduced service quality and capacity to participate in coordinated care (Furst, Salinas-Perez & Salvador-Carulla 2018, p.593). Staff cohorts report that monitoring of MH and safety issues and communicating these issues to clinical MH supports is rarely occurring under the NDIS. Similar issues occur for G. P's and private psychiatrists who have limited ability to participate in shared care due to a lack of funded time to connect with the care team.

2. Getting lost in the maze

Consumers who have complex support needs often rely on carers to navigate services (Olasoji, Maude & McCauley 2017, p.407). Locating services is challenging for the following reasons: 1. There is no one central point of information about all services available; 2. Access criteria for services can be confusing and leave gaps in the service system; 3. Multiple system reforms mean that information is quickly out of date. Carers need to rely on staff knowledge in many cases.

Staff say that too many systemic changes occurring simultaneously are leading to increasing problems with service navigation. Difficulties with navigating services and a lack of knowledge about other providers can make it unlikely that service providers will make suitable connections to enable CC.

3. The need to level the playing field

Jones and Delaney (2014, p.12) searched for the meaning of CC with a qualitative study involving 4 MH professionals and discovered that strategic healthcare leads to intrusive medically driven systems that support power imbalance and erode collaborative practice between service providers and consumers. In relation to MH, much of this hierarchy pertains to the MH clinicians' ability and requirement to manage crisis and ameliorate risk for consumers and the community at large.

With the introduction of Recovery Oriented Practice (ROP) across MH services, both clinical and non-clinical, there exists an understanding that the consumer is the expert in their own care, and that services are to support them to progress along their journey of recovery from the consequences of mental ill-health. It appears that this remains aspirational despite efforts to introduce the ROP to clinical MH services (Davies & Gray 2015).

4. Overcoming stigma

Mental illness continues to attract stigma despite targeted community efforts to alleviate it (Victorian Government 2015, p.14). Consumers report that the stigma of mental illness can prevent them from seeking support, and when they do, they can find some staff perpetuate the stigma and confirm their fears. Carers may be stigmatised for their perceived role in the consumers illness.

Some staff also report experiencing stigma e.g. AOD practitioners were stigmatised as “ex-users”. This can inhibit the development of a working relationship with clinical services.

The challenges of reinventing ways forward

Leaders noted the various disruptions caused by service reforms and were keen to support the continuation of collaborative practices, outlining a range of measures to support improvements to health and community services’ connectivity. They say CC needs not to be a ‘nice to do’ but rather a ‘need to do’ aspect of service provision and that a ‘culture of collaboration’ is needed. Development of this culture will require a systemic and multi-level investment that has suitable outcome measures attached, as opposed to the current reactive and short-sighted policy and short-term service funding that is output focussed. Leaders re-iterated that FFS models such as the NDIS do not encourage such an approach. Desire was expressed for a co-design of the sectors and system with all stakeholders having equal opportunity to provide input into redevelopment.

Leaders believe CC and collaboration should be written into all funding and tender applications, with clear accountability mechanisms. They suggest the NDIS should have billable hours for CC and networking. G. P’s and Psychiatrists also need to be funded to work across sectors when necessary if true ‘wrap around care’ is to be achieved. The change may be best driven through accreditation processes whereby services have a set of key performance indicators to measure the shared care practices.

Participants suggest information sharing could be improved by aligning data systems, consent processes and paperwork. Ideally, shared care plans should be visible across services. Consent is required for this to take place. Technology is required to enhance accessibility to care team meetings and networks. Online communication platforms allow busy workers to engage when time and resources do not permit movement between services.

Sharing resources across services and sectors can enhance consistency of practice and avoids “reinventing the wheel”. To sustain this practice in a competitive environment, the use of creative commons enables sharing whilst acknowledging the original developer.

Conclusions

Summary of findings and implications for practice

Building on the work of a local MH Service coordination alliance, this study set out to identify potential ways in which CC and collaboration could be preserved and improved by investigating this complex phenomenon from the viewpoint of service users and service providers. This multi-level study included a variety of service sectors and provided an opportunity to engage in a rich understanding of the enablers and barriers from a range of perspectives. Much of this discourse has confirmed results of previous studies on the topic while addressing key gaps in the literature. Knowledge of how the various and rapid sector reforms are affecting service providers and users, and exploration of what people think needs to change, has led to a series of recommendations for future research and potential system change.

The overarching theme across all sets of data is captured in the phrase “it is who you know *and* what you know that makes collaborative practice work”. As enablers, relationships and service knowledge are critical factors in CC. These are supported by a gentle and flexible service environment, service navigation tools and roles, clear communication mechanisms, cross-sector training, staff networks and alliances. Appropriate resourcing of health and human services is needed to support the human connections that enable coordinated supports and consumer engagement. Significant barriers to CC and collaboration included: stigmatisation of MIH; the complex and unnavigable service system; a hierarchical system; and most significantly, the rapid and frequent system reforms including the introduction of FFS models to deliver psychosocial disability supports.

All 59 research participants were asked to consider ways of improving and supporting CC and collaboration. A series of clear recommendations have emerged from the study data in relation to service navigation, consumer friendly environments for support, stability of the workforce and developing a standard knowledge base across service sectors. These address the research question of what can be done to improve CC and collaboration.

1. The importance of service navigation

There is a clear and demonstrated need for a simple and comprehensive tool to enable navigation of supports, both for the community and for service providers themselves. With easy access to up-to-date information about which services are available and appropriate for people, consumers are more likely to locate the right supports to enable their journey of recovery and are less likely to fall through the gaps in service provision. This in turn will reduce future costs.

2. The importance of a gentle environment

Consumers have requested consideration of the development of service environments that reduce anxiety and enable connection. The worker is an intrinsic aspect of the service environment and capacity building of staff needs to include trauma informed practice and customer service skills. When consumers are most disabled by their symptoms their home environment is likely to be the most useful place for services to engage in provision of supports.

3. The importance of a stable workforce

Policy and system reform should focus on stabilisation of the workforce across all health and community service sectors to enable relationships to be established and sustained for optimal CC. Consideration should be given to abandoning FFS models and identifying better methods, such as long-term block funding, that support collaborative practices. Output driven models allow little time for workers to communicate and develop shared understandings. It seems likely that a change

in focus, to measure the outcomes of collaborative practices, would enable services to provide more flexible and coordinated responses to the needs of consumers and carers.

4. The importance of standardising worker knowledge across sectors

When staff know how to identify the consumer's issues effectively, they are better equipped to communicate and advocate for them in accessing services and planning their care. This requires training and tools. Both tertiary and non-tertiary education providers should consider how they can effectively broaden the knowledge base of health and community service workers as part of their initial training. Once in the workforce, support is required in the form of funding and policy to enable both a) the development and delivery of, and b) attendance at cross-sector training. Screening tools can support staff to better identify a broad range of consumer needs and encourage the use of appropriate language for cross-sector communication.

Recommendations for future research

Future research is required to identify the most efficient methods of providing a more stable workforce and reducing staff attrition. An economic evaluation and cost comparison of existing health and community service funding models would be useful to guide future policy decisions. A contemporary Health Impact Assessment (HIA) of FFS models can support any proposal to avoid future use (and abandon current use) of these in relation to health and human services.

Further studies are required to, investigate useful and cost-effective ways to optimise the environment for service provision, and direct funding to support developments to service structure and practice. A co-design approach is recommended to ensure the service users' needs are incorporated into future service design.

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Appendix

List of Abbreviations

AOD - Alcohol and other drugs

CC – Care Coordination

DHS – Department of Human Services

DHHS – Department of Health and Human Services

EMHSCA – Eastern Mental Health Service Coordination Alliance

FFS – Fee-for-service

GP – General Practitioner (medical)

MH - Mental Health

MIH – Mental ill-health

NDIS – National Disability Insurance Scheme

PCP -Primary Care Partnership

PSW – Peer Support Worker

ROP -Recovery Oriented Practice

Terminology

Carer – Family members or friends of a consumer who provide care to the consumer within their relationship as defined by the Carers’ Recognition Act 2012 (Victorian Government 2012, p.2). Carers may not necessarily live with the consumer for whom they care. Children can be carers too.

Collaborative – 1. Two or more people or organisations working together for a particular purpose; 2. All parties to the recovery plan participate as equals in all processes of coordinated shared care required.

Consumer – Someone who has been diagnosed with a mental illness, has direct experience of MH services or identifies as a consumer (VMIAC). The term “consumer” refers to people who directly or indirectly make use of MH services.

Dual Diagnosis – the term use to describe the co-occurrence of MH and Substance Use diagnoses.

Recovery Oriented Practice - A core component of ongoing health care reforms that emphasises the personal journey of people with mental illness (Australian Government, 2019)

Recovery Plan – A consumer’s plan that articulates what is important in their life including goals, hopes, dreams and identified supports (Glover 2013).