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Impact of care coordination on Australia's mental health service delivery system

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Abstract. Care coordination models have developed in response to the recognition that Australia's health and welfare service system can be difficult to access, navigate and is often inefficient in caring for people with severe and persistent mental illness (SPMI) and complex care and support needs. This paper explores how the Australian Government's establishment of the Partners in Recovery (PIR) initiative provides an opportunity for the development of more effective and efficient models of coordinated care for the identified people with SPMI and their families and carers. In conceptualising how the impact of the PIR initiative could be maximised, the paper explores care coordination and what is known about current best practice. The key findings are the importance of having care coordinators who are well prepared for the role, can demonstrate competent practice and achieve better systemic responses focused on the needs of the client, thus addressing the barriers to effective care and treatment across complex service delivery systems.

What is known about the topic? Care coordination, as an area of mental health practice in Australia, has not been well defined and the evidence available about its effectiveness is uneven. Even so, care coordination is increasingly identified as having the potential to deliver a more person-centred response to the health and social needs of people with severe and persistent mental illness (SPMI), as well as enhance the responsiveness of Australia's mental health service delivery system. The introduction of Partners in Recovery (PIR), a new Australian Government initiative based on coordinated care approaches, provides the impetus to investigate the hoped for mental health system enhancements and related improved client outcomes.

What does this paper add? This paper offers a rationale for care coordination, referred to in the PIR model as support facilitation, as a primary enabler for enhanced person-centred, cost-effective and sustainable mental health service delivery. The paper discusses support facilitation as an integral practice platform for supporting the successful implementation and sustainability of the PIR initiative. It also addresses issues that may be encountered in establishing the roles and functions of various components of the initiative's care coordination model.

What are the implications for practitioners? The key implications for PIR support facilitation practitioners are to reconsider their function and roles within a mental health service delivery system that places care coordination at its centre. This paper establishes that any model of care coordination requires well-trained and enthusiastic practitioners with a sophisticated appreciation of current barriers to care. Practitioners will be required to value partnerships as a means of addressing barriers that impact on the establishment and maintenance of robust, system-wide responses that are genuinely consumer focused.

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Introduction

In the 2011–12 Federal Budget, A$549.8 million was committed over 5 years to establish the Coordinated Care and Flexible Funding for People with Severe, Persistent Mental Illness and Complex Care Needs program, now called the Partners in Recovery (PIR) initiative. This initiative is part of the Australian Government's A$2.2 billion investment over 5 years in its National Mental Health Reform package to deliver on its commitment to expand services in effective programs, and to create a more targeted and better integrated mental health care system.

People with severe and persistent mental illness (SPMI) and complex needs are commonly reported to experience difficulties in accessing the range of services required to meet their needs. This moves well beyond specific mental health issues and extends to recognise the importance of social connection, stable housing, physical health, education and employment.[1] The PIR initiative is intended to enhance access to and coordination of health and welfare services.

'Support facilitation' is a key element of the PIR initiative. Although not named 'care coordination', the role of the PIR support facilitator is best understood as a variant of care coordination. In the initiative, support facilitators are responsible for undertaking assessments, developing multisectoral action plans, coordinating services and being a single point of contact for people with SPMI and complex needs; the fundamental elements linked to care coordination in other programs and models.

Understanding the context and rationale for this initiative is important. The PIR initiative represents an innovative approach to addressing current service delivery gaps. The initiative does not include direct funding to clinical services, where much of the state-based funding for people with complex mental health issues is currently focused. Rather, this Australian Government strategy, influenced by the evidence base for recovery-focused support and inclusive of clinical interventions, provides an alternative innovation to enabling people with SPMI and their families and carers to gain access to a person-centred, holistic support, care and treatment approach.

Current context

The evidence for the effectiveness of care coordination highlights the inherent complexity in this approach. A review of care coordination models in the US[2] found few models were able to demonstrate consistency in meeting their respective aims. In some instances, this was possibly because of pressure to reduce costs.[2] However, in successful models, one key element was common: 'first-name, caring, personal relationships in which the care coordinator was an advisory friend who got to know the individual and connected with him or her at a personal level.'[2] In contrast, systematic reviews of chronic care models have found successful care coordination relies on a focus on both system change and supporting individual self-management and decision making.[3,4]

In Australia there has been a rise in the number of care coordination programs spanning chronic disease management, people with significant social health issues and people with serious mental illness. Models have differed according to design, target group and the resourcing available to support the program and its implementation. Much of the rationale behind care coordination is the emphasis on individual and family assets or strengths, coupled with the supports received from the formal service sector.[5] There is a realisation that these types of supports (family support, community ties, peer support and relationships with other social service providers) are critical and can be leveraged to improve a person's health and well being outcomes. Fine[6] argues that deinstitutionalisation and the availability of a range of community-based sources of care and treatment have made a division between formal and informal sources of care less meaningful. Within the mental health sector, care coordination is being strengthened at a time when partnerships, hybrids and new forms of mixed care have become more valued. As Fine[6] asserts, the shift is increasingly towards the individualisation of care with greater focus on care being experienced:

> . . .not simply as a one directional activity undertaken by the care giver, but as an outcome of a relationship between the different parties in which mutual respect, and the fostering of the capabilities and autonomy of the recipient are foremost.[6]

Coupled with this is the need for a systematic approach to care coordination that focuses on values, service design and service delivery.[2]

In psychiatric services there is currently a shift away from case management because it appears to have only partially met expectations about providing the holistic response to care envisaged by its early proponents. Kanter[7] suggested case management was 'handicapped by the lack of conceptual models that delineate the diverse activities of the case manager'. Although case management models have always included linkage and system interventions as purposeful components of the role (and, in a brokerage case management model, the sole purpose of the role), it appears that within the community-based mental health system it is this aspect of contemporary case management that has not been achieved or sustained effectively. This suggests that case management has suffered mission drift and, as a consequence, has not represented an opportunity to further develop holistic and cross-sectorial strategies and practice.

In a review of the evidence for case management, Rapp and Goscha[8] found the least evidence for brokerage case management models (which is most akin to care coordination) and the most evidence for assertive case management (ACT), particularly in situations where case loads were contained. Many problems have been attached to case management, including the terminology itself, implying that people are 'cases' to be 'managed'.[8] Other problems include that those in case management roles have often been prepared inadequately for the broader aspects of the role and, therefore, despite being called 'case managers', are inclined to retreat to the more narrow or clinical roles their professional education prepared them for. Another explanation for the sense of failure of case management may lie in psychiatric services becoming more dominated by the need to manage crisis and risk and, in turn, encouraging a more procedural response to providing care.[9,10] Within the psychiatric service system, case managers have faced an entrenched and siloed service delivery system such that gate keeping and disintegration of services have discouraged attempts to engage with, and work across,

other sectors.[11] Accordingly, the case manager role has risked being inadvertently redefined as a role that is focused inward, negotiating services available within a particular silo or service sector, rather than boundary spanning and working across a complex and often tightly boundaried service network.[12]

Strong current evidence for the problems in case management is located in the recent Survey of High Impact Psychosis (SHIP).[13] According to the National Standards for Mental Health Services,[14] the development and regular review of a treatment, care and recovery plan in consultation with each consumer is an expectation of both non-government organisations and public community mental health services. If an assumption is accepted that good case management is reflected in collaborative treatment planning involving consumers and their families, then the SHIP data suggest that this is an inconsistent feature of Australia's mental health services. Most respondents did not have an individual rehabilitation, care or recovery plan, and even fewer were involved in its development.[15] Findings from SHIP also confirm the ongoing issues for people with serious mental illness in relation to very poor physical health, social isolation and poverty. The major problems faced by people with serious mental illness are also acknowledged by the National Mental Health Commission's National Report Card.[16] The report card describes many similar problems to those represented in the SHIP data and calls for a more holistic approach that will enable people with mental illness to be 'thriving not just surviving'.[16]

Hence, the title of the initiative 'Partners in Recovery' suggests that the focus of the program will be a collaborative, person-centred and more holistic approach to intervention. The evidence base for a recovery-focused approach is strengthening, in particular the importance of taking an empowering approach in the interpersonal work with people, stabilising housing and assisting people to find meaningful activities or employment.[17]

Implications for practice and the PIR initiative

Governance

Governance arrangements between the different partners engaged in the PIR initiative will need to be robust and clearly articulate the role and function of the support facilitation organisation (which may differ from the fund holder organisation), and its relationships with partner organisations. Ideally, formal partnerships and agreements should be in place to clearly identify the expected roles and responsibilities of the different local partner organisations. It will be essential to form these across the broad spectrum of agencies engaged with people with SPMI and complex needs to ensure that the problems associated with siloed services are not replicated within the PIR initiative.

Target group

An important consideration is whether support facilitation is targeted at those most in need of, and most likely to benefit from, this service. Currently, many people with SPMI who require treatment, support and care from multiple agencies either access services that are unable to meet the challenge of their complex needs or have minimal contact with services due to poor engagement or access. The Australian Government's expectation of the PIR initiative is that it will foster a collective, system-wide response to the needs of people within the target group. Taking a client-focused approach enables recognition that difficulties with access and engagement are the responsibility of service providers, rather than seeing the problem in the people being served and the resources available. Such an innovative and value-based approach focuses the work on the rights of people to access the services they need.

Referral pathways

Core referral pathways should include primary health care providers, state-funded mental health services, police and emergency services, and non-government mental health organisations. It may be possible to colocate support facilitators with key partner agencies to assist with referral and assessment pathways.

In order to be consistent with a 'no wrong door' approach, other agencies, such as homelessness support services, outreach services and first responders, should be able to refer individuals to the program. In instances where a referred person appears to have a mental illness but is not currently engaged in clinical treatment, the support facilitator could enable contact with clinical services. A service agreement would need to be in place between the care facilitation organisation and the area mental health service to ensure referrals occur respectfully and seamlessly.

Given that some potential clients may not be known to services, there will be a need in some settings to proactively identify clients who can engage and potentially benefit from the PIR initiative. This highlights the spectrum of intervention possibilities for clients, from those with little or no engagement with services to those who are multiple service users.

Workforce

The support facilitator role is not seen as a specialist role for clinical mental health professionals. It is likely the role will be filled by those with demonstrated competencies in social care and welfare and experienced in providing personalised support to clients with specialist needs. Support facilitators will be employed principally by specialist mental health non-government services. These organisations have witnessed significant growth in recent years due to the investment of both Federal and state governments in mental health support services. The support facilitation workforce is likely to reflect the current specialist mental health non-government workforce as profiled in the 2011 report of the National Health Workforce Planning and Research Collaboration.[18]

The mental health workforce challenges in relation to supply, recruitment and retention are well documented. The National Mental Health Workforce Strategy[19] has comprehensively considered these challenges and developed a workforce plan. However, in describing the current mental health workforce, this plan has not anticipated the large number of care coordinators about to be recruited and employed in the PIR initiative as support facilitators. It works against the PIR initiative to draw too heavily from the existing mental health workforce. The role and purpose of the support facilitator needs to be well understood by all partners engaged in the PIR initiative, and this will enable the

potential for vocationally based training that is able to contribute to expanding the mental health workforce.

Role of a boundary spanner

Given that the support facilitator is expected to be highly engaged at the client level, their capacity to be engaged in broader health and welfare system change needs support. Because this is a critical area of work requiring a significant level of resourcing, it raises the question as to the need for an additional service integration and coordination role or function. A term that has been adopted internationally is that of 'boundary spanner'.[20] This role or function has been described as:

> . . .[a] *network manager. . .building effective personal relationships with a wide range of other actors; the ability to manage in non-hierarchical decision environments through negotiation and brokering; and performing the role of* '*policy entrepreneur*' *to connect problems to solutions, and mobilise resources and effort in the search for successful outcomes.*[12]

Critical to the success of the PIR initiative is the overarching system change required to facilitate a more joined-up and collaborative way of working. Different PIR initiatives need to incorporate 'boundary spanning' into their service model. This needs to complement the activities of the support facilitator and, therefore, should be resourced from within each PIR initiative and locally determined. PIR management (coordinator) positions are being established within the 51 PIR initiatives across Australia, with the role being responsible for the coordination functions described above. The PIR model supports the function of a neutral or backbone support organisation, with this lead agency generally being the fund holder for the local PIR initiative. In most cases the Medicare Local has been allocated this leadership function with its staff taking up dedicated coordination and collaboration development roles. The expectation that collaboration can occur without a supporting infrastructure and coordination-dedicated roles is cited by Kania and Kramer as the most frequent reason why large coordination projects fail.[21]

Introduction of the National Disability Insurance Scheme

No new health or disability initiative in Australia can ignore the potential relevance of the introduction of the National Disability Insurance Scheme (NDIS; see http://www.ndis.gov.au/, accessed 17 December 2013). The NDIS represents a profound policy and system change to the way many services are organised and conducted. A successful NDIS will require a service delivery environment that encourages a personalised approach to care, enabling greater consumer choice and a wider range of options and providers. Support facilitation is likely to be complementary to the NDIS, but adds an extra layer of complexity that support facilitators will need to negotiate.

Conclusion

This paper has established the rationale for the care coordination role in mental health service delivery. PIR, an important new Australian Government initiative, provides an opportunity to develop a robust service model that is focused on strengthening an individualised approach to the support of people with SPMI and complex care needs who require engagement with a range of sectors and service types. Learning from the successes and challenges of previous attempts to introduce and sustain more effective service delivery coordination has provided guidance regarding what needs to be in place for support facilitation to lead to positive outcomes. In particular, the proposed PIR model requires well-trained and enthusiastic support facilitators who have a sophisticated appreciation of current barriers to care, are competent in establishing and maintaining effective partnerships and are able to exert the authority that enables an integrated and sustained system response focused on the needs of the client. It has also developed structures and functions that directly support these activities at a local level. This innovative initiative offers an opportunity to build on the strengths of existing roles and service delivery environments in developing and monitoring a sustainable model of support facilitation. The effective implementation of the PIR model requires clarity about the essential elements of the role, a shared understanding and commitment across all stakeholders and an infrastructure that supports the work.

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