

Mental Health  
Council of Australia



**CO-ORDINATED CARE AND SERVICE INTEGRATION WORKSHOP**

**Report of key issues and themes**

House of Representatives Alcove, Parliament House, Canberra  
11 August 2011

## **Acronyms and Abbreviations**

DEEWR	Department of Education, Employment and Workplace Relations
DoHA	Department of Health and Ageing
FaHCSIA	Department of Housing, Community Services and Indigenous Affairs
MHCA	Mental Health Council Australia
NGO	Non-Government Organisation
NMHC	National Mental Health Commission
NRAS	National Rental Affordability Scheme
PHaMs	Personal Helpers and Mentors
PM&C	Department of Prime Minister and Cabinet

# **Table of Contents**

## **Executive Summary**

### **Priority considerations**

1. Access
2. Partnership development
3. Care facilitators
4. Governance

### **Group discussions – thematic analysis**

1. Opportunities
2. Risks
3. Models of practice

**Appendix 1 Summary of guest presentations**

**Appendix 2 Background papers provided to workshop attendees**

**Appendix 3 Co-ordinated care and service integration workshop agenda**

## Executive Summary

The Coordinated Care and Service Integration Workshop brought together service providers from around Australia, to discuss implementation challenges and opportunities related to the coordinated care and flexible funding initiative announced in the 2011-12 Budget.

Four key issues emerged:

1. Access
2. Partnership Development
3. Care/Service Facilitators
4. Governance

Participants identified many risks and opportunities throughout the workshop. These can be summarised into the following key areas:

- **Consumers and carers** must be central to all decisions and processes
- Acknowledging and building upon existing **networks and services rather than imposing new ones**
- Using the initiative to build and strengthen meaningful, **collaborative partnerships** across the system
- Clarifying **roles**, responsibilities and expectations
- Formalising **agreements** between partners
- Keeping it simple

It is not the intention of this report to outline every issue raised, but the priorities listed above and key issues discussed below, give a good sense of the themes raised throughout the workshop. This summary report is based on notes taken by the scribe throughout the day.

## Priority considerations

### 1. Access

The group was very focused on ensuring that consumers are able to get the right service and that services are provided within their own community, wherever possible.

Issues that arose included: the way in which eligibility will be determined and ensuring that there were multiple pathways to service entry. The group also consistently emphasised the need for the consumer to be the central focus of any intervention as well as during the functional and support stages of care.

### Discussion

Eligibility: how will eligibility be determined: by capacity of care/service facilitator and/or local agency network? Will eligibility be linked to eligibility for the Disability Support Pension?

Referral: should include multiple processes including self-referral, carer-referral or via agency/service- referral. The importance of a no-wrong-door approach was emphasised. The importance of systematic, simple and flexible processes across the continuum of care was also stressed.

Focus: emphasis on the centrality of consumer and carer input with a focus on goals and values. Early intervention and effective early stage support was discussed as was the importance of considering the functional and social aspects of a persons life, rather than simply their diagnosis. Meaningful, well coordinated discharge plans and follow-up should be built in to the system.

Increase access: particularly to psychiatrists and psychologists. Coordination in isolation from services is meaningless. Care needs to reach the right people at the right time, which means identifying those most at need, and those who are falling through gaps. Flexible and responsive service models are needed, which are able to operate according to the needs and capabilities of a particular community, especially in rural and remote locations. Access to information about services was considered an important part of any systematic response.

Service provision: it is always preferable to engage people in their own environment, in a timely manner, ensuring that there isn't discrimination on the basis of a particular diagnosis. It was acknowledged that security was an issue. Participants were concerned that diagnosis is often a poor indicator of suitability for service. Participants also observed that as service profiles vary greatly in from community to community arrangements will have to vary considerably according to location. .

### 2. Partnership Development

The group emphasised the importance of stakeholders being engaged and working collaboratively to achieve the best outcomes for the consumer. This included government, NGO and support service stakeholders working together to build networks, skills, knowledge and processes.

Core service providers: the key component is ensuring participation of all stakeholders including consumers, carers, Medicare Locals, Centrelink, Divisions of GP, mental health services, non government and community organisations and various government departments (e.g. health, housing, employment, education and justice). The group identified the challenge in coordinating public and private services.

Focus: there are already very good networks in place in many communities so it is more a matter of building on and strengthening the existing ones, with an emphasis on sustainability and flexibility in any collaborative partnerships. Tendering arrangements that are not respectful of existing arrangements can be very disruptive to services. Similarly, considerable efforts need to stop the revolving door where existing services have less connection to each other – this can happen through the identification of leaders and champions and broad representation to achieve a deeper skills and knowledge base across the sector.

Governance: clear governance processes to be utilised (e.g. Terms of Reference, Memorandum of Understanding, service agreements) to clearly define the roles, responsibilities and expectations of each partner agency. Other issues that require consideration include boundary issues, and funding for training and support and high level and well coordinated communication.

### **3. Care / Service Facilitators**

The role and responsibilities of care/service coordinators need to be very clearly defined, and the group felt they will need to be highly skilled. A care facilitator will have to be well-versed in the services available locally and foster and manage relationships and partnerships. Ideally, the care facilitator will be a well-networked individual who is familiar with the full range of support services available locally across the various portfolios (e.g. housing, employment). Further, the group stressed the importance of having enough care facilitators to ensure they are not overwhelmed, and that they are provided with coordinate support and development once they are appointed.

Approach: community development and engagement approach.

Roles/responsibilities: it would be important to first identify the work that has already been done in this area by community workers locally. The group was clear that a care facilitator is not a service provider or case manager, rather, they are a coordinator of service provision. This will include – building quality partnerships, designing and coordinating care plans, ensuring local area service mapping is established, updated and maintained and contributing to cross-sectoral knowledge development and sharing.

Skills and experience: this role requires highly skilled, well networked individuals with capacity to implement change.

Auspice: arrangements should look different in various community settings. The group identified a need for flexibility to respond to local structures and arrangements, with guidance to ensure close collaboration and shared governance arrangements.

Governance: ensure ongoing training and support for facilitators as well as ensuring an adequate number of facilitators to support the population. Caseloads should be determined according to the needs and numbers of the region. Care facilitators should have enough authority to enable them to keep services accountable. Links to existing programs (such as PHAMS) should be clearly explained. Arrangements should allow care coordinators to be supported nationally, in addition to local support arrangements.

#### 4. Governance

The forum emphasised the importance reviewing existing models of best practice, the development of effective change management processes and high levels of accountability. Further, that the target consumer group needs to be specifically defined to ensure that assessment tools are adequate and that workforce development and planning is undertaken to meet the additional need.

Discussion

Business rules and models: to be client centred and recovery focused as well as transparent and accountable. Any services should link the acute and recovery stages seamlessly, with a whole of life focus and consumer, carer and family input at every stage (Consumer and carer engagement should be demonstrated. Centrelink identification should be one pathway to access services. A flexible approach to models of governance best practice is needed. In addition, clear eligibility, entry and exit criteria need to be agreed upon. A system of shared record keeping should be established and it will need to be determined whether brokerage will be individual, community or service based. Consideration will need to be given to how specialty areas will fit with this model (e.g. communities of practice, subject matter experts) and how any non-clinical and regional service agreements will work with care plans.

Tools: assessment tools need to be valid and meaningful as well as being standardised/consistent (i.e. everyone uses the same form for the same process), as much as practicable. As various assessment tools are already in place these will need to be considered. IT systems should be employed to develop appropriate referral systems and care plans. The group stressed that any care plans should be simple but specific, while still being flexible and organic. The group also emphasised the importance of developing a strong feedback loop that includes regular reviews and evaluation of the plan and service providers so that various stakeholders all have access to the same information.

Tender process considerations: the consumer target group will need to be clearly defined, which will mean the establishment of clear criteria. Attendees discussed funding and emphasised the need to match and weight funding according to need and complexity (e.g. rural and remote communities) as well as link funding agreements to partnerships and KPIs. That is, funding will need to be allocated to the support of partnership arrangements, communications, training and development, evaluation and other functions – not just direct service delivery. Much of the discussion was on utilising the tendering process as an opportunity to develop collaborative partnerships and creative consortium approaches as well as strengthening existing services, boosting community services and engagement. In many areas service mapping will be required to identify regional/local service provider networks. It was expected that agencies would have to demonstrate not only their understanding of 'severe and persistent mental illness', but also be able to identify and reach this group within their own communities. Specific mention was made about the cultural considerations that would apply to high-risk groups such as Aboriginal people or culturally and linguistically diverse people. It was agreed that links to Medicare locals would be important. Lastly, the issue of having appropriate funding periods was raised, as was the need to have funding recipients with a proven track record of local engagement and independent review and evaluation processes.

Workforce capacity: the forum was concerned about how an already stretched workforce will be able to implement yet another system – this highlighted current issues about insufficient staff numbers and remuneration levels across the sector. This also highlighted the need to engage with and enhance existing service providers. Other issues raised included the need for further support, ongoing training, the development of core competencies and the importance of developing capacity building and resourcing initiatives such as mobility.

Communication and marketing: the forum was clear that simple, consistent and positive messages about hope and recovery were most effective when advertising services. The emphasis was sending the message that it is not about replacing existing services, but rather that there is a need to improve services for those considered to be in the 'too hard basket' and those falling through gaps. They felt that the focus should be on breaking down barriers utilising a well targeted anti-stigma campaign. The forum recommended promoting existing services and technologies (e.g. e-Health) that work and focusing more on sharing information across community partners. The group also stressed the need to undertake further consultation, increasing stakeholder input into the development of the initiatives through the circulation of draft papers, conducting workshops and the like, to gain feedback at the community level.



## **Group discussions – thematic analysis**

### **Opportunities**

The group highlighted a number of ways of achieving positive outcomes for consumers through effective care coordination. These centred on the importance of service efficiency, being consumer focused, strengthening relationships and boosting community-based services. Key issues raised by the forum included:

- Using this initiative to break down barriers, establish meaningful relationships and brokerage funding
- Streamlining existing services to reduce duplication, thereby increasing available resources and service efficiency as well as improving communication channels
- Using these initiatives to support culture change
- Potential for common/joint workforce development and increased service efficiency
- Improving quality assurance
- Research and evaluation opportunities
- Reduce the number of people falling through gaps
- Potential to link to the National Disability Insurance Scheme
- Capacity to increase accountability across sectors
- Recognition that people are more than their illness
- Providing a boost to community based services
- Reducing hospitalisation
- Freeing up clinicians to focus on clinical considerations

### **Risks**

The group identified several risks that require careful consideration during the development and implementation of this budget initiative. Concerns held by the group related to the additional burden that would be placed on services. Service providers were concerned that there was a risk of services becoming fractured as a result of this initiative. Some of the key issues raised included:

- It will potentially be creating an extra layer
- A competitive tendering process could fragment services if they are pitted against each other
- Existing providers could see this as a means of securing additional funding, without delivering additional output – with a risk that larger providers are more likely to secure funding
- It won't overcome the systematic issues in the clinical sector, if a competition culture remains
- Lack of ownership over the initiative could see disengagement
- There are limited resources in rural and remote communities to be able to take on this additional work
- It could lead to service confusion
- Existing services could become overloaded, leading to workforce burnout
- Under-valuing existing services
- High percentage of people will continue to fall through the gaps with the risk that it will have limited impact on waiting lists
- Age (and other) specific needs may not have been adequately considered/represented
- Case management will be left to the Care/Service Facilitator
- Acute medical clinical model will continue to dominate. There is a risk of creating

dependency rather than empowering

### **Models of Practice**

Throughout the day, workshop attendees discussed several existing jurisdiction based models of practice that are thought to be positive examples for the Government to look at when deciding on the best ways of developing and implementing this budget initiative.

- *Lutheran Community Care* model, Sunshine Coast, Queensland
- *Exceptional Needs Program*, South Australia
- *Abbeyfield* model
- *Micah Project*, Queensland
- *Homeground Service*, Melbourne
- *Townsville Case Coordination Group*
- *Townsville Institute of Mental Health*, Service Integration Coordinator
- *Catholic Care*, St John of God

## Appendix 1 – Summary of guest presentations

**Georgie Harman**, First Assistant Secretary, Mental Health and Drug Treatment Division, Department of Health and Ageing. Ms Harman emphasised the importance of the MHCA workshops in seeking input from service providers, regarding implementation options. The workshops extend and build on previous discussions and broaden the focus on NGO service providers, giving them an early opportunity to influence directions. From these workshops, a discussion paper will be released, followed by a report to Minister Butler. Future consultation with stakeholders, including consumers and carers, will also be occurring.

She noted that this is one of the largest and most significant budget initiatives and that it will make a real difference if we get it right. The initiative puts the person at the centre of coordination. We do not want duplication or short-term shots in the arm. It is a holistic measure with a strong partnership approach to implementation. We are currently working across portfolio's, including with FaHCSIA, DEEWR and PM&C.

During 2010, Minister Butler's national consumer and carer forums produced an overwhelming theme; *we need better coordinated care*. Carers and consumers are fed up with inequality in the system and with being bounced in and out across a range of services.

The Government has responded with \$549.8m over 5 years, and then ongoing, to address the needs of people with severe, persistent, complex multi-agency care needs. Money has been provided to employ care facilitators around Australia. Service delivery will be ramped up to provide 24,000 people with better-coordinated services by 2016. Care facilitators will be the single point of contact and will facilitate holistic assessment via a coordinated service plan.

Locally based organisations will have the opportunity to tender (via Medicare Local regions) to provide a coordinated brokerage model of service. A consortium approach will be the preferred model and the process will be looking closely at organisational capabilities.

There will be 4 funding phases:

1. Nationally consistent Access Framework - to be established by June 2012 and driven by DoHA and FaHCSIA
2. Coordinated Care Agencies will be established by the end of 2012
3. Implementation of Coordinated Care
4. Evaluation

Timing for the tender process for Care Facilitator Organisations is still to be determined, but is expected to proceed in the later part of 2011-12. The Department will be keeping in regular contact with the sectors and stakeholders throughout the year to ensure you are kept abreast of developments.

**Ben Mathews** is a Mental Health Consumer, and an advocate who works for MIE ACT (a schools and community education program covering Years 9-12). He also runs his own Mental Health Training Consultancy. Ben had a positive story to share with forum participants, but he did not wish to make participants comfortable; he wanted to challenge them.

Ben spoke about the reality of mental health in Australia and how the budgetary initiative is on the right track, but will only touch the surface.

He also spoke about his own personal experience with mental illness, commencing when his

father committed suicide when Ben was just 13 years old. His experience has continued into his adult life; he has developed a mental illness, which considerably impacted on his career, his family and his life generally. He spoke about therapeutic communities and rehabilitation and how they have a veil of secrecy, with many people not wanting to admit they have been treated in one. He spoke about Karralika (<http://www.adfact.org/index.htm>) community in Canberra, where he embarked on a 12-month program (with 12 months of follow-up) and where clients run the program, which is intense and extremely challenging. The structure creates a positive therapeutic framework. Ben completed the program 2 years ago and is living proof of what is possible with solid, coordinated care and whole of life support.

**Craig Allatt**, a carer, opened his presentation with the statement that “love just ain’t enough!” His story commenced when his son was born and his partner (Emily) developed a psychosis; she had no prior history of mental illness. She committed suicide nine months later and Craig was literally left holding the baby. During the nine months, they had considerable resources thrown at them, with regular visits to all services; none of which was coordinated or took a holistic approach. Nor did those services assist either Emily or Craig to cope. Craig spent endless hours researching the Internet. He read, talked to people and came up against many dead ends and blind alleys. He went back to basics, looked at what had triggered her symptoms and discovered statistics around environmental conditions leading to her suicide.

Craig identified five themes:

1. *He was a co-worker* with health professionals. However, he did not receive handovers or the required level of support. He did get instruction around medication, which he was expected to manage by himself - without supervision or support.
2. *He was a patient advocate*: he needed information about Emily’s illness and about the system. What he was given was a pamphlet and he was left to figure the rest out for himself.
3. *As a carer*: he needed considerable amounts of professional support, but had only his family and friends. He was offered respite and access to a support group, however, this was not an option as Emily and his son needed him. He asked the professionals “What should I do?” the response was “I don’t know”. There was no offer of referral.
4. *Resources*: Carers are not a costless resource. Considerable amounts of downtime from their own professional work is expensive to the Australian economy, and the personal health costs of being a carer can be astronomical.
5. *System User*: eligibility for the Carers Allowance is not set up for illnesses of unknown duration. As well, the coronial system is not designed for suicide cases.

Craig ended his presentation with a strong statement that treatment needs to be comprehensive and preventative and that policy needs to be responsive and timely. He urged policy makers to consider how they would feel if placed in the same situation. Craig said that carers are underutilised, undertrained and unfunded part of the system. He reminded the audience that the fact he has a case manager made no difference to his and Emily’s situation – he emphasized that proactivity is the key! The audience responded that Craig’s story was powerful, important, insightful and compelling.

**Kerry Staines**, Lutheran Community Care (LCC), Sunshine Coast, Queensland, provided an overview of the LCC model of best practice and what has contributed to its success.

She noted that initially 20 project workers were funded through Queensland Health – there were few guidelines and each worker was looking at a different roll out model.

#### *LCC Model Focus*

- Recovery
- A holistic approach
- Person centred
- Family/carer inclusive
- Socially inclusive
- One plan to meet all needs
- Accountability.

#### *Establishment*

- Established a steering committee to agree eligibility and undertake assessments
- Established stakeholder meetings (includes consumers and carers) to secure buy-in and ownership and link with the community and carer support team. Anyone can call a meeting
- Called for volunteers
- Employed Service Integration Coordinator (SIC)
- Set up 12-month local partnership agreements

#### *SIC Role and Skills*

The person needs passion, values, drive, understanding of the whole story and strong ability to navigate the system – hub/conduit in the community.

#### *LCC process*

- Referral from anywhere
- SIC coordinator contacts client
- Eligibility assessment meetings (10-15 people at any given time)
- Eligibility is passed through the steering committee
- Stakeholders have case meeting and a plan is developed

#### *Outcomes achieved*

- Formal local partnership agreement
- Client focused; 40 clients since 2009
- Flexible, responsive, holistic service delivery

#### *Challenges*

- Eligibility – must have a diagnosed mental illness
- Mental Health Services - after hours closure
- No brokerage fund available – further stretch for already stretched community services
- Lack of housing (8 years wait minimum in Qld); LCC has now formed NRAS partnerships

#### *Opportunities*

- Empowered to work in areas not previously considered
- Have avoided duplication
- Identified gaps which has enabled stronger lobbying
- One central contact point for families/carers

## **Appendix 2 – Background papers provided to workshop attendees**

As part of the 2011-12 Federal Budget *Delivering National Mental Health Reform* package, the Government has committed \$549.8M over 5 years including \$343.8M in new funding to establish a new measure; coordinated care and flexible funding for people with severe, persistent mental illness and complex care needs.

Through this measure, up to 24,000 people experiencing severe, persistent mental illness who have complex care needs, and their families and carers will, for the first time have one point of contact for coordination of all their clinical and non-clinical care needs.

Regionally based care facilitation services will be established through an open tender process. Regions will be determined using Medicare local boundaries. Eligible organisations are expected to include Medicare Locals and other non-government organisations.

The care facilitation services will support the facilitation of services at the local level by providing a single contact, assessment, navigation and referral point for people with severe and persistent mental illness and their families and carers.

Care facilitators will be responsible for coordinating eligible individual care needs, clinical and non-clinical, to ensure those needs are being met. Nationally consistent assessment tools and processes will be developed and care facilitators will use these to develop multi-disciplinary service care plans.

The measure will seek to use services already provided through existing Australian Government and state programs, such as Medicare subsidized psychiatric consultations, the Personal Helpers and Mentor (PHaMs), Mental Health Respite; Carer Support, Family Mental Health Support services, family, accommodation, income and employment support and state specialist mental health services. Effective partnerships across the range of service providers at the local level will be important to maximize the coordination and avoid duplication.

Care Facilitator Providers will have access to a level of gap funding to be used to purchase services where service needs are identified but not locally available. Services will be funded from 1 July 2012, with access steadily ramping up toward an ongoing service availability of 24,000 places per annum by 2015-16.

### **Implementation**

The Government will be working closely with a range of stakeholders including states and territories over the coming months to design the measure. Particular priorities in 2011-12 include development of:

- a communication strategy
- eligibility criteria, that is, how and on what basis do people do people get referred to a Care Facilitator
- an appropriate service needs assessment tool and associated coordinated care plan
- a monitoring and evaluation framework for the measure

- operating guidelines for Care Facilitator Service Providers including guidelines on the management of flexible funding to address service gaps
- a tender process for the selection of Care Facilitator Service Providers

Service delivery is not expected to commence until 2012-13. It is anticipated that early in the 2012-13 year, service providers will need an establishment period prior to the commencement of service delivery.

## **Principles**

To improve consumer outcomes for people with severe and persistent mental illness with complex needs through:

- better co-ordination of clinical and non-clinical services in accordance with consumer need
- better referral pathways and strong partnerships with existing services through a nationally consistent approach
- effective coordination of clinical and non-clinical care in the delivery of wrap around care
- Adopting a 'No Wrong Door' approach to service access and referral

## **Successful implementation will require:**

### Clear identification of outcomes for the measure

Outcomes for this measure will need to be clearly articulated to ensure that local level strategies meet the Government's intention. This is particularly important as the mental health reforms are breaking new ground in terms of multi-disciplinary approaches that incorporate the needs of families and carers.

### Clear eligibility criteria, effective assessment and care planning systems and processes

Multidisciplinary service needs assessment and coordination of case management for people with severe mental illness is not nationally consistent. People with severe and persistent mental illness with complex needs, their families and carers do not necessarily get access to the services they need to stay well in the community and break the cycle of hospitalization.

### Appropriate referral mechanisms pathways and effective linkages between services

The measure is intended to improve coordination of services for people with severe and persistent mental illness with complex care needs and to help connect these people to services they need. Care Facilitators are expected to be coordinators of service access, not service deliverers in their own right.

Appropriate agreed local referral mechanisms and a strong partnership approach with clinical and non-clinical service providers will be essential to improve better outcomes for the consumer to assist them to maintain recovery in the community.

### Support for consumers to access existing services and, through flexible fundholding, to purchase services where gaps exist

This measure will not duplicate existing services but rather glue them together. Where service gaps exist at the local level, Care Facilitator Providers will be able to draw down a capped level of funding for the purchase of clinical and non-clinical services, toward ensuring the consumer is able to access the services they need. It is intended that this 'gap funding' is to be utilized for increasing capacity where services are needed and exist, but where no capacity is available; and to provide services where they do not already exist.



## Appendix 3 – Coordinated care and service integration agenda



### Coordinated Care and Service Integration Workshop

House of Representatives Alcove, Parliament House, Canberra  
9:00am – 4:45pm, Thursday 11 August 2011

**0900-0930 Registration including tea/coffee**

**0930-0935 Welcome by Frank Quinlan, CEO, MHCA**

**0935-1030 Background and scene setting:**

- Overview of the Government's Budget Proposal
- Perspective from mental health consumer
- Perspective from mental health carer
- Perspective from NGO service provider

**1030-1045 *Morning tea***

**1045-1215 Small group discussion:**

- Targeting and referral – identifying those eligible for this new service
- Assessment and care plan – role of the Care Facilitator and design of the Care Plan including referral processes
- Enablers: The who, what and how to make the system work
- Achieving successful implementation – including planning, consultation and development processes

**1215-1300 Group feedback of priority issues**

**1300-1330 *Lunch***

**1330-1430 Implications of this initiative for the co-ordinated care and service integration for mental health consumers and carers generally**

- What has worked well in the past (including existing state/territory models)
- What priority issues from the 'severe and persistent' could be applied generally

- What priority issues from the 'severe and persistent' would not be able to be applied to the general mental health consumer population
- Any other areas relevant to general co-ordinated care and service integration

**1430-1500 Summary and priority issues**

**1500-1515 *Afternoon tea***

**1515-1645 Feedback and questions for Minister Butler**