



ORIGINAL ARTICLE

Understanding collaborative and coordinated care in a mental health and well-being context: Essential elements for effective service integration

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Email: bronwyn.williams@dffh.vic.gov.au; bronwyn.williams@easternhealth.org.au**Abstract**

Multiple system reforms in Australia, including the National Disability Insurance Scheme (NDIS), are changing mental health (MH) and disability-related service provision, whilst policy drivers continue to require service integration. This has necessitated service providers discovering new ways of working collaboratively to achieve an integrated model of care. This qualitative study examined what does and does not work to support collaborative and coordinated care (CCC), as essential components of service integration. The study sample ($n=59$) included four cohorts: health and community service leaders ($n=16$), staff ($n=23$); MH service consumers with complex needs ($n=10$), and MH carers ($n=10$). Thematic analysis from interviews was applied to data from each cohort to identify overarching themes that described the lived experience of current CCC delivery. COREQ and EQUATOR guidelines were applied to reporting the findings. Themes emphasized CCC is enabled by the development and sustainability of positive working relationships, and depth of knowledge across health and community services. Unnavigable service systems, stigmatization, perceived power differentials, multiple and rapid service reforms and Fee-For-Service (FFS) models provide significant barriers to CCC. Recommendations include the need for accessible service navigation, consumer-friendly service environments, a stable workforce, standardization of knowledge across sectors, outcome measures and funding attached to CCC as part of a raft of potential changes.

KEYWORDS

care coordination, healthcare reform, integrated care, mental health services, service delivery

INTRODUCTION

Of the total number of Australians living in the state of Victoria who experience mental illness (MI) at any time (1 147 000), there are approximately 213 000 who experience ongoing severe MI and require care involving multiple services (Armytage et al., 2021). Coordination of this care; and collaboration between healthcare and community support providers are essential elements of integrated service provision (Armytage et al., 2021), ensuring that service access and safety issues are effectively

managed (Department of Human Services, 2009). Collaborative and coordinated care (CCC) simplify the experience of help seeking for consumers with complex needs and their families (Armytage et al., 2021; Baxter et al., 2018).

Although supported by Australian health policy for decades (Rosen, 2006), CCC is fraught with a lack of structural support for inter-agency partnerships and insufficient resourcing of the sectors (Shergold, 2013). Further, it is poorly defined, resulting in inadequate translation to practice and evaluation of effectiveness

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(Banfield et al., 2012; Baxter et al., 2018; Cheng & Catalo, 2020; Flatau et al., 2013; Jones & Delany, 2014; King & Meyer, 2006; Minkoff, 2006). To some degree, this is understandable because CCC is complex by nature (Ehrlich et al., 2009; Vrijhoef, 2019), requiring adaptive and creative solutions (Vrijhoef, 2019) as well as multi-level support and analysis (Ehrlich et al., 2009; Van Houdt et al., 2013).

Several disruptors to CCC have emerged in recent years in the Australian context in the form of multiple service sector reforms such as the introduction of the National Disability Insurance Scheme (NDIS) (Hancock et al., 2018). Staff attrition is expected with each reform and formed relationships between providers are lost resulting in a new, less skilled workforce that has emerged with limited capacity to attend care team and linkage meetings and cross-sector capability-building activities (Furst et al., 2018; Hancock et al., 2018; Mavromaras et al., 2016). Consumers and carers are often caught in the middle, trying to navigate the system as ongoing worker changes necessitate the establishment of new and vital care connections (Tandem, 2023).

Service integration and care coordination

Service integration at the client/family interface can be defined as a mutual commitment of various health and community service providers to the provision of a cohesive, holistic, respectful, team-based approach, with consumers and their families being integral to the care team (Armytage et al., 2021; Cheng & Catalo, 2020; Minkoff, 2006). Collaborative and coordinated care is a key functional element of service integration (Carrigan et al., 2023; King & Meyer, 2006), involving a multi-disciplinary team of professionals who work together to meet the needs of consumers, including consumers themselves who are considered central to the work (Armytage et al., 2021; Jones & Delany, 2014; Marel et al., 2022). Teams typically include primary care physicians, specialists, psychologists, MH nurses, alcohol and other drug (AOD) practitioners and other providers who collaborate to deliver CCC.

The concepts attached to CCC 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). The goal of CCC is to improve consumer outcomes by avoiding preventable gaps in service provision, reduce healthcare costs through minimizing the duplication of effort (Shergold, 2013), and to improve the overall consumer experience (Coffey et al., 2017; King & Meyer, 2006; Poku et al., 2019). Poku et al. (2019) describe an inverse relationship between care coordination and service integration, proposing that as service provision

becomes more integrated, the need for care coordination decreases.

Giving voice to consumers and carers

The existing CCC literature appears to have focused on the service providers and has seldom sought the views of the consumer and their carers. This is evidenced by Davidson et al. (2021) who identified just seven studies exploring complex needs of consumer experiences of CCC in their systematic review of literature between 2012 and 2019. Only three of these studies pertained to people experiencing MI (Davidson et al., 2021). The ability of current research to identify and address complex mental healthcare problems is limited when it has not surveyed the target population of consumers and carers (Green et al., 2018; Kumpunen et al., 2020). As service recipients, consumers are considered experts by experience (Roper et al., 2018). Given consumers are central to the CCC frameworks, they are a critical cohort to include in any narrative about enablers and barriers to coordinated care. Accordingly, this study sought to integrate the views of consumers, carers and service providers alike to create a holistic understanding of the phenomenon of collaborative and coordinated care and identify how it might be improved.

Aims

Through drawing on the perspectives of service providers, consumers and carers, this study investigated the enablers and barriers to achieving collaborative and coordinated care and explored what was required to connect the 'care team' to avoid preventable gaps in service provision, given the current changes in service models due to multiple sector reforms.

As such, building on the work of a local MH service coordination alliance (VAADA, 2018), this study provides a multi-level, cross-sector perspective on collaborative and coordinated care and gives voice to consumer and carer experiences to provide impetus for effective systemic change, including improved funding models and supporting structures. It was anticipated that defining a joined-up service system of accessible and navigable supports could reduce the toll on consumers and their families (Armytage et al., 2021) and ameliorate the effects of multiple-sector reform on care coordination and collaboration.

Therefore, the following questions guided this research:

1. What are the perceptions and experiences of MH consumers and carers regarding collaboration with and between services?



2. What are the perceptions and experiences among health and community service staff and their leaders, regarding the enablers and barriers to collaborative and coordinated care and support for people experiencing mental illness and co-occurring issues at this time?
3. What do all cohorts perceive needs to change to preserve and improve collaborative and coordinated care?

METHOD

Design

It is recommended by Crocker et al. (2020) that qualitative methods be employed when evaluating patient benefits of integrated health and social care (Crocker et al., 2020). For this study, a descriptive qualitative research design was used (Sandelowski, 2000), drawing on data from interviews, to gain a deeper understanding regarding the lived experiences of health and community service users and providers (Liamputtong & Serry, 2013).

A semi-structured approach for both individual and group interviews encouraged exploration of the specific phenomenon (CCC), provided a degree of consistency so that participant experiences could be compared and was designed to promote participant dialogue. Findings are reported in accordance with COREQ (Tong et al., 2007) and EQUATOR guidelines.

Recruitment

The study began following ethics approval from the two principal committees. Participants were sought between the ages of 18 and 64 years of age, who were connected to health and community services located in the inner- and outer-eastern areas of Melbourne, either as clients, consumers or carers, or currently employed within the same services.

Recruitment and consent process

Recruitment of staff and staff leaders was conducted through emails and at bi-monthly leadership meetings which included multiple stakeholder health and community organizations associated with the Eastern Mental Health Service Coordination Alliance (EMHSCA). Consumer and carer recruitment took the form of posters placed in service waiting areas, and printed invitations passed on by support providers. Verbal and written invitation for carers to participate in interviews was delivered by staff at participating organizations.

Data collection

Data were collected through 40 individual interviews and seven group interviews. This resulted in a total of 59 participants; health and community service leaders (16); staff (23); MH consumers (10) and carers (10). Interview settings included service sites, a public library and private homes.

The sessions were semi-structured, and participants were provided with a list of interview questions prior to commencement. Interview questions were guided by a review of the relevant literature. Participants were also provided with a list of services they had potentially encountered in their region, to assist them to recall the types of supports they may have been engaged with in the past. This process also assisted the researcher to contain the scope of the data gathered and provided clarity to the participants about the research. All sessions were recorded on a digital recording device to support accurate analysis of the data via transcription.

Data analysis

To analyse data, this study drew on reflexive thematic analysis as described by Braun and Clarke (2021). Specifically, this involved becoming thoroughly familiar with the data, coding data and generating initial themes, followed by refining, defining and naming the themes subsequent to further development and review. Consistent with hermeneutical circle methodology, analysis was applied within individual data, extended to being conducted within cohorts and then across cohorts to refine the findings (Crist & Tanner, 2003), resulting in a final set of overarching themes. This was achieved by regular consultation between the research team. Although consensus is not a requirement of Braun and Clarke's (2021) process, it was achieved, nonetheless.

RESULTS

Description of study cohorts

Originally four cohorts were identified to be of interest: consumers, carers, staff and leaders. During the 'staff' interviews, a fifth cohort emerged from the study. Four participants identified as lived and living experience workers (LLEW) who were staff employed for their lived experience as service users. These staff function as program advisors and peer support for consumers and carers in mental health and AOD service settings.

A description of the five study cohorts including definitions, demographics and examples of service affiliations is provided below (see Table 1).

**TABLE 1** Study subjects and characteristics.

Cohort	Age range	Sex	Examples of service sectors
Consumers <i>n</i> = 10	21–55	7F; 3M	Tertiary subacute MH residential services and Community care teams; NDIS; AOD; Primary health
Carers <i>n</i> = 10	45–55	7F; 3M	Tertiary and Community MH; AOD; Dual Diagnosis; Homelessness/Housing; NDIS; Centrelink; Stepped care; Primary health
Staff <i>n</i> = 19	26–65	11F; 8M	AOD; Community Health; Subacute MH residential; Tertiary MH Triage; Stepped care; Specialist Family Violence; Dual Diagnosis Service; Homelessness/Housing; Community MH Rehabilitation; NDIS; Psychosocial supports
Leaders <i>n</i> = 16	30–65	8F; 8M	AOD; Family Violence; Housing/Homelessness; Tertiary MH Triage; Community Health; Dual Diagnosis service; DHHS; Primary MH; Youth MH rehabilitation; NDIS; Community MH; Tertiary subacute MH residential services
Lived and Living Experience Workers <i>n</i> = 4	30–55	2F; 2M	Clinical Mental Health

Abbreviations: F, females; M, males.

Enablers to collaborative and coordinated care

Several consistent themes emerged requiring attention when implementing a coordinated approach to care. These were: the consumer as central, the human element, sharing and owning (the importance of teamwork), networks and partnerships and resourcing.

The consumer as central

The consumer as the centre of care is a concept that is commonly understood within service coordination models and MH recovery frameworks (Brown, 2013; Partnerships, 2012), and this concept was mentioned by most of the staff and leader participants in this study. Participants reported that when the consumer is central to the work and they are well engaged, it is the consumer's goals that guide the composition of the care team. Further, consumers stated that when they are treated as individuals, it helps them to engage more effectively. One consumer participant said, 'Every case and every person is different. Take each case as an individual case' (Participant C23).

The human element

Most consumer participants said they need a 'gentler', trauma-informed approach to care. As one stated, 'with my condition I can pick up on a vibe in a room instantly' (Participant C46).

Another gave an example, "this particular doctor would listen to what I *say* and 'let's try this' or 'let's try that'. He was gentle. He didn't just *say* 'you've gotta have this' or 'gotta have that'. We talked about it and came up with a plan" (Participant C41).

Consumer participants also said that less stimulating service environments enabled them to access supports and work with service providers. Some carer, staff and

leader participants suggested that being visited at home can reduce the barriers for people in accessing supports such as anxiety about leaving home, meeting unfamiliar people, uncertainty about the service providers and difficulty with transport. This approach can allow relationships to develop that enabled a team approach to care planning.

The value of having workers (LLEWS) with a lived experience of MI was mentioned multiple times by every cohort, through comments such as, "having workers with a lived experience is just gold, mate. People with a lived experience know exactly what you are talking about when you are NQR [Not Quite Right]" (Participant C46).

It appeared from the data that consumers found it easy to trust LLEWs than other support staff: "I know one (staff member) cares cause we talk. And she's been where I've been" (Participant C22). One explanation may be that the LLEW has lived through mental illness and knows something about the consumer's experience, which made them feel understood.

Sharing and owning: The importance of teamwork

Staff and leader participants valued cross-sector work and described the utility of connecting consumer's supports through several categories, such 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. A staff participant described the importance of the care team as follows: "Having a care plan so the client and everyone involved knows who's doing what [is important]. [We need to establish] what is my responsibility and what's their responsibility? [CCC] takes the burden off the client to coordinate supports" (Participant S19).



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. Several leader and staff participants spoke of the value of having a regional protocol (VAADA, 2018) aligning the partner organizations with a common set of principles to support coordinated care. One leader participant said, "The joint training exercises, shared care protocol, [and] opportunities to meet face to face and get to know each other [mean] EMHSCA is a positive experience" (Participant L2). Another leader commented,

EMHSCA is a shared commitment by a large group of organisations which creates a culture of 'collaboration is important,' 'collaboration is valued.' When I was working in the west, there was nothing like this really. It's really hard to get that buy-in if you haven't got that culture.

(Participant L9)

Consumers voiced that the coordination of supports was important to them, especially when they are experiencing exacerbations in MI, as it lifts some of the burdens of engagement at more challenging times. One commented, "sometimes it is hard because they ask me how I've been, and I have to go through it all again. They should just go to the [staff] office and find out how I have been, and then I can just fill in the blanks. I think they should communicate more" (Participant C41).

Carers described a desire to have their role acknowledged by staff and to have more open communication with the care team, expressed through comments such as, 'carers are looking for a partnership with service providers' (Participant Ca48J). 'You stand at the nurses' station, and they don't acknowledge you. They don't really want to talk to you at all. You are just an inconvenience' (Participant Ca40N).

In many cases, the carer was 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: 'We know best – we care the most. You're the expert on your loved one' (Participant Ca40N).

Networks and partnerships

A strong theme emerging from the data across cohorts was of the need to build the knowledge and capability of staff to work more collaboratively across service sectors and to provide a high-quality service to consumers. Additionally, the importance of a personal relationship

with other providers was highlighted by staff and leader participants, and the view commonly held that effective coordination of supports was person dependent. "Like any relationship we need to spend more time with each other and connect" (Participant S13). Another staff participant said: "It's more about a personal relationship. Knowing who's who in the zoo" (Participant S7 S). Another emphasized the importance of networking by saying: "It is not the clients that are the problem. It is getting the professionals together that is the challenge" (Participant S19).

All leader participants described the importance of the local service coordination Alliance (VAADA, 2018) in uniting services, sharing information and problem solving. Participants from this cohort described the orientation forums where staff could learn about local providers, the service linkage meetings, information-sharing forums and the shared care protocol as "really important vehicles for coordinating collaborative activities" (Participant L37). "EMHSCA provides a shared space for collaboration and hope for change. It brings people together" (Participant L9). Other leader participants spoke of the importance of the project coordinator role in keeping it all together and functional as stated thus: "EMHSCA has supported services embedding service coordination and partnership into policy. We cannot underestimate the importance of funding for a project officer to facilitate the Alliance" (Participant L45).

Another form of partnership that goes beyond networks and alliances was the concept of collocating service providers at one service site. One staff participant explained the advantages of collocation as follows: "You don't have to make a dozen phone calls to get to the right person. You've got the information right there" (Participant S5).

Resourcing

Consumers in this study reported that when staff are busy and task focused, they are not getting the person-centred support they need, and the human element is lost. Consumer participants stated that services should be flexible and tailored to the individual's needs to enable consumers to engage with support services. Carers shared these perspectives and added that staff only seek to collaborate with carers when consumers are in crisis.

Staff and leader participants reiterated the importance of being well resourced to provide responsive and coordinated services, and when there are insufficient staff hours, it is not possible to work as a care team across services. It was suggested by leader participants that an important development to support CCC would be the introduction of key performance indicators linked to collaboration. A staff participant echoed other participants in saying: "Collaboration needs to be valued via funding and policy" (Participant S24). One staff participant said,



“You've got to be supported from the top and across the board. [CCC] also needs to be supported way back at university” (Participant S7).

Leader and staff participant cohorts reported that when staffing is stable, the relationships built between services are preserved and can develop. System change means formed relationships can be lost and it takes time to establish new ones. This was expressed as follows: “It has gone from a milieu of collaboration and coordination to one of competition with particular stakeholders competing against each other and consortiums” (Participant S7).

Barriers to collaborative and coordinated care

There were four key identified barriers to collaborative and coordinated care (CCC), including rigid models and approaches, unnavigable systems of support, power imbalances and stigma.

Rigid models and approaches

A lack of staff time and resources was mentioned by most participants as a key barrier to CCC. The various system reforms brought with them staff changes and attrition which disrupt the relationships necessary for CCC. Staff talked about playing ‘phone tag’ due to limited hours of employment, or limited time working during weekdays, and how many projects and programs are only funded for short terms, leading to a substantially reduced capacity for service coordination. One staff participant said, ‘Privatisation seems to ignore all those human things like a system with built in generosity’ (Participant S18).

Staff cohorts reported that monitoring of MH and safety issues and communicating these issues to clinical MH supports was rarely occurring under the NDIS: ‘Capacity for really positive collaboration and coordination has been seriously hindered by changes to the sector. It's a big step backwards’ (Participant L2).

It was noted similar issues occur for GPs 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. One leader participant reported, “Fee-for-service affects collaboration because everything is about the invoice. You're purchasing this from me. It's gone from relational to transactional” (Participant L16). Another Leader participant said: “[with NDIS] your entire business is focused on survival” (Participant L9).

Unnavigable systems of support

Participants mentioned that locating services is challenging. Examples included the fact there is no one

central point of information about all services available, access criteria for services can be confusing and leaves gaps in the service system and that multiple system reforms meant that information is quickly out of date. A consumer participant said, “[People are] wanting the help but not knowing who to turn to, who to call” (C23). Carers said they need to rely on staff knowledge in many cases: “A patient is dismissed from hospital and left to go and see their GP. There is a wealth of services available. Maybe the staff don't know what is available” (Participant Ca40D). Another carer said, “Everything stopped at the GP... and that was it ... you're on your own” (Participant Ca40N).

Staff said too many systemic changes occurring simultaneously were 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 CCC. One staff participant expressed their concerns as follows:

How did I not know about this organization? I feel I work in this bubble. Who the heck knew that was there? You don't know what you don't know. [I'm thinking] this is a common thing people struggle with, so there must be something out there, but I don't know what it is.

(Participant S11)

Power imbalances

Power dynamics between providers occur when there is lack of respect for the skills and knowledge of other sectors and supports. ‘So why are you ringing me? You are just the podiatrist’ (Participant S15). The perceived service hierarchy may be one reason for the lack of communication between non-clinical support services, such as AOD and homelessness services, and clinical MH services, as suggested by the following insights:

Case managers have told the podiatrist not to get involved, so we don't bother. We don't tell them about what the client is telling us anymore. We are like a hairdresser. Clients tell us everything. [Mental Health Case managers] are not willing to acknowledge any of that.

(Participant S15)

I find it hard to collaborate when there is a power dynamic between you and the other worker. There are times when you are both on the same side, but you don't feel like you are on the same side. I wonder if it is ego or whether we are having a different experience with the client.

(Participant S28)



Stigma

Consumers reported that the stigma of MI can prevent them from seeking support, and when they do, they find some staff perpetuate the stigma and confirm their fears. One participant stated, “trust has been abused so many times by people who call themselves the professionals and that are there to help. I really feel that it's just going to be held against me instead of getting help ... I'm just going to be punished for it” (Participant C23).

Service providers described particular stigmatization in relation to people with diagnoses of personality disorders. A staff participant reported: “One woman had five or six referrals to [the public mental health crisis assessment team], and she was not hospitalized until she broke her legs jumping out of a window” (Participant S6).

DISCUSSION

Recent MH sector reforms in Victoria require the implementation of service integration for people with MI and co-occurring substance use disorders (Armytage et al., 2021). However, multiple studies have demonstrated conflicting results of such policy mandates (Baxter et al., 2018). As a key element of service integration, it is necessary to understand what enables and inhibits collaboration among service providers, consumers and carers and how to achieve practical care coordination (Savic et al., 2017). This was the aim of the study outlined here.

This paper has identified several strong and consistent themes that address current knowledge gaps, emphasizing what specifically requires attention when implementing a coordinated approach to care. These are: the consumer as central, the human element, the importance of teamwork, networks and partnerships and resourcing. There were four commonly identified barriers to collaborative and coordinated care (CCC): rigid models and approaches, un navigable systems of support, power imbalances and stigma.

These themes and their relationship to each other can be represented schematically (see Figure 1).

The consumer as central

With the introduction of recovery-oriented practice (ROP) across Australian MH services, there exists an understanding that, although aspirational, the consumer is the expert in their own care and services are there to support them to progress along their journey of recovery from the consequences of mental illness (Brown, 2013). This current study revealed that all participant groups understood and emphasized the importance of centring the collaborative work around the individual consumer.

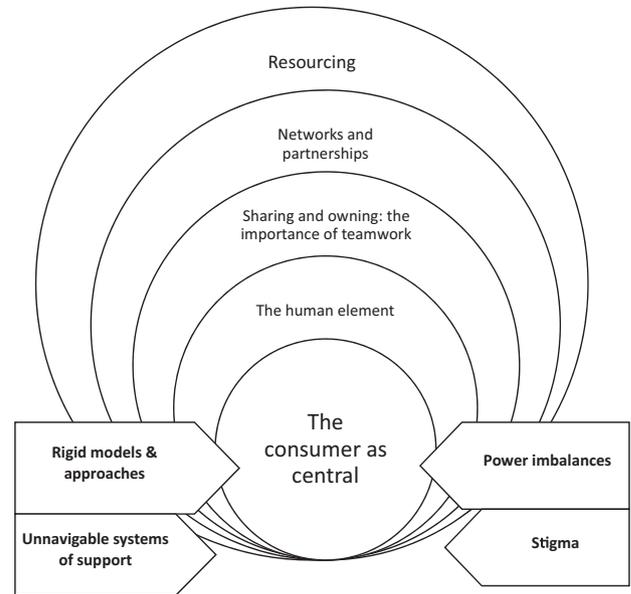


FIGURE 1 Depiction of the key enablers and barriers to collaborative and coordinated care for people who experience mental illness and co-occurring issues.

The human element

Many people accessing services have been traumatized at some time, and the effects can be enduring (Marel et al., 2022). The Royal Commission into Victoria's Mental Health System (Armytage et al., 2021) found that trauma is a feature of the consumer's MI and also of the mental health system. Consumer participants from the current study said a gentler, trauma-informed approach to care would better enable them to connect with supports. This included being listened to and being seen in low-stimulus environments or at home.

Sharing and owning: The importance of teamwork

Flatau et al. (2013) found that there was ‘significant overlap’ of consumer characteristics across service sectors and recommended a need for improving inter-service communications. A key aim of the Service Coordination Framework outlined by PCP Victoria (2012) is to have just one care plan for the consumer, which articulates the roles of various service supports.

It was found that coordination of the care team was valued by all cohorts in the current study, and this was supported by historical studies. Rollins et al. (2017) found consumers viewed staff collaboration as convenient and it reduced the burden on them. 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., 2017). Flatau et al. (2013) found



similarly that consumers appreciated CCC as it reduced their confusion and the uncomfortable re-telling of their stories.

In this study, carers described their desire to have their role acknowledged by staff and to have more open communication with the care team, aligning with findings by Olosoji et al. (2017). They found consumers who have complex support needs often rely on carers to navigate services (Olosoji et al., 2017). In the present study, respondents found locating services challenging for the following reasons: there was no one central point of information about all services available; access criteria for services can be confusing and leave gaps in the service system; multiple system reforms mean that information is quickly out of date. Consequently, carers need to rely on staff knowledge in many cases.

Networks and partnerships

A key enabler of CCC found in this study was having staff connected across sectors in networks, training environments, partnerships and alliances. Researchers and policymakers agree that resolving the issue of system fragmentation is crucial to improving outcomes for individuals with chronic and complex needs. To address fragmentation, it is necessary to provide continuity of care for consumers via integrated networks and care teams using quality knowledge sharing as noted by Ehrlich et al. (2009). However, coordinating the diverse components required to support people with complex needs presents a significant challenge (Coffey et al., 2017; Shergold, 2013).

Broadbent and Moxham (2014) 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 were valued by numerous participants in the current study, and previous research supports the idea that they provide useful opportunities to connect and educate staff for the purpose of achieving a shared understanding across service sectors (Broadbent & Moxham, 2014; Carrigan et al., 2023; Crotty et al., 2012).

Additionally, the importance of a personal relationship with other providers was highlighted by staff and leader participants, and the view commonly held that effective coordination of supports is person dependent. This idea is supported by studies by Groenkjaer et al. (2017), Banfield and Forbes (2018), Crotty et al. (2012) and Overbeck et al. (2016) who all found there was a need for personal relationships to enable CCC, with most identifying specific traits of staff that enhance relationship development.

Resourcing

Concerns about effective resourcing of CCC were outlined by participants from each study cohort and included adequate and skilled staffing, and flexible longer term funding arrangements. Several studies concluded that a well-resourced service system enables CCC (Banfield et al., 2012; Cranwell et al., 2017; Groenkjaer et al., 2017). A focus on outcomes rather than outputs is recommended by key authors on the topic of evaluating CCC efforts (Banfield et al., 2012; Flatau et al., 2013; Frost et al., 2017). Leaders from the current study also suggested that there be a shift from output measures to outcome measures to better meet the needs of consumers and their families. Output measures are commonly attached to funding for support services and seek to know the number and type of people that were engaged with care amongst other demographic information. In contrast, outcome measures aim to understand the client's experience of services and the extent to which the support has been useful.

Rigid models and approaches

This study found that multiple-sector reforms have seen significant staff attrition causing disruption to relationships that support CCC and this was supported by the work of Frost et al. (2017). The NDIS was a focus for study participants from all cohorts, with many commenting on the inadequacy of Fee For Service (FFS) models in providing a coordinated service response. Other studies have found that tight costing models and efficiencies under the NDIS mean reduced service quality and capacity to participate in coordinated care (Furst et al., 2018).

Power imbalances

Power imbalances were described by consumers and carers in relation to staff, and by staff in relation to other service providers. Commonly, tertiary mental health providers were viewed by other service providers to have the most power. This was described as a key disruption to the collaborative relationships that enable coordinated care. Jones and Delany (2014) searched for the meaning of CCC with a qualitative study involving four MH professionals and discovered that strategic health-care 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 (Jones & Delany, 2014).



Stigma

It is estimated that stigma related to MI affects more than 4 million Australians (Government, 2022) despite targeted community efforts to alleviate it (Government, 2015). These findings were affirmed by participants of this recent study as they described difficulties accessing services due to stigmatized ideas about mental illnesses and substance use, particularly for those exhibiting high-risk behaviours.

Implications for clinical practice

The respondents in this study expressed views that have considerable potential to enhance the quality of health and community services. Many of these are found in the existing literature. For example, according to Flatau et al. (2013), modes of CCC include internal provision of multiple services such as via colocation arrangements, and external collaborative partnerships that develop out of necessity due to service gaps. Consequently, service integration requires effective models of integration for people who have complex needs and the development of structural mechanisms within service networks to assist with sharing policy, protocols, and care plan documents. Also, CCC is improved by effective cross-sector communications and connectivity (Flatau et al., 2013). Flatau et al.'s (2013) suggestion that governments should be responsible for meeting the associated costs of these measures are further supported by the current study. All 59 research participants were asked to consider ways of improving and supporting CCC. A series of 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.

Participants suggested a simple and comprehensive tool be developed locally to enable navigation of supports, both for the community and for service providers themselves. This may be an online navigation tool and a printable resource that are targeted at consumers, families and staff. These need to be in an accessible format for consumers and carers with literacy limitations, and in various languages for culturally and linguistically diverse populations.

Participants emphasized the importance of providing a consumer-friendly environment to enhance their engagement with supports. They recommended an increase in the availability of home visits, and that service delivery environments include quiet, comfortable spaces that reduce anxiety and enable connection. This could be further enhanced by having the worker, an intrinsic aspect of the service environment possessing capabilities that include trauma-informed practice and good customer service skills.

Participants advised that having a stable workforce provides a base for building and maintaining essential worker and consumer connections. Consequently, policy and system reform should focus on stabilization of the workforce across all health and community service sectors to enable relationships to be established and sustained for optimal CCC. Additionally, findings from this study would suggest that consideration be given to abandoning FFS models and identifying methods that support consistent staffing and collaborative care, such as long-term block funding. Output-driven models allow little time for workers to communicate and develop shared understandings. Rather there needs to be a shift towards achieving good service outcomes by establishing outcome measures for improving and monitoring collaborative practices.

It was recommended by our respondents that the knowledge base of service providers be broadened. Both tertiary and non-tertiary education providers should consider how they can effectively widen and deepen the knowledge base of health and community service workers as part of their initial training. Once in the workforce, additional support may be 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 could be implemented to support staff in identification of a broad range of consumer needs and encourage the use of appropriate language for cross-sector communication.

Strengths and limitations

This study investigated a particular region and generalisability of its findings to other areas of Victoria, Australia and internationally are not possible without further comparative research. However, given the size of the eastern healthcare region, the representative nature of the participants suggests that there are important insights gained with respect to CCC. The fact all staff and service leaders had some relationship with the work of the local regional mental health service coordination alliance in supporting CCC across the region may have been both a limitation and a strength. Their knowledge may have skewed responses; however, all participants would have good knowledge of the concept of CCC, and their responses were well informed.

Consumer sampling was restricted by availability of willing participants, resulting in consumers being almost exclusively sourced from tertiary MH services and at a more acute point on the continuum of recovery. It is not known how this impacted on the findings voiced by consumers. However, findings successfully revealed significant issues with respect to CCC despite group sizes of 10, with data saturation achieved prior to full analysis.



This research involved a broad range of service providers with a varied mix of disciplines and experiences. The large overall sample sizes enabled a thorough analysis of the enablers and barriers and the ability to provide significant recommendations that have the potential for positive systemic change.

CONCLUSIONS

This study set out to identify potential ways care coordination and collaboration could be preserved and improved by investigating this complex phenomenon from the viewpoint of service users and service providers across a variety of service sectors. Findings confirmed results of previous studies; however, further knowledge and practice gaps were identified and addressed. This enabled a series of recommendations for future research and potential system change.

In essence, this study reinforces the multifaceted nature of CCC and its potential to transform mental health service delivery. By placing the consumer at the centre, prioritizing human connection, fostering teamwork and partnerships, ensuring adequate resources, addressing barriers and challenging stigma, the healthcare system can move closer to achieving the goal of providing comprehensive, coordinated and compassionate care for those with mental illness and co-occurring substance use disorders.

This likely includes development of the lived and living experience workforce as central to the strategy. It is acknowledged that this is no small undertaking, and a longitudinal approach which carefully monitors the impact of such changes should be applied.

Recommendations for future research

Future research should aim 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 of FFS models could also guide any proposal for future use of these in relation to health and human services. In addition, inclusion of a larger LLEW cohort will help to understand their unique needs to a greater degree, as well as avenues for optimizing their contribution to CCC for those with MI.

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

AUTHOR CONTRIBUTIONS

Study was designed by BW and SM. Interviews were conducted by BW. Thematic analysis, discussion and review were done by BW and SM. First draft for publication was preferred by BW, RC and SI. All subsequent iterations were reviewed by all authors.

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CONFLICT OF INTEREST STATEMENT

The authors declare that they have no competing interests.

DATA AVAILABILITY STATEMENT

Research data are not shared.

ETHICS STATEMENT

Ethics approval was gained by Eastern Health Ethics Committee (Approval No. LR72/2018) and Deakin University Ethics Committee (Approval No. 2018-361) and was conducted accordingly.

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