Southern Suburbs Integrated Case Management

Year One Report

UNIVERSITY OF WOLLONGONG

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Summary of SS ICM in the First Year

Project outline

The goal of the SS ICM project is to provide integrated case management across NSW Government and non-government human service agencies, with Local and Australian Government involvement to contribute to the well-being of families with multiple and/or complex needs who have exhausted other avenues of support.

The coverage of the project includes one of Wollongong's six substantial public housing estates which exhibit significant concentrations of households with complex issues. The coverage for SS ICM is the Wollongong 2502 post code area. The selection criteria focus the project's efforts on families with significant and recurring issues of domestic violence, children at risk, housing insecurity and criminal justice issues.

The project, while small in scale (limited to 10 families within a small geographic area), is strategic in its aims, and managed within the NSW Government's Regional Coordination Program. Its first year has focussed on refining the selection criteria and testing the abilities of the local service system, through the interagency model, to respond in a flexible and coherent way to the needs of the families.

The interagency model is designed to be broad in its operation, using an interagency coordinator role in support of family-level case management. While it shares similar aims, it is focussed more broadly and funded differently to children at risk or domestic violence programs initiated or funded though single NSW agencies such as those under NSW level initiatives such as the Action Plan for *Keep Them Safe: a shared approach to child wellbeing* or *Stronger Together: a new direction for disability services*.

The project's Lead Agency is the Department of Health, through the South East Sydney Illawarra Health in 2009-2010. The partners are Wollongong City Council, The Illawarra Forum, Centrelink, South East Sydney Illawarra Health, Community Services, Housing NSW, NSW Police, Department of Education, Juvenile Justice, Department of Corrective Services, Ageing Disability and Home Care and the Department of Premier and Cabinet.

Funding for the project is tailored to its planned operations being on a small scale with minimal resources beyond the normal budgets of the participating partners. Voluntary contributions from government agencies totalling $136,147 have been dedicated to the project from September 2009 to September 2010. This amount covers only the coordination and evaluation expenses and there are no additional program funds from the partners for purchasing or brokering services. The project started in September 5, 2009 and with agreement from the partners will continue into a second year in 2011.

Results

The project has established its coordination processes and templates, has achieved what it expected to achieve in its first year and is continually improving the useability of its systems. There is consistent positive feedback from the surveys of the Steering Committee members, the interviews with the Panel members, the participants in the workshop with the Teams, and from the reports by the Coordinator. There are some indications of useful outcomes from the families that have exited the project to date.

The evaluation is small in scale and does not cover family-level information on their views of the outcomes for them. This level is not in scope due to the ethical, logistic and

resource issues involved in that level of inquiry. The results in the first year are therefore primarily at the level of the structures and processes being established, not family-level outcomes.

In summary, the judgement at each level of the three-tiered structure is that the model works. This is based on the surveyed views of the Steering Committee, interviews with all members of the Panel, the shared interagency experiences analysed at a workshop with the Teams, and (anecdotally at this early point) the outcomes for the families who have exited the project.

The project has developed and maintained a three-tier structure to address the integration issues, held together by the role of a Coordinator, who acts as an 'honest broker' and facilitator across the different activities of the project.

1. The project is a practical model of local integration where the initial motivation was to bring the relevant Health programs into a stronger and more formalised relationship to other NSW Human Services, Local Government and non-government agencies in responding more flexibly to the complex needs of long term and recurrently 'crisis-prone' families.

2. By the end of the first year, Centrelink has become a formal partner in recognition of the importance of income support in formulating a more comprehensive, as well as integrated, case management plans.

3. The Steering Committee of senior local managers provides the authority and permissions required for more flexible responses. An entry point Panel has the clinical and operational expertise to ensure the selection of families who can benefit most and who will test the local system's level of integration. The composition of the Teams for each family includes a Lead Agency and the service providers/key agencies required to meet the goals included in the integrated case management Plan.

4. The senior managers have a 'common currency' for understanding the range of reforms their particular agencies are engaged in, including other interagency work in child protection, criminal justice and domestic violence:

   - Probation and Parole have indicated the value of helping to shift their thinking from individual and formal court order-driven and mandatory methods to a more 'issues-oriented focus on more flexible' options in the persons' or the families' environment;
   - Mental Health and Police have both indicated they are being assisted in working through the difficulties of operating at this more planned and interagency level when much of their concerns are more crisis-oriented, shorter term and more single-issue focussed,
   - Community Services invited Housing NSW to present at a staff meeting – over 50 staff attended.
   - Police have indicated the value of having access to a case management approach that is consistent with their Integrated Crime Management Model, given the limitations of their own resources in the area of detailed case management with social problems.

5. The six Panel members who were interviewed all said their practical decision making is well-supported and they are using their collective local knowledge to get the best plan to address the families' circumstances. At a strategic and system development

level, this tests the local system in terms of its flexibility and responsiveness to complex problems.

6. At the level of the Teams the workers operating in direct contact with the families have reported practical changes:

- Illawarra Family Services noted that the benefit of the SS ICM referrals into the pilot has been more regular and routine collaboration occurring with Community Services workers. This is due to face to face planning sessions and the use of common templates.
- Police and Community Services conduct home visits together (hitherto not attempted) to provide the parents with intelligence on their children's behaviour (described as a 'tough love' approach) to encourage them to discipline their sons.
- Juvenile Justice staff members have recognised that they can better fulfil their 'duty of care' in very complex cases by referring the family to SS ICM.
- DET reported that they now have a capacity to be more flexible with recognised 'problem families' when participating within an interagency model. However, DET have acknowledged some practical limitations as Education staff can not be available during the school holidays.
- As a result of the relationships built up in the Teams, Housing and Police have stated they have more ability to be 'frank' in their dealings with other agencies. For the small number of families involved in SS ICM, Housing and Police in particular say they now have capacity to be more creative and flexible, without having to develop their own family case management capacity, and the results at this time are considered positive.

Current issues

1. Because of the aim of SS ICM is primarily local system integration (through promoting better family case management), the Steering Committee decided it was important to initially keep the project small and manageable. It is now at a stage where its lessons are becoming clearer and it could expand on a geographic basis, but that may be at a cost of being less 'manageable' because of the numbers of front-line staff and managers involved.

2. There is a continuing training and/or information requirement of the model that has been recognised by the Steering Committee. The training requirement arises because of the turn-over of management and direct contact staff, because of the involvement of a different mix of staff in each Team and because one aim is to carefully 'test' and improve the local integration capacity of the agencies.

3. Good relationship building is occurring because of the project's scale and the level of local sector buy-in. How the model is described to the local human services system influences the level of demand and the types of referrals that are made. The description of SS ICM emphasises the importance of the criteria for the selection of the families *most* able to benefit from this more complex interagency-level intervention.

4. The continual refinement and clarification of how the selection criteria are used (by the Panel and the Steering Committee) has reinforced the strategic importance of documenting and using the lessons to date in the local system by way of training materials. A training proposal has been prepared, focussed on the competencies of interagency work, and flexible interventions for domestic violence and children at risk. The training is planned to address how terminology differences need to be

clarified (speaking a common language) and how a higher level of standardisation (i.e. more routine use of templates) needs to be achieved to help the model work smoothly.

5. Situating the SS ICM interagency model within the context of agency-specific programs and core responsibilities is a challenge due to the continuing and growing complexity of the field. Action plans and programs such as *Keep Them Safe* and *Brighter Futures*, new pilot projects on women and homelessness and domestic violence, the Police *Integrated Crime Management Model*, and the *Children of Parents with a Mental Illness* (COPMI) Framework for Mental Health Services, all have similar aims. Other targeted case management models in Health (e.g. in domestic violence, managing severe chronic conditions, mental health and drug and alcohol case management), also cross boundaries in similar ways to SS ICM. One resulting challenge is to resist the model becoming a repository for all the cases/families that are judged to be 'too hard' for the agencies' own mainstream 'integration' activities to address.

6. Staff members need to be the right 'fit' to engage in the model. For example, NGOs are said to be better advocates for the families than government agencies. Mental health workers may be more occupied with their clients currently in crisis than with aspects of longer term prevention. Similarly, within the local Police structure the Crime Management Unit within the Local Area Command is a better fit for the preventive model than is the role of the detectives in the Investigations Unit who are focussed on the investigation of incidents of crime. There has been some resistance by workers who traditionally deliver services to individuals and are less enthusiastic about participating in a Team working with all of the family, and some are still insisting that their agencies' policy and procedures have to be followed in all instances.

7. The SS ICM model with the role of the Steering Committee and the Panel as a local group that sensitively manages joint responses to serious, long term and 'expensive' clients is an example of interagency governance with wider applicability. It has already attracted some interest both within NSW and from the Northern Territory. In terms of local system-level and interagency planning and service development, the SS ICM project is reported by the informants to the evaluation as being a strategic forum that has highlighted service gaps in a practical way and has flagged emerging system-level problems.

8. It is vital to have the right people "at the table" within the Teams. In particular the Teams have drawn attention to:

    *   the lack of practical programs to help adolescent males
    *   the limiting effects of re-orienting Community Services funded programs around early intervention and early years' services
    *   the limitations of Commonwealth-funded counselling and psychological services (funded under Medicare fee for service sessions) where the direct contact workers are not covered for their time in the 'integration' tasks and interagency space.

9. The role of the Coordinator in acting as a facilitator and honest broker across the agencies and in with the Steering Committee, the Panel and the Teams is crucial to the operation of the model. The Coordinator role relies on high level agreement and permission to operate differently within the interagency space. No single local agency could legitimately operate in this manner.

10. The informants to the evaluation emphasised the next stage of SS ICM (Year Two) will have to address both the outcomes for the families and the sustainability of the model. Measuring outcomes will be a complex task and changes will be difficult to see in the short to medium term. Sustainability may be in terms of broadening the scope to increase the number of families involved, either by expanding geographically, or by replicating the model in areas with similar population needs profiles. Both these elements will require strategic thinking about how to move to another stage while maintaining the complex functions performed by the Steering Committee, the Panel and the Coordinator.

Lessons to date

Evidence from the literature, reviews of current practice and the evaluation of the project shows effective projects start from local conditions. Although small in scale, the SS ICM project has emerged out of a strong local history and NSW policy and operational context of working on integration issues. As a result of the experience it has drawn on, the project has been able to carefully manage a set of complex interagency issues in a practical way that helps families with complex problems.

The SS ICM model emphasises the importance of acquiring the informed consent and buy-in of all the relevant family members, and recognises that this can take some time. The model acknowledges the importance of agreement about the desired outcomes from the families' perspective, not just from the agency-level viewpoint.

Agencies need to acknowledge that the families' success is based on their motivation and readiness to participate in the Teams. Agencies need to have realistic expectations. They can 'throw resources at the family' but achieve no changes unless the family is willing to engage. The families' feedback on the process to date is that participation is happening and they are feeling listened to.

The involvement of senior management in proposing the project and through participation on the Steering Committee has been noted as essential to its success to date. The work of the middle managers at the level of the Panel has given permission and encouragement to staff to try more flexible solutions and to thoughtfully 'bend the rules' for this selected group of clients. The rule-bending can then be done without negative consequences.

The lessons that have been documented in this first year's evaluation/project description are an important resource for managers within NSW and also in other jurisdictions with an interest in the interagency space around child and family issues, domestic violence, criminal justice and drug and alcohol issues. They result from the local managers' experiences and skills and the support they receive from the policy work that has gone into the development of the NSW Regional Coordination Program. As a case study, SS ICM is relevant to the aims of the *Regional Governance Framework*, the strategies of the participating agencies, and may have useful lessons about the future roles of area-based planning in the health and human services sectors.

The many statutory responsibilities of the participating agencies, whether they be for collecting rent, organising income support, handling information about children and women at risk of abuse, meeting criminal justice and court-mandated requirements, have been shown in practice to be able to be reconciled locally with the flexibility mandated under the SS ICM model.

Agencies report they are getting better at recognising and managing the risks of dealing with the SS ICM families as 'exceptions' to their regular policies and procedures. This suggests the experience is being built into local agencies' strategic planning. The local system appears to be changing (at least in this area of the 'integration space' and in small increments) to accommodate frank discussion of the agencies' own (and other agencies') limitations and rigidities. Having explicit permission to work around problems is leading to more constructive middle level management relationships and the Teams' joint work with the families.

There are also useful lessons from SS ICM for the health sector in particular. NSW Health (through South East Sydney Illawarra Area Health) as the lead agency has recognised its own role as a significant part of the 'integration problem' for the SS ICM target group. Increased specialisation and a retreat into each health program's 'core business' has led to increased fragmentation for families/people with complex problems. This tendency has limited the capacity for interagency planning in spite of the general policy directions towards multi-disciplinary and cross-sector models.

Within the health sector, mental health, drug and alcohol, youth services, Aboriginal health, women's health, health promotion and population health, domestic violence counselling services and chronic disease management, all have a significant role in achieving better integration. The care planning and navigation support roles in, for example severe chronic disease management and the interface of mental health with child protection, have similarities to the SS ICM model.

The project's geographic area is limited to the Southern Suburbs of Wollongong and changes have been made to the entry criteria to give more flexibility in the selection of eligible families and their associated Teams in Year Two. It was noted by some informants to the evaluation that there will be pressure to make a trade-off between flexibility (dynamic efficiency) and scale (technical efficiency) as the model evolves. Increasing the scale of the project mostly dominates the decision-making process because of how poorly understood the processes are that actually have the potential to increase the system's flexibility and how long real changes in dynamic efficiency actually take to implement and 'bed down' in local systems.

Because it is recognised in the Regional Governance Framework and more broadly based in local interagency processes than the many single agency initiatives that exist, the project holds the potential to more broadly influence the way the human services agencies in the Illawarra work together. It therefore represents an opportunity to make a wider and practical investment in changes to the efficiency of service delivery systems in the near future. This might be encouraged by position papers sent from the SS ICM Steering Group to the Justice and Human Service managers group.

Recommendations for Year Two

Sustaining the model

It is possible to strategically situate SS ICM as part of a 'virtual network' or hierarchy of models promoting 'integration' such as Family Case Management models under the Keep Them Safe initiative, the Integrated Crime Management model, as well as the growing number of coordinated or integrated care models in the health sector, in both the Local Health Networks and the proposed Medicare Locals.

An example of the hierarchy of integration might be presented as SSICM being a tertiary model aimed at change at the system level, elements of the KTS models are promoting integration at the secondary level within and across agencies with providers as the focus,

and the primary level includes models that operate at the level of changing the service delivery experience of the families.

To offset the tendency to over-burden the Coordinator with tasks that might be more usefully handled at the family, agency or system levels, the characteristics of eligible families (i.e. emphasising the SS ICM system level aims and strategic use of the selection criteria) should be clearly described and as much as possible built into the continuum of service responses available for each agency.

Recommendation 1: *Each participating agency to build the SS ICM headline indicators (as well as its aims and selection criteria and its expected levels of participation) into its own client management, risk management and planning systems. With a focus on risk management, each participating agency should be encouraged to assess what 'building in' will mean for its policies, protocols and processes.*

Participating SS ICM agencies may have a role in encouraging and supporting mainstream agencies to better manage both potential and real risks rather than risk alone forming the basis of decisions about service provision. This becomes essential when preparing and transitioning clients/families from the SS ICM program. Policies, protocols and processes my assist in this, but for mainstream agencies a more in depth understanding of underlying issues that generate potential or real risks might be achieved through training in case planning and the management of risks.

Strategic use of the lessons to date

There is a continuing need to strategically manage demand for the model as the number of referrals being received has to remain manageable, and the entry criteria have to be clearly articulated and understood in order to offer the model to those families most able to benefit.

Some agencies are concerned with raising expectations that cannot be met, or with moving too far or too fast with the necessary 'de-bugging' of their processes and templates, given SS ICM is not an 'established' program. Others are concerned that even though they feel they understand the model and its processes, they have difficulties in getting their own 'most difficult' clients/families into the model.

These dilemmas suggest that as well as building consistent understandings within agencies, there is also a need to identify training gaps and how efficiencies might be achieved in promoting common and shared training opportunities across agencies.

Recommendation 2: *The Steering Committee continue to pursue training opportunities for the participants. This should be through another workshop with the Teams in Year Two and through approaches to training providers. The training strategies can use the relevant SS ICM guidelines and other documented material, and the lessons to date and other resources identified in the evaluation, in each agency's own (and shared inter agency) staff and management training materials, courses and programs.*

Collaboration between agencies is occurring both "top down and bottom up". Horizontal integration is working because of the current levels of shared understanding within the Teams, where members are addressing those issues and problems that can only be solved in partnership. Middle management is using the collective 'family case management' capacity to respond to the complexities of the clients' circumstances and system 'rigidities' are being addressed.

The task of maintaining the momentum to date is large and could be assisted by 'promotional' material pitched to the sector as a whole within the current geographic catchment area, while also being useful on a wider scale in promoting the SS ICM approach to issues that are also commonly encountered elsewhere.

One common issue is capacity building; if agencies are better able to manage both potential and real risks then the tasks of meeting family needs may be better met without the need for the SS ICM program. Just because an 'at risk' family is declined within SS ICM does not mean the risk cannot be managed, collaboration cannot be initiated, or gains cannot be achieved.

Recommendation 3: *The SS ICM Guiding Principles document, along with any selected and relevant material from this Year One report, should be turned into an accessible and short Briefing Paper with 'practice implications' drawn out for the local service sector from the lessons learned to date through the project.*
A Briefing may also minimise perceptions of working in isolation and could be followed closely by an interagency workshop to establish more formal working relationships with identified key agencies.

Using planning opportunities and common information

Because it is recognised in the Regional Governance Framework and is more broadly based in local interagency processes than the many single agency initiatives that exist, the project holds the potential to more broadly influence the way the human services and health agencies in the Illawarra work together. The lessons to date therefore present opportunities to make wider and very practical investments in guiding changes to service delivery systems in the near future.

Formalising communication 'up' through the Justice and Human Services Senior Officers' Group with firm (and evidence-based) recommendations on the (say) three most important gaps in service provision, would be a direct way to influence cross-program and inter-agency planning.

Recommendation 4: *Workers and managers from both government and non government agencies have collectively identified important service gaps and the capacity of the SS ICM Steering Committee should be used to assist the service sector to respond. For example, for boys aged between 8 to 14 years who are requiring intensive intervention at the tertiary level (essentially adolescent psychiatry), there are few opportunities in the local environment to address their needs.*

There is already a negotiated arrangement for the Department of Premier and Cabinet to be a repository of the common information on the families after case closure. There was also recognition of the need to consider longer term engagement with families past the 6 months of the SS ICM intervention, due to the complexity and long term nature of the families' problems.

The maintenance and upkeep of client files and information supporting the Team activities varies, meaning that understanding what has been achieved in the interagency activities may be limited in some agencies unless they can hold (or get access to) a common case summary. Because the Teams are composed of a limited number of the participating agencies, all agencies need to have a system of 'flags' so they can identify families or family members who have been involved with the model. This will also assist with longer term follow-up and/or assessment of outcomes for the families who have had a common case plan with a set of achievable goals.

The collective perception of gaps in adolescent psychiatry may be due to local agencies managing high demand with limited resources and at times working in isolation. As a result they feel unable to manage the risky nature of adolescents on their own. Alternative models may develop over time to challenge the assumption that tertiary level care is the only place to manage them.

Recommendation 5: *The maintenance and updating of a family/client 'register' or a system for flagging SS ICM involvement should be formalised in the form of more standardised agency information and processes to give access to a common (but simple) case summary.*

This will promote interagency collaboration. A standardised interagency approach to information sharing should be designed or developed at interagency workshops.

Build in an ongoing evaluation process

A useful evaluation, but one of suitable scale, can be based on the use of the goals in the case plan that can act as a "common currency" between providers and the families and that can be reviewed at case closure and/or at subsequent contacts of the families with individual agencies. This would be a way to examine family level outcomes where the families' agreed goals become a useful tool for outcome measurement.

Examining the outcomes for the families will be more useful (but may be harder to achieve) in the longer term. Later follow-up and data collected for the purpose of measuring the outcomes for the families may be better done by individual agencies that still have routine contact (rather than by the SS ICM project.

Evaluation at this point is more about the experiences of the 'process' for the families looking back to see what they say helped or hindered them. One aim is to inform how it is best to engage them and how to tailor the plan to meet their needs better than any single agency can do on its own.

Recommendation 6: *The project should examine the most practical ways of monitoring and following up the families who have exited after 6 months to see if the SS ICM intervention was perceived as being helpful to them, in order to open up opportunities for more sophisticated outcome measurement.*

The findings from the first year of SSICM, in particular the on-line survey, suggests it is possible to build and support an evaluation system that can routinely capture a manageable set of key indicators that can help each agency to plan and deliver support. The aim would be provide a good picture of how well the service system is doing, not only how many services of different types are being provided.

The questions in an on-line survey should be directed at more than just the *frequency* of interagency contacts, but be directed at assessing the usefulness and quality of those contacts. This information may lead to better tools for the system-level improvements that SS ICM aims to achieve. This recognises that more frequent contacts between agencies may not be sufficient if the quality of those contacts is judged as poor.

Evaluating and measuring gains over time should be built into the project and if an interagency approach is rolled out more widely this evaluation process would become part of the core business of all agencies.

Recommendation 7: *Use an enhancement of the on-line survey tool to ask simple questions of all participants about service coordination and collaboration, any 'blockages' experienced and the quality of interagency involvement in various activities and generate an aggregate 'relationships index' for the local system (see Appendix 4 and Figure 1, p.8).*

More standardised information on the families collected in the initial and ongoing processes of assessment can form part of a continuous client record inside each agencies' client information systems. Supplementing the family-level information with interagency and relationships information should give a more comprehensive picture of the project's achievements by the end of its second year.

1   Southern Suburbs Integrated Case Management in 2010

1.1   Background

The Steering Committee for the Southern Suburbs Integrated Case Management project (SS ICM) commissioned the Centre for Health Service Development (CHSD) to undertake a review of the project in its first year. The evaluation approach used was more 'formative' than 'summative', because establishing the integration *structures* and *processes* was important in the first year and the outcomes for the families are difficult to determine in the short term and will be more evident in the second year and after more families have experienced the model.

The background to the project is extensive, in terms of its relevance in policy terms, its similarities and differences to other projects and programs and also in terms of its local history and current context. This background section covers material that 'situates' the project in its wider policy environment as part of a *system integration* agenda, and in terms of its local context.

The goal of better integration is a long standing concern in the human services, being seen as a solution to the problems of fragmentation and lack of continuity resulting from inter-governmental, departmental and program boundaries (Parker et al. 2010). Managing across those boundaries is not always necessary, but becomes more important the more complex the problems are, and the more that a human service 'interagency space' is expected to be useful to solve them (Farland 2009).

Taking a relatively limited time scale and a mostly NSW and local focus is helpful in understanding the model and putting it in context, rather than attempting to be too comprehensive. It is useful to start in 2000, Michael Fine and his colleagues prepared a report for the New South Wales Cabinet Office on '*Coordinated and Integrated Human Service Delivery Models*' (Fine et al. 2005). That report presented empirical evidence of the use of coordinated and integrated approaches to human service delivery in Australia, particularly in New South Wales, and overseas.

The Cabinet Office report focused on the evidence of successful integration initiatives involving community-based projects and those that cater to the needs of specific population groups. Ten case studies of (then) current initiatives involving improvements in the integration of human services were identified and summarised as *thirteen lessons* for policy makers and service providers in NSW:

1.   The advantages of co-location
2.   Building on the MPS success - advantages of combining services.
3.   Linking services through assessment and client assignment processes
4.   Schools as a venue for delivering human services
5.   The value of community consultation
6.   Integration initiatives need time to develop
7.   Preference for personal delivery of services
8.   Drawing appropriately on case management
9.   Locally based social partnerships
10.   The importance of commitment and support from senior levels of government
11.   Clear objectives and achievable goals
12.   Building trust and promoting communication between agencies
13.   The importance of funding and administrative arrangements

The model used in the SS ICM project has been shaped by these lessons as well as by the subsequent work within the NSW Government's Regional Coordination Program and its Regional Governance Framework. In particular the evidence from the case studies emphasised important caveats for "drawing appropriately on case management":

> *'…it is important to warn against uncritical adoption of Case Management as a sort of universal panacea for problems of fragmented service provision. Nonetheless, Case Management does present a useful and flexible approach that can be of value to service providers and policy makers in NSW for **carefully selected** individual cases in which the complexity of problems or service provision over a short or medium time frame is likely to be an issue. Its greatest contribution would appear to be as **one option** in the development of more integrated patterns of service delivery in particular types of innovative services, such as that outlined above for 'vulnerable children' presenting in medical or educational settings, that can be used, not instead of other approaches, but **as an adjunct** to them for use with individual clients.'* (Fine et al.2005, p. 39, emphases added)

Many additional integration, coordination, place management, prevention and early intervention projects and reviews have been undertaken across the human services since the Cabinet Office commissioned the review undertaken by the Social Policy Research Centre (see McDermott et al. 2010, Hilferty et al. 2010, Thomson et al. 2006, and 2006a). The evidence about what does and does not work for improving integration has been published in various forms and periodically updated in the academic and practice literature and in various reports (Masso et al. 2007, Powell Davies et al. 2008, Eagar et al. 2005, Perkins et al. 2001, Fine 2001).

A more recent useful summary based on a wide range of studies reached the obvious but still sobering conclusion:

> *'Integrated care is not only a difficult concept to understand, but also one that in the final analysis is enormously challenging to implement and manage.'* (Kodner 2009, p.130)

A brief review of useful lessons from other projects and programs, including the suggested indicators for interagency outcomes, is covered in Appendix 1.

1.2   The Policy and Program Environment

In the NSW policy context, the Regional Coordination Program (RCP) and its Regional Governance Framework provides a regional infrastructure to coordinate and support the management of a broad range of projects and issues, including SS ICM.

The RCP provides the larger policy context to support service innovation and community development, particularly responding to locational disadvantage, the Wood Royal Commission implementation, crime prevention and Aboriginal communities' development (Farland 2009).

NSW Department of Premier and Cabinet Regional Coordination Program has its Regional Managers Cluster (Health and Social Justice Senior Officers' Group). There are a number of State-wide program management groups that cover related initiatives at the Regional level:

- Families NSW Project Management Group

- Wood Coordinating Committee (since 2009, Child Protection)
- Aboriginal Child, Youth and Family Strategy Regional Engagement Group of Senior Officers
- Early Childhood Intervention Coordination Area Committee
- The Anti-Social Behaviour Pilot Project Senior Officers' Group
- The Housing and Human Services Accord has been in place since 2003 – it includes the NSW Department of Housing, NSW Health, NSW Department of Community Services, Aboriginal Health and Medical Research Council of NSW, NSW Aboriginal Housing Office, NSW Consumer Advisory Group, Mental Health Inc., South Eastern Sydney Area Health Service.
- Crime Prevention Partnership - NRMA Insurance partners with the NSW Police Force and local councils to combat burglary and car theft at the neighbourhood level.

SS ICM therefore sits within this larger human services interagency 'space' at the State programs level which is also occupied by a set of existing and new programs and projects, with similar (but not always common) aims:

- Aboriginal Communities (through *Two Ways Together*)
- Keep Them Safe – including Child Protection Interagency – Child Wellbeing Units – Brighter Futures program
- Families NSW - Better Futures prevention and early intervention initiative to improve support and services for children and young people aged 9 to 18 years.
- Safe Families
- Early Childhood Intervention Coordination (ECIC) Action Plan 2008 to establish a stronger coordination framework and set of initiatives to support NSW Government reforms in early intervention for children with a disability or developmental delay (aged 0- 8 yrs).
- Homelessness Projects
- Housing and Human Services Accord - Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing
- Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services
- Domestic and Family Violence Projects
- Crime Prevention Partnership Projects - ten Integrated Case Management (ICM) Projects have been funded in NSW under the Department of Community Services' Community Solutions and Crime Prevention Strategy
- Integrated Crime Management Model
- COAG Initiatives – including the Illawarra Shoalhaven Local Health Network, Aged Care 'one stop shop' and the Medicare Local proposals.

In addition, the involvement of NSW Health as a lead agency in SS ICM reflects both the concerns within Health to adapt to the national health reform agenda in ways that improve allocative and dynamic efficiency and local concerns that the Health sector is not *one* agency and has its own internal integration issues to resolve. An internal Health coordination group for SS ICM includes:
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- Manager Women's Health and Community Partnerships Unit - Chair
- Acting Violence and Abuse (Adult) Prevention Program Coordinator - Minutes
- Domestic Violence and Community Counselling Service (DVACC)
- DVACC Psychologist for Southern Illawarra
- Service Manager Drug and Alcohol Counselling Team, Southern Network

- Nurse Manager for Child & Family Service, Southern Network
- Clinical Nurse Consultant (CNC) Community Mental Health
- CNC Child & Adolescent Mental Health Service
- Area Coordinator, Child Wellbeing Unit
- Area Director of Population Health

At the operational level, similar issues of wider system *continuity*, partnership management and navigation support for selected enrolled populations are being addressed in chronic disease management, mental health integration, coordinated care trials, disability care planning, family case management, and in integrated crime management.

Local case management pilot projects have recently started in domestic violence prevention. One is under the Homelessness Action Plan (Domestic Violence Support Project) with the Wollongong Women's Refuge holding Supported Accommodation Assistance Program funding for Community Services and with an MOU in place. It will employ a coordinator and will broker a form of coordinated case management with funds for covering the brokerage costs and the costs of a coordinated package. The other is Staying Home - Leaving Violence Project - also funded from Community Services and expecting to help 30 families a year, where the focus is on safety and justice issues. It has a State wide and a local MOU managed through a local coordination group[1].

As well as the local and State-level environment, the policy, program and organisational context for SS ICM is also likely to be influenced by the national *Health Reform* agenda in 2011. The advent of the NSW Local Health Networks from January 1 2011 and the proposed (but increasingly contested) Medicare Locals from late 2011[2], will have implications for access to resources for the SS ICM model and the emerging health system changes can in turn be informed by the SS ICM findings to date.

Under the COAG Agreement, the Australian Government will take full funding and policy responsibility for *primary* mental health care services for common disorders such as anxiety and depression of mild to moderate severity, including those currently provided by states and territories. There are plans to deliver up to 30 new *headspace* youth services over four years, plus an expansion of the Early Psychosis Prevention and Intervention Centre model.

The Australian Government is also expecting to have a role in improving services for people with severe mental illness and has reached some levels of agreement on a new program of Flexible Care Packages for People with Severe Mental Illness, which is being implemented through Access to Allied Psychological Services arrangements[3]. These arrangements give access to additional clinical services, non clinical support and case coordination for people with severe mental illness. The implications for the project of these proposed changes are that they potentially give greater access to resources, but have a risk of further fragmenting an already complex system. How NSW central agencies navigate through these changes will have implications for the SS ICM model and these issues are discussed in Section 5.

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[1] http://www.stayinghomeleavingviolence.org.au/about_the_project.htm

[2] *'The VHA is concerned that Medicare Locals will usurp existing community health groups that, in a small state such as Victoria, work well.'*
http://www.theaustralian.com.au/news/nation/state-of-revolt-in-victoria-on-medicare-locals/story-e6frg6nf-1225993890961

[3] http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-boimhc-ataps-cons

2   Evaluation Methods

The SS ICM model is an example of a complex intervention in a complex service system, where the emphasis is on building and strengthening a *network*. A series of Canadian *Summit Meetings* between agencies and researchers was convened as part of an effort to understand, support and create networks linking key stakeholders within health systems (Canadian Health Services Research Foundation 2009). The meeting examined best evidence and experience to date and concluded that:

> *'(T)here is no one way to approach network evaluations and … context is the key to success. There is not one method that works; rather, we need to acquire a suite of approaches that we can pull from and apply to particular contexts taking into account the diverse voices and opinions that create a network… To evaluate a network, you need to capture both the original intent and the evolution of the network over time.'* (Canadian Health Services Research Foundation 2009, p.3)

The aim of the independent evaluation as described in the contract documents was to examine and document the agency and inter-agency level outcomes of the SS ICM model, with the focus on:

1. Reviewing indicators for interagency outcomes
2. Advising on a suitable ongoing evaluation process
3. Designing and implementing surveys as required
4. Managing a data collation process
5. Preparing reports on interagency issues as required
6. Preparation of a final report

Family/client-level issues are not in scope for the Year One evaluation and are being examined by the Coordinator.

The evaluation used a mixed-methods case study methodology similar to that used in the Service Integration Project in Queensland (Keast et al. 2004). It included triangulation of the data through interviews, focus groups, and reviewing documentation. The empirical data were collected over a ten-month period from February 2010 to November 2010.

The evaluators attended Steering Committee meetings as well as several departmental meetings as observers and surveyed the Steering Committee members using an email prompt and on-line survey. Semi-structured interviews were conducted with Panel members and regular meetings were held with the Coordinator in order to assist in understanding and interpreting the processes. A workshop with Team members was also attended to understand the client/family level of the systems and the network dynamics in order to gain additional insights.

The documentation that was reviewed included government reports, minutes of meetings, templates, guidelines and other written materials from the project and a range of related initiatives. It also involved a brief review of relevant literature on integration and the evaluation of complex interventions.

This Year One report incorporates a summary of the agency and interagency issues for the Senior Managers Group (via the Steering Committee). The aim is to provide advice on the best indicators for interagency outcomes and a suitable ongoing evaluation process. It may also be useful to support decisions on how the project should continue and whether or not to expand to other geographic areas or other groups of clients.

3 Results for the Key Elements of the SS ICM Model in Year One

3.1 The Steering Committee

This summary covers seven meetings over one year (November 2009 to November 2010). On the Steering Committee there are 11 Government agencies and the Illawarra Forum, represented by 28 individual members and their delegates.

Minutes are sent to all who have attended (and to any of the members who have not attended). Centrelink is the only Commonwealth agency and has attended since August 2010 and is now participating in the Team approach.

After each meeting, respondents were set and email prompt and asked to complete a brief survey that included five questions about local integration and one question about how useful they found the most recent meeting to be. Comments were requested on the questions and on any suggestions about ways to improve interagency cooperation.

All dot point comments in the sections that follow are direct quotes from the survey responses.

Attendance and engagement

There was an average of nine attendees per SC meeting over seven meetings.

Table 1   **Steering Committee attendance**

Date	Attendances	Apologies
5/11/2009	8	2
5/02/2010	10	4
1/04/2010	10	10
17/06/2010	10	6
26/08/2010	10	7
23/09/2010	9	11
4/11/2010	10	9

Did you find that this meeting was…?
- A waste of time   3%
- Somewhat useful   33%
- Very useful   64%

Are you the usual representative to this Steering Committee from your agency?
- 85% answered 'Yes'
- 15% answered 'No'

Keeping an active and relevant agenda and an effective quorum with consistent attendance and a rate of 15% for 'new' attendees (or delegates) is a considerable achievement. This is in a context of many other programs with similar aims and given the other demands on the time of the senior management level participants.

How the project's processes have developed

The following sample of the open ended comments in the survey showed how the participants' views changed over the course of Year One.

The contents of the Steering Committee comments at the start were cautious and realistic about the difficulties of getting beyond the initial enthusiasm to more sustainable arrangements:

- *High level intent but not necessarily follow through.*
- *The non-government sector is stronger in this regard than the government sector. Even within government agencies there is often a silo approach within program areas - this is particularly true of Health and Education.*
- *Continuous change of staff contributes to communication and access to services more personality driven rather than predicated upon need. Open, timely and continuous access to services among Government departments is crucial in case management.*
- *A lot still depends on relationships between individuals.*
- *"Adequate" implies relationships that are just good enough. I think things like the SS ICM take more than just good enough.*

Comments around the middle of Year One reflected some optimism and growing levels of trust and cooperation:

- *Generally the partner agencies are well engaged and well represented at the Manager Group level.*
- *I think they are developing well and there is a lot of good will.*
- *This level of cooperation is very new and far from bedded down, even on the "pilot" cases.*
- *Depends on who you know - personal relationships.*
- *It seems representatives are working though issues and collaborating; last meeting it was interesting to see the discussion about NOT rejecting a client/case because they didn't fit into what the agencies wanted to provide.*

Comments towards the end of 2010 reflected an appreciation of how well-managed the process was perceived to be by the Steering Committee participants:

- *The ICM has strengthened relationships and cooperation between agencies.*
- *This project aims to improve the inter-agency linkages as a lack of coordination has been widely acknowledged as a barrier to good outcomes in complex cases.*
- *The project is on target to achieve its outcomes.*
- *I've enjoyed the relationships with other agencies through SSICM, however, usually work in isolation with a small amount of contact.*
- *The SSICM management group is working together well.*

Interagency relationships

Do you think that current inter-agency relationships are adequate?

Across all responses over the course of the survey:
- 56% answered 'Yes'
- 32% answered 'No'
- 12% answered 'Not sure'

Those agencies most likely to reply 'No' the question of adequacy were the NGO-Illawarra Forum representative, Community Services, ADHC, Corrective Services and Mental Health.

How well do you think that your agency works with (list of all participating agencies)?

The aggregated results give an indication how a 'relationships index' might be constructed by tracking changes in these scores over time. This should be clarified to represent more than just the frequency or closeness of contacts; the wording of the question should more clearly reflect judgements about the quality of the relationships.

Figure 1.Relationships between partner organisations
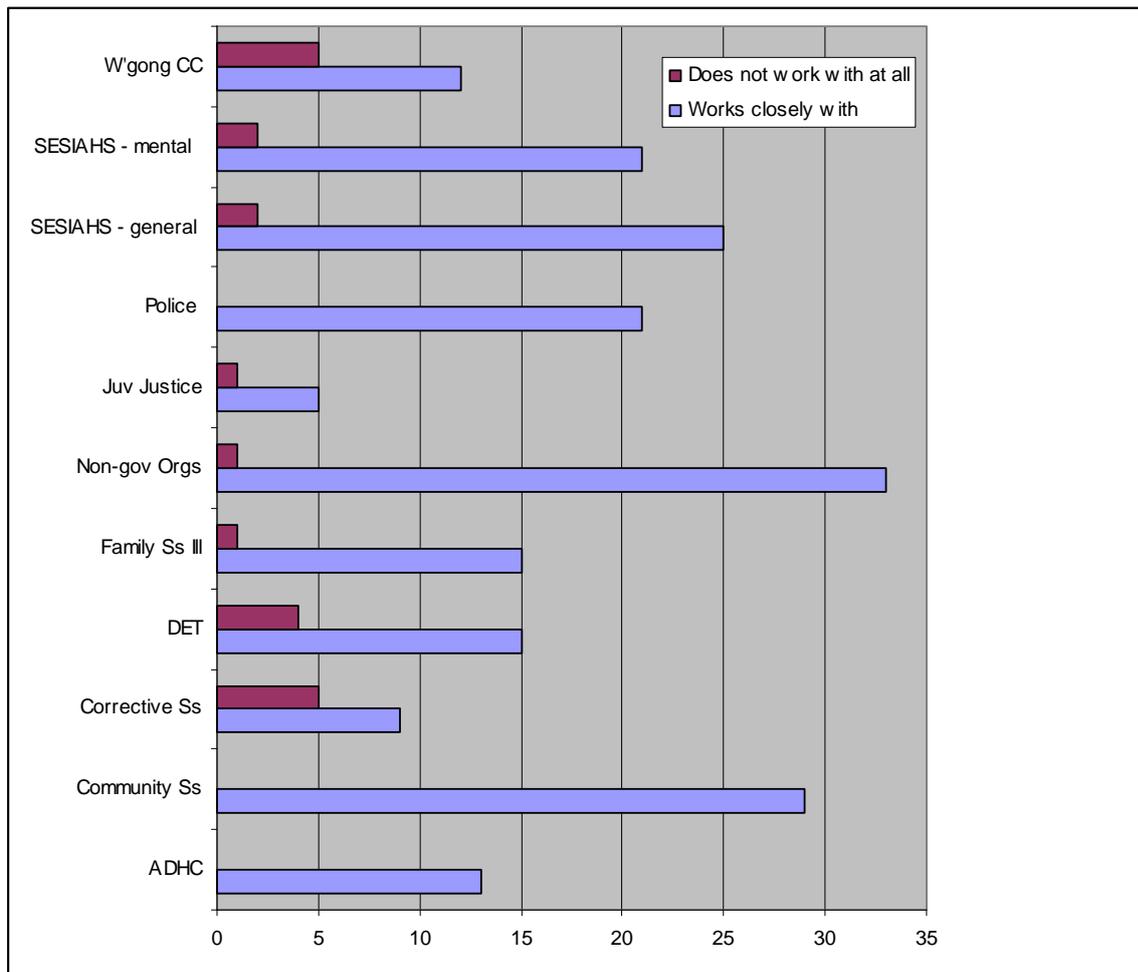
- *Housing NSW is not included in this list and I would have thought they were one of the key agencies? Should they not be included?*

This comment points out that there was an error in the survey that was not corrected. With that important caveat noted, the pattern shows most agencies are working closely with NGOs and Community Services, and (highly likely given the results of the Panel member interviews) Housing NSW. Juvenile Justice and Corrective Services have a 'mandatory' model and the least amount of common 'clients', so that will influence their scores for close working relationships.

Do you think that the case management model for this Project will be effective at improving inter-agency co-operation?

During the project:

Yes	95%	No	0%	Not sure	5%

After the project:

Yes	49%	No	0%	Not sure	51%

The Steering Committee is evenly divided on the question of whether effective inter-agency cooperation could be actually be maintained after the project ends. Their survey comments on this question express the issues involved in achieving sustainable change:

- *The sustainability of the changes - how they are internalised into agency practice - is what concerns me for the future.*
- *Sustainability will be the issue.*
- *I am concerned that the size of the project will be insufficient to bring about real change.*
- *In my experience interagency cooperation is not a given - it takes vigilance, focus and commitment.*
- *The model will only be as effective as the people leading the process around each family.*
- *It is not yet clear if the project will leave a strong legacy of inter-agency cooperation. Certainly there is intent to achieve long term change. The most recent meeting discussed developing some agreed 'principles' that could provide a guide for interagency collaboration and identified a pathway for this work - this could help to build the desired legacy.*

Maintaining and supporting the role of the Coordinator was seen as the key:

- *I believe the project will establish a system that can be ongoing even when the Coordinator for the project finishes.*
- *Depends on our capacity to maintain it without the coordinator role.*
- *Not sure if we will succeed in institutionalising cooperation mechanisms without the project and coordinator.*
- *It appears to be practicing how agencies can work together. I hope it is setting the ground rules and creating the relationships and practices to allow this to happen beyond the project.*
- *At the end of the project I think there is a high risk that the good working relationships now being established through SS ICM will be eroded over time as staffing in agencies shifts and changes. The work the coordinator is doing to continually link agencies is necessary to sustain cross agency engagement. If integrated case management is established as an effective way to support 'frequent flyer' families paid coordination will need to be institutionalised as a standard practice.*

And being realistic about the trade offs between the scale of the project and the efficiency of the processes given the demands from the wider system were noted:

- *We need to ensure that all agencies participate in the joint assessment sessions but alas some who should be attending are not.*

- *Inter agency work is a major time commitment. I actually work in a school setting. My case load is >1000. I doubt whether I could commit 2 hrs once a month for each family - even if there were only 10 families who would benefit - that is 20hrs of meeting time in a 120hr month (each meeting including travel takes up more than half a working day - some schools only get half a day a week service). Plus the follow up work. Apart from individual work, I also have responsibilities for whole school programs. Staff not attached to schools might be able to work at case management level.*
- *Sustainability in the absence of a coordinator position remains questionable. I feel all staff are aware of the benefits of interagency case management and understand how to have it happen, however lose motivation due to the personal commitment needed to make it work effectively.*

Steering Committee comments on system, agency and direct worker issues

System issues

Steering Committee members see the 'right' level of representation and commitment on the management group as essential to steering an effective into its next phase, but there is some concern that the structure relies a lot on goodwill and the current level of local enthusiasm – ingredients that require clear thinking about how to sustain their supply.
.
There is recognition that the role of the coordinator is essential as an 'honest broker' of the relationships between agencies. This is the 'new' role in the system that shows how integrated case planning and management differs from what agencies can do separately within their own programs.

Improvements in the integration tools and providing clear governance were identified as important to sustaining momentum in the project in the next period.

- *Having the right level of managers on the SSICM management group has made this an effective meeting in overseeing the project and it should continue as the project enters the next phase*
- *Mandate it at the legislative level.*
- *It seems that the role of the coordinator is critical, as this person can be the neutral 'honest broker' to troubleshoot issues that arise in the relationship between workers from different agencies as they implement case plans for client families. It is hard to see how inter-agency differences and conflicts could be constructively resolved without this position being in place.*
- *I think there will be a need for some reflective practice on the part of Lead Agencies and the Project Coordinator, at least, in relation to how integrated case planning and management differs from individual case planning and management.*
- *I think that at this stage that this project is achieving improvements by developing the appropriate ICM tools and providing clear governance. It will be interesting to test if this early momentum can be sustained.*
- *I felt that there was positive energy in this meeting. Almost every member at the meeting contributed in some way. One participant at the meeting was able to share positive feedback from NGO stakeholders not involved in the meeting. This was very encouraging for everyone. There is a strong sense of action and positive progress. Important issues such as the budget were openly discussed and actions resolved by the group.*
- *Continue on as is.*

Agency issues

Continuity is an issue for practitioners as well as managers. The same people should be able to attend meetings and follow up on the agreed program. There can be better use of technology for inter-agency info sharing. Involving NGO's and other organisations has been achieved over time by using *MOU's* and shared protocols, but more opportunities for joint training are still needed.

- *Reduce staff turn-over in Government agencies. Have the same people attend meetings.*
- *That all the agencies involved actually attended the meetings and followed up on the agreed program.*
- *Increase the opportunities for staff at all levels to know what other services have to offer (e.g. Annual or bi-annual Community Services Expos). Promote better use of technology for inter-agency info sharing.*
- *As per the manner in which many agencies are required to work with Community Services, the expectation is that (all) stakeholders have a legitimate claim (and expectation) to access services in a quick and open manner.*
- *Our close working relationship with the Police, Health, NGO's and other organisations has been achieved over time and due to effort. Suggestions: 1. Whole of agency MOU's; 2. Whole of agency protocols to work with specified agencies; 3. Interagency joint training re same.*
- *Build it into all agencies' operating framework in such a way as to keep the issue firmly in the mind of practitioners as well as managers.*

Issues for Direct Workers

The right skill mix for integrated case-management means training and supporting local staff and their managers in the agreed principles and in using resources tailored to cross agency work.

- *Identify skill set critical to effective integrated case-management and develop opportunities to train and support local staff at all levels. It will also help to develop agreed principles that guide interagency collaboration, and a 'resource kit' that could be provided to workers as they are recruited to involvement in cross agency work.*
- *We need to maintain the pressure to expand training and development opportunities in all agencies in relation to collaborative practice.*
- *We need as many opportunities as possible for agency staff to work together with managerial support and so see the benefits of this approach*
- *Training for managers and front line workers together*
- *Agencies consciously reflect internally on how they contribute in this context, and see what changes they need to generalise*

Summary of Steering Committee views

The level of attendance by senior management and the content and tone of their comments in the on-line surveys reflect a positive view of the SSICM process. There was an absence of negative or critical comments.

The breadth of the membership and level of delegation and overlap in the membership has ensured a working quorum for each meeting. The contributions of partner agencies are able to cover costs and the commitments for continuing into a second year mean the arrangements are broadly perceived to be both useful and sustainable.

The comments from the Steering committee members help map out the most useful next steps after Year One:

1. Promote the model through the existing regional and central governance structures.
2. Promote the model through inter-agency training opportunities.
3. In the next period, work on how to consolidate the tools for integration and role of the Coordinator.

3.2   The Panel

This section summarises the views of Panel members, with selected relevant quotes from the interviews. The aim of the interviews was to understand the role of the Intake Panel and its core elements and the competencies/permissions required to make it work. This included the role of the Coordinator (see section 2.4) and the interviews also addressed the sustainability of the model.

Appendix 1 contains the consolidated views from interviews with six Panel members, and the quotations used in this Section are taken from that material.

The role of the Intake Panel

The Panel is the gatekeeper to the SS ICM model, with its guidelines and methods of standardisation of assessment and the allocation approach being assisted and directed at the level of the Steering Committee.

> *The main role is in selecting the most difficult ('hardest of the hardest') families, but with an ability to exercise good judgement that they will have a capacity to benefit from the considerable amount of inter-agency work involved.*

> *It is testing the Government service system, to challenge its rigidities, tackle problems, looking for service gaps and proposing other solutions as well as giving access to SSICM.*

What is required to work effectively in this interagency space?

The skills for working in the interagency space are knowledge of the local service agencies and service delivery issues for these complex families' problems.

> *The Panel is designed around knowledge that can span the local service system – it is a multi-agency panel that considers the paperwork as well as having the attendance of the person making the referral, so it has rich sources of information to understand and interpret the referral.*

> *We bring our own way of working into the inter-agency space. We have good experience with integrated methods as we are expected to be preventive, pro-active and analytical.*

> *Other elements that make the SSICM project and its criteria different to other programs and projects:*

> - *The model is locally derived, not centrally determined and then 'handed down';*
> - *Senior managers have created the expectation for their staff that they will cooperate and engage with the project*

- *Senior managers have given permission to bend the rules to operate under the model for the small number of families managed this way 'by exception'.*

Benefits of the model

The benefits are in legitimising a more flexible approach to the problems than can be expected from a separate program perspective, given the pressures of 'business as usual'.

> *Other elements that make the SSICM project and its criteria different to other programs and projects:*
>
> - *The model is locally derived, not centrally determined and then 'handed down';*
> - *Senior managers have created the expectation for their staff that they will cooperate and engage with the project*
> - *Senior managers have given permission to bend the rules to operate under the model for the small number of families managed this way 'by exception'.*

Selecting the right families

As in other models using intensive case management, the reflection on, and continual refinement of, the selection criteria is important. If the mix of those families offered the intervention does not match the program's specific aims, then the outcomes are unlikely to be shown to be positive and the costs of the program will appear to outweigh its observable benefits. This is an issue for the project in assessing its outcomes because the benefits may in fact be longer term and any actual or modest positive outcomes may be either perceived to be of marginal significance or out of scope for the available evaluation methods.

SS ICM shares this same concern with programs such as for coordinated care, packaged care, early discharge and hospital avoidance, severe chronic disease management, family case management and so on. Each of these similar models has its own selection criteria, but once eligible and enrolled, the client/family may experience a similar approach or 'model of care'. However, measurable changes are likely to be hard to find because of the many factors (apart from the case management intervention) that will be involved in a complex case.

> *The criteria are not (too) specified as such, as the decision depends on a lot of local knowledge in the Panel in order to match the family with a Lead Agency and a Team based on what contacts (good and bad) that they have already had with the system, and their practical problems that will benefit from a SS ICM 'integrated' approach.*
>
> *There is a new section on the Intake forms used for making the Panel's assessment including the 'readiness' dimension that, as well as finding out what has already been tried, asks about the family's 'capacity to benefit' from the ICM approach.*

Composing the right Teams

This is seen as the way to improve the appropriateness of referrals and also as a way to improve agency-level planning around complex families and influence the local service system in the way it deals with domestic violence issues.

The decision making is complex and 'issues-based' and the immediate task is to accept or decline and if accepted to identify a potential Lead Agency.

Beyond the formal criteria there is also strategic thinking and planning around the family's situation and capacity to benefit to get the right mix of providers and agencies signed up on the Team level.

The strategic thinking depends on the Panel's use of its joint knowledge of the family's problems and the match to the available system/agencies' resources. The family coming to the planning meeting is where there is agreement reached on what the Team will work on.

Panel views of the Coordinator's role (*also see the next Section for more detail*)

The Coordinator helps with interpreting and developing the selection criteria, the planning the interventions, and working to draw out lessons for the local system. Standardising the processes and ensuring the coordination role is not captured by any one of the agencies is important.

SS ICM was fortunate in finding someone competent at working in the multi-agency space and across Government and non-government agencies. The role also benefits from familiarity with this particular set of health and social issues – it is an area that spans police and criminal justice, youth, domestic violence, mental health and drug and alcohol – so finding the right person with this mix in their background is not easy.

With the Panel the skills are a mix of administrative support, getting people together and getting the information moving in the right way, intervening at different levels as needed to sort out problems. It is like a relationships manager role across the agencies - working at the level of finding and maintaining the right links and keeping the focus on the overall strategy - using common tools and templates and explaining the model.

Improving the model

The Panel members were confident that the model and its governance were on track and had the capacity to improve how it functions in the next year. In particular, the informants emphasised that more attention to measuring the outcomes for the families will be important.

We expect to continue to get better over time – better at specifying the goals for the families, improving the processes and refining the tools (e.g. getting better ways of explaining the criteria for referrals, understanding what we mean by capacity of the family to benefit) and getting better at securing the families' 'buy-in'.

Agencies have to be able to do their risk analysis so they understand what is involved for them in managing a small number of their clients 'by exception' inside the SS ICM model because it clearly can't be offered too widely or set up so that there is demand from clients for being managed this way.

As for standardising, we are getting a more refined way of describing the entry criteria over time – fine tuning the guiding principles and the forms. The

integration happens through a better fit of existing or new plans within agencies and being too standardised or prescriptive is a risk.

The model should be tracked over time with outcome measures for the clients/families and the agencies/departments in the longer term before we can make a call on the efficacy and effectiveness of the model.

Sustaining the model

Not being a separate new program with dedicated funds is seen as an advantage for SS ICM as it has to show the local partners it is useful to get their continual support. Clearly articulating and promoting how SS ICM is different to similar program-based models, offering training courses and demonstrations, and describing agency-level and client-level outcomes should all help in sustaining what has been achieved to date.

The resources needed for the 'set up period' have to come from somewhere and initially the integration work is always going to be expensive. It does not require the most senior operational people all the time but they have to show a high level of commitment and the process has to be more than signing off a MOU.

The testing of the model and the learning to date is what we are paying for initially, and subsequently that learning has to be shared more widely across programs. The aim is to get the joint planning into routine practice for the small number of families who will benefit from it.

There are two similar projects with a similar target group about to start that can illustrate the differences:

- *Homelessness Action Plan Domestic Violence Support Project – with the Wollongong Women's Refuge holding a SAAP budget for DCS and with an MOU in place. It will be over 3 years and have about $3m for supporting 30 women per year in private rental and social housing. It will employ a coordinator and will broker a form of coordinated case management with funds for covering the brokerage costs and the costs of a coordinated package.*
- *Staying Home - Leaving Violence Project – funded from DCS (about $150k per year) and expecting to help 30 families a year where the focus is on safety and justice issues. It has a State wide and a local MOU for a local coordination group.*

SSICM is different in being in the area of the Government Departments and it does not hold funds for brokering the packages of support services – just pooled funds for covering the 'coordination' costs.

If the pilot were to bring in more of the GP-related services, then there may be funding issues as a lot of background work goes on around the client and they cannot be expected to sign off for each service or pay gap fees.

The privatised community counselling sector is not funded for working in the interagency space and GPs can get reimbursed for a Plan, but contract counsellors are not directly funded for going to meetings and doing interagency-level work unless the 'client' is actually there and receiving therapy.

The Panel members were in agreement that in practical terms their decision making is well-supported and they can accept or decline a referral and if accepted they use their local experience to identify the best Lead Agency for the family.

At the more strategic level, the selection criteria are able to be used to match the family's needs to the right mix of providers and also this serves to 'test' the local system so as to encourage it to be more responsive to the families' circumstances.

3.3 The Teams

Through the Steering Committee and as a result of the Department of Premier and Cabinet's concerns to promote a broader understanding of the model and its relationship to similar initiatives under *Keep Them Safe*, representatives from the ten Teams and the Steering Committee were brought together for a Workshop in Dapto in August, 2010. This section is edited from the complete Workshop findings.

The aims of the SS ICM Workshop were to identify the achievements and strengths so far, to identify the vision for 12 months from now, explore development strategies for bridging the gap between now and in 12 months and to allow the participants to meet and hear from each other about their experiences to date. These aims also served to provide very useful material to inform the evaluation.

Individuals were asked to consider what has been working well in their Teams and the four of the Lead Agencies were then asked to present a précis of their team where the focus was on the process used/what worked/the outcomes achieved and what could have been done differently.

The four case study presentations were selected to cover a range of experiences and levels of difficulty/complexity. The excerpts from the Workshop Findings that follow below give indications of the range of experiences and outcomes to date.

Case One

> *The team achieved their housing outcome which was to find the mother her own accommodation. The mother was offered and accepted a transfer into her own home. The eldest son and his pregnant girlfriend and two of the four brothers are now living with their mother and attending school. The team considered the transfer as a means to strengthen the boy's prospects. The boys' issues range from their own sexual abuse, legal issues concerning drug use and perpetrating violence in the community and in school.*

> T*he team believe that the SS ICM process enabled them to successfully facilitate a family visit by the NSW Police and Community Service to speak to the family about the brothers' behaviour at the beginning of the ICM process. Unfortunately, the father undermined the process after the agencies left the household.*

Case Two

> *Juvenile Justice made the referral but stepped out of the team after attending the first workers' meeting… The principal contact worker is a community development worker not a case worker. The mother has mental health and drug and alcohol problems. The family consists of two teenage boys, two younger siblings and a 4 year old daughter. The grandmother was also living in the household and is an alcoholic. The mother has an active AVO out on one of her teenage boys.*

The team have made some great progress with this family because the mother has been very motivated to change. At the beginning of the team formation the mother felt powerless. After 5 months of intensive intervention the mother is in better control over the household and has improved her parenting capacity.

The SS ICM structure benefited the coordination of tasks to support the family as the principal contact worker is not a case worker. Housing NSW also saw positive engagement with the family as a result of the process.

Case Three

The mother's non-attendance at meetings raised the issue of the difficulties that Family Service's Illawarra have had in engaging with the mother, and with the father even with his signed agreement to the Project. This raises the larger issue of the family's relative lack of engagement with the SSICM Project despite signed and verbal agreement to be involved.

Centrelink have attended a number of meetings and offered to sit down with the mother to discuss her income and debt levels. At this time it is not clear that this has occurred, again because of limited opportunities to engage with the mother.

Case Four

Community Services feel that they have we put a huge amount of effort into this family with little result - not for want of trying but due to a decided inability of (the mother) to work consistently with any service. The daughter has now decided to remain with her mother. Community Service is now focusing their efforts on (the son's) long term placement as the mother is unable to offer her son any appropriate alternative certainly in the foreseeable future.

What's Working

- Mandated authority.
- Interagency coordination.
- Trust building.
- Clarity in planning.
- DV complexity acknowledged.
- Goodwill, common goals.
- Shared learning.
- Family moving forward.
- Networking.
- Case plan keeps everyone responsible and accountable.
- Reduces excuses for not changing.
- Buys time for family.
- Coordinator role and skills vitally important.
- Increased knowledge of agency policies and parameters.

- Client readiness.
- Face to face communication.
- Gaps identification.
- Teamwork.
- Managerial commitment.
- Family ownership.
- Whole if family supports.
- Potential for on going collaboration.
- Strong leadership.
- Reduces system abuse, of, and by the system.
- One stop shop.
- Gives family a voice.
- Communication between NGOs and government.

What's Not Working

- Families' capacity to sustain change.
- Some inconsistency in messages to clients.
- Too optimistic, both clients and agencies.
- Client expectations differ.
- Some lack of client engagement.
- Teenager engagement./Teenage boys.
- Time intensive.
- Non attendance by some agencies at meetings.
- Understanding of domestic violence trauma.
- Case management knowledge and skills.

The mostly 'positive' tone was deliberately planned to be the focus in this initial workshop because of the expected difficulties in bedding down new processes, leading some participants to give subsequent feedback that they wanted more scope for discussing in more depth the practical difficulties they were experiencing.

3.4   The Coordinator

The SS ICM project was fortunate in finding a Coordinator who was already competent at working in the multi-agency space and across Government and non-government agencies. The role benefits greatly from familiarity with this particular set of health and social issues; an area that spans police and criminal justice, youth, domestic violence, mental health and drug and alcohol. Finding the right person with this experience in their background is not easy and would be hard to replicate elsewhere or to find from within one agency.

The Coordinator's skill set is not only about knowledge of the content area but also about credible negotiation across the service delivery, program management and policy levels. It requires a sophisticated understanding of the service system as well as its component agencies/departments. This is a 'higher-level' form of 'case management-type' skills where the competencies include maintaining the right level of dialogue within and across the different agencies. It also needs a measure of comfort with, and understanding of, the circumstances of the families.

> *The Coordinator has been excellent and my perception of the role is significantly influenced by current practice. I see (them) as the 'coordinator' i.e. the central reference point for all system 'players' with capacity.* (Panel member interview)

The Coordinator's role is to help communication between the Panel members and between the Panel and the Teams by writing up decisions and trouble-shooting the right information for making decisions and getting the Lead Agency and Team arrangements sorted out.

With the Panel the Coordinator's roles are a mix of administrative support, getting people together and getting the information moving in a timely way, intervening at different levels as needed to sort out problems. It is like a 'relationships manager', working at the level of finding and maintaining the right links and keeping the focus on the overall strategy - using common tools and templates and continually explaining the model. It also involves reporting up to the Steering Committee and the Senior Officer' Group on how the project as a whole and how the intake role of the Panel is going.

The Coordinator helps with the planning of the agencies' work with the families and in interpreting the families' mix of problems; the aim being to balance the 'too hard' and

'too easy' families so as to get the maximum learning for the local system and outcomes from the pilot for the families and the agencies.

Panel members noted that it is important that the role is not owned or captured by any one of the agencies, as then the role would become diluted over time – inevitably subsumed into routine Departmental tasks and crisis management.

3.4.1 Can the Coordinator role be standardised or generalised for use elsewhere?

Most Regions will have particular localities where small numbers of frequently encountered families could be selected as the 'exceptions' that could benefit from being offered a model like SS ICM. However the cost of employing a coordinator operating at this level on a small scale in many areas would not be justifiable in economic terms.

The resources to pay for a lot of the skills that are required are scarce, as they are not seen part of 'regular business' for existing programs as they are not easily categorised as 'client-level interventions' and are not amenable to being supported under the care planning items in Medicare as they are not easily attributable one individual.

The Panel members pointed out that it is hard to see the role working well if it is rotated around between agencies, or added on as a part of another job. In practice, if the role were to be located in one agency, then '*how can they test us out at the system level if we pay them?*' It was also noted that a high degree of flexibility is required and '*formalising or automating the Coordinator role too much may destroy it.*'

The Panel members also noted that it would be difficult for the current model to work on a much bigger geographic scale, or with much larger numbers, given the complexity of the problems and the differences in agency structures and boundaries and so on. '*The role seems about 'right' for the scale and the number of families in the model.*'

The continued commitment of the Human Services senior managers' group could maintain some of the role, but would not have the authority for *all* of it. For example, a duty officer doing mental health liaison in a DV case could have some influence, but it would not be at the same level as practiced in the SS ICM model. Panel members saw the main risk as

> *'going back to dealing within the agencies on a family by family basis rather than being part of a bigger strategy.'* *'It makes sense to be part of the joint service responses and to be able to share the burdens, do common training.'*

The scan of the policy and program environment in Section 1.2 describes at least twelve other local programs or projects with some form of 'coordinating' role, just in the related social welfare/human services sector. Within the health sector there is recognition of the benefits of joint efforts with other human services, creating an environment of increased support for similar models for complex clients and families in chronic disease, domestic violence, child protection, and in mental health and drug and alcohol services.

The potential for generalising the lessons from SS ICM could be realised more broadly by attention to the two key elements in program sustainability – by efforts to *standardise* (i.e. reduce the variability of how the processes work across the agencies) and *routinise* (i.e. build into the agencies systems and procedures), its products to date (Pluye, Potvin and Denis 2004).

The Steering Committee and Panel members suggested that the Coordinator role is already more than a part-time position. The interviews and survey results suggested the sustainability of the model can be improved by getting resources for shared training across sectors, and by disseminating awareness of the model through reports, presentations fact sheets and other publications. The suggested strategies and their associated recommendations are addressed in Section 5.

3.5   Summary of the Year One Results

The project has established its coordination processes and templates, has achieved what it expected to achieve in its first year and is continually improving the useability of its systems. The project has developed and maintained a three-tier structure to address the integration issues, held together by the role of a Coordinator, who acts as an 'honest broker' and facilitator across the different activities of the project.

The Steering Committee of senior local managers provides the authority and permissions required for more flexible responses. An entry point Panel has the clinical and operational expertise to ensure the selection of families who can benefit most and who will test the local system's level of integration. The composition of the Teams for each family includes a Lead Agency and the service providers/key agencies required to meet the goals included in the integrated case management Plan.

The judgement at each level of the three-tiered structure is that the model works. This is based on the surveyed views of the Steering Committee, interviews with six members of the Panel, the shared interagency experiences analysed at a workshop with the Teams, and (anecdotally at this early point) the outcomes for the families who have exited the project as reported by the Coordinator.

The project is a practical model of local integration where the initial motivation was to bring the relevant Health programs into a stronger and more formalised relationship to other NSW Human Services, Local Government and non-government agencies in responding more flexibly to the complex needs of recurrently 'crisis-prone' families.

On the Steering Committee the senior managers have a 'common currency' for understanding the range of reforms their particular agencies are engaged in, including other interagency work in child protection, criminal justice and domestic violence:

- Probation and Parole have indicated the value of helping to shift their thinking from individual and formal court order-driven and mandatory methods to a more 'issues-oriented focus on more flexible' options in the persons' or the families' environment;
- Mental Health and Police have both indicated they are being assisted in working through the difficulties of operating at this more planned and interagency level when much of their concerns are more crisis-oriented, shorter term and more single-issue focussed,
- Community Services invited Housing NSW to present at a staff meeting – over 50 staff attended.
- Police have indicated the value of having access to a case management approach that is consistent with their Integrated Crime Management Model, given the limitations of their own resources in the area of detailed case management with social problems.

The six Panel members interviewed all said their practical decision making is well-supported and they are using their collective local knowledge to get the best plan to address the families' circumstances. At a strategic and system development level, this tests the local system in terms of its flexibility and responsiveness to complex problems.

At the level of the Teams the workers operating in direct contact with the families have reported practical changes:

- Illawarra Family Services noted that one benefit of the SS ICM referrals into the pilot has been more regular and routine collaboration occurring with Community Services, due to face to face planning sessions and the use of common templates.
- Police and Community Services conduct home visits together (hitherto not attempted) to provide the parents with 'intelligence' on their children's behaviour (described as a 'tough love' approach) to encourage more effective discipline.
- Juvenile Justice staff members have recognised that they can better fulfil their 'duty of care' in very complex cases by referring the family to SS ICM.
- DET reported that they now have a capacity to be more flexible with recognised 'problem families' when participating within an interagency model. However, DET have acknowledged some practical limitations as Education staff can not be available during the school holidays.
- As a result of the relationships built up in the Teams, Housing and Police have stated they have more ability to be 'frank' in their dealings with other agencies. For the small number of families involved in SS ICM, they say they now have capacity to be more creative and flexible, without having to develop their own family case management capacity, and the results at this time are considered positive.

The results of the workshop with the Teams suggested more attention to what was identified as *not* working and what could have been done differently, should be the focus of a second Teams' Workshop in 2011. The Teams were concerned about their understanding of the families' capacity to sustain change, building in realistic expectations of client engagement and the amount of time involved for agencies at meetings, and more consistency in their communications with the families.

Strategies for teenager engagement and in particular the lack of positive engagement programs for teenage boys was identified as a 'systemic' deficit that limits the effectiveness of the model. Several informants to the evaluation pointed out that the model also assumes a shared understanding of the effects of domestic violence trauma on women's decision-making and participation in programs.

The Panel members in particular noted the continual role of situating SS ICM in the 'continuum' of case management knowledge and skills across the participating agencies. Panel members said a coherent and ideally more standardised approach to measuring the outcomes from the families will sustain the model through organisational change. More attention to these areas was identified as a necessary focus for Year Two.

The project's geographic area is limited to the Southern Suburbs of Wollongong and changes have been made to the entry criteria to give more flexibility in the selection of eligible families and their associated Teams in Year Two. Some informants to the evaluation said there will be pressure to make a trade-off between flexibility (dynamic efficiency) and scale (technical efficiency) as the model evolves. Increasing the scale of the project without understanding the processes needed to increase the system's flexibility is a risk. Expansion has to be guided by the experience of how long changes in dynamic efficiency actually take to implement and 'bed down' in local systems.

Because it is recognised in the Regional Governance Framework and more broadly based in local interagency processes than the many single agency initiatives that exist, the project holds the potential to more broadly influence the way the human services agencies in the Illawarra work together. It therefore represents an opportunity to make a wider and practical investment in changes to the efficiency of service delivery systems in the near future.

4 Discussion

The findings from Year One show how the project has developed its tools and procedures and articulated a role within a continuum of case management interventions. This has laid a foundation for navigating the project through a more 'fluid' organisational context as a result of anticipated changes across human services at National and State level in 2011.

4.1 Situating the SS ICM Model

The various trials, demonstrations and pilot projects that have come before, along with lessons drawn from their evaluations, show how most of the published work has been on the issues of community care for the frail elderly and people with disabilities, family support, mental health and palliative care, with interagency initiatives emerging from the health sector.

However, the common ground across most models is using strategies relevant to the social determinants of health, rather than to keep the relatively short term focus on the management of demand for hospital services. Good examples that balance the Health sector dominance are found in the set of evaluation findings resulting from the Commonwealth's *Stronger Families and Communities Strategy* and the NSW Government's *Keep Them Safe* initiative in the areas of children's services and prevention of violence/criminal justice.

Being planned and managed on a small scale, and being relatively labour-intensive in its processes and with the requirement of attention to the families' own perspectives, SS ICM has the potential to be treated as a marginal activity, to be seen to be inconsistent with each agency's internal and 'regular' processes, or to be used as a repository for the participating agencies' 'too hard' cases.

As the project enters Year Two there are going to be a range of pressures effecting agencies' levels of engagement with the model. Some of these are likely to result from wider system changes and some may be more 'generic' in the sense of being the result of the recognised tendency for pilot projects to not be sustained in the longer term. This has been called 'pilotitis' referring to the way systemic lessons from local efforts can be neglected as individual active participants (the initiators or local 'champions') move out of, or around, their local systems.

> *'Pilotitis might be understood as dissatisfaction (of service funding agencies, government departments and service providers) with isolated pilot projects which may have been successful, but were not rolled out into enduring changes in broader service provision or policy'* (Kuipers et al. 2008)

Externally to the immediate context of the project, there is a high degree of uncertainty in the policy domain for Year Two of the project, both at the State level with an anticipated change of government and recent changes in response to national level reforms, in particular with the advent of the State-level re-organisation of Local Health Networks and the planned Commonwealth-funded Medicare Locals in NSW.[4]

Within NSW Health as the major contributor of funding to SS ICM in Year One, and with a change of local administration that has taken place in 2011, the benefits of the model

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[4] See the analysis of the current Health Reforms in a presentation by Eagar (2010):
 http://chsd.uow.edu.au/content/groups/public/@web/@chsd/documents/doc/uow091319.pdf

will need to be clearly described and strategically promoted to both of these new health administrations in Year Two.

In particular the Local Health Network in the Illawarra – Shoalhaven has a new administration that can be expected to be primarily oriented to managing the short-term demand for hospital services and this administration has no role in population health and planning, the part of the Health sector that represented the origin of the support for the SS ICM model[5].

It is not yet clear from where (and how) the residual community health services, community mental health and drug and alcohol and population health programs will be managed. What is clear is that the State-based Health sector is going to be all about managing hospitals. That analysis suggests the importance of situating the SS ICM model's interface with the Health sector more closely in alignment with the emerging structure of the Medicare Locals.

4.2 Lessons from the international literature

The reference list and the material in Appendix 1 describe more of the past and current projects and programs with lessons relevant to the service integration aims of SS ICM.

In the international literature, Kodner and Spreeuwenberg (2002) identified a wide range of methods and tools, and organised them according to five integrated care levels: funding; administrative; organisational; service delivery; and clinical.

> *A case study of several vertically integrated eldercare models in North America concluded, for example, that the following cluster of methods and tools appear to be responsible for their success: a closely-knit organizational structure; case-managed, inter-professional care with a single point-of-entry and the use of comprehensive service packages; an organized provider network with defined referral and service procedures and enhanced information management; and the pooling of funds (i.e., a single funding envelope*) (Kodner 2009, p.12).

Table 1 below contains comments that illustrate how the SS ICM model uses this *Typical Range of Integrated Care Methods and Tools*. In situating the SS ICM model in the broader territory of integration initiatives, this shows the model is comprehensive and uses most of the recognised and recommended methods and tools. Where it differs from other methods and tools is in some of the funding and service delivery areas:

Table 2 Typical Range of Integrated Care Methods and Tools (Kodner 2009)

Integrated Care Methods and Tools	*SSICM*	*Comments*
Funding:		
Pooling of funds (at various levels)	✓	Pooled funds cover only operating and evaluation expenses
Prepaid capitation (at various levels)	X	Not applicable
Administrative:		
Consolidation of responsibilities and functions	✓	Takes place through the Steering Committee and Panel functions
Inter-sectoral planning	X	Some elements of planning around unmet need and training at the Steering Committee and Panel
Needs assessment/allocation chain	✓	Takes place through the Panel and Teams - more standardisation of assessment is possible
Joint purchasing or commissioning	X	Commissioning takes place without purchasing

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[5] See the functions of Local Health Networks at: http://www.health.nsw.gov.au/islhn/functions.asp

Integrated Care Methods and Tools	*SSICM*	*Comments*
Organisational:		
Co-location of services	X	Coordinator is co-located with population health
Discharge and transfer agreements	✓	More needed on follow-up strategies to determine longer term outcomes
Inter-agency planning and/or budgeting	✓	Some elements of planning around unmet need and training at the Steering Committee and Panel
Service affiliation or contracting	✓	Takes place through the Panel and Teams
Jointly managed programs/services	✓	Takes place through the Steering Committee
Strategic alliances or care networks	✓	Takes place through the Steering Committee and Panel
Consolidation, common ownership or merger	X	Common 'ownership' through Steering Committee
Service delivery:		
Joint training	?	Resources have been sought to promote the model
Centralized information, intake and referral	✓	Through Coordinator and the Panel
Case management	✓	Takes place through the Panel and Teams
Disease management	X	Limited role through Health
Interdisciplinary team work	✓	Takes place through the Panel and Teams
Around-the-clock (on call) coverage	X	Limited role through Police and Mental Health/Health.
Integrated information systems	X	Limited at this point except through Coordinator
Clinical:		
Standard diagnostic criteria (e.g., DSM IV or other common language)	X	Limited role through Health – but diagnosis is less important than a common understanding of the social problems
Uniform, comprehensive assessment procedures	X	Uniform nut not comprehensive - takes place through the Panel and Teams
Joint care planning	✓	Takes place through the Panel and Teams
Shared clinical record(s)	X some	Common records held by DPC
Continuous monitoring	✓	Not after exit
Common decision support tools (i.e., practice guidelines and protocols)	✓	Limited at this point except through the Coordinator – needs an approach to measuring outcomes
Regular family contact and ongoing support	✓	Regular contact but not systematically organised after exit

In the 'bigger picture' of integration-based reforms, SS ICM in some senses is 'just another pilot project'. What is it that makes it different to much larger program-based activities like *Keep Them Safe*, and the myriad of more 'partial' integration programs like for chronic diseases or co-morbidities in Health, or initiatives within one population group such as the homeless, or women in domestic violence situations, or Aboriginal communities?

Assuming other pilots, projects and programs are all integrating at some level, SS ICM may be seen as different in having a broadly-based and well-functioning Steering Committee reporting upwards and outwards via the Regional Governance Framework. The project has a recognised local history and a manageable scale that has helped its capacity to be 'embedded' in agency systems, and a set of methods and tools that has 'added value' to the work of the agency participants in their contacts with the families. In practice for some agencies this gives easier access to a family case management capacity they are not expected to develop 'in-house'.

Some of the reasons contributing to this element of 'uniqueness', as reported in Year One are:

▪ SS ICM is not a fund holder for the interventions for the families, but operating funds and in-kind contributions are pooled from the partner organisations to cover the costs of the coordination role and the formative evaluation. This has increased a sense of ownership and reduced the potential for competition.
▪ The funding model means the partner organisations are clearly expected to manage their own levels of contribution and their risks (i.e. the opportunity costs arising from going too far outside their own 'business as usual' strategies.

- The funding model also minimises the risk of SS ICM becoming seen as another separate 'program' within an already very busy policy and program context.
- The SS ICM model is relatively under-developed in terms of its formal relationship to broader service planning issues in the local environment. It may have an opportunity to inform the planning of changes under regional governance structures and health reforms in the next period.
- While the Coordinator is co-located with Health (population health and planning under the SESIAHS), the Health role as the project's lead agency has been managed so as to ensure that no single agency is perceived to be 'calling the tune'.
- The tools for coordination (the family selection criteria and assessment forms) are continually being refined as the model 'beds down' in the local service delivery network. That refinement process is expected to continue as more referrals assist the project to get better at selecting the 'right' families and strategically managing and 'testing' the flexibility of the service system.

The model covers most of the recognised attributes of 'best practice' in integration and is well placed to contribute constructively to expected changes to the organisation of human services.

The areas where the model does not closely match the *Typical Range of Integrated Care Methods and Tools* gives some useful indications of the areas where additional planning and development might be considered by the Steering Committee:

- Prepaid capitation (at various levels) – suggests project funding contributions might be more clearly linked to the rate of 'usage' by different agencies.
- Inter-sectoral planning – could be more formal if the model were linked to the proposed population planning roles of the NSW Department of Human Services and/or Medicare Locals
- Joint purchasing or commissioning – this is the role in proposing new training programs and service types or re-orienting existing programs, e.g. for new models adolescent boys.
- Co-location of services – might be represented by a virtual network of case management-based programs with clear role delineation.
- Consolidation, common ownership or merger -– might be represented by a virtual network of case management-based programs with clear role delineation.
- Disease management – more explicit descriptions of any health-related conditions would assist in managing the transition of the model to new health organisations.
- Around-the-clock (on call) coverage – may be a designated role a sub-set of agencies with this capacity, or may not be relevant.
- Integrated information systems – build on initial efforts through CHIME and try to make use of HSNet for referrals and other information sharing by Teams.
- Standard diagnostic criteria (or at least a common language) – may not be so relevant to the social welfare space.
- Uniform, comprehensive assessment procedures – continual efforts at improvements in this area are likely to be useful.
- Shared clinical record(s) - procedures – continual development in this area is likely to be useful; initial agreements brokered by DPC to store the shared information from closed cases have been useful.

4.3 Anticipating the wider system changes in Year Two

As the SS ICM model is more relevant to the 'social determinants of health' than to the relatively short term management of demand for hospital services, there is likely to be some risk to the project from changes to the level of health system engagement in 2011. How best to manage that risk will be influenced by a number of State and National level

developments, in particular the future roles of the NSW Department of Human Services and the Regional Coordination Program, and the advent of the Medicare Locals which are likely to be developed by building on the current roles of the Divisions of General Practice[6].

Submissions on the role of Medicare Locals from the social welfare sector (Queensland Council of Social Service 2010) have emphasised the importance of incorporating a social model of health (including the social determinants of health and social justice concepts) in principles underpinning health reform and health care decision making. If these principles drive the funding, objectives and activities of Medicare Locals, then this should provide an additional basis for support for the SS ICM model.
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The Council of Social Service network's submission states that Medicare Locals should develop comprehensive local health plans in collaboration between Local Hospital Networks, NGO-based health and community services and local government. If this aim is realised, then the opportunities for promoting the lessons from the SS ICM project may be very useful to assist the Medicare Local to

> *'work towards a more integrated planning system overall that incorporates the multiple factors that impact on health (and) promote a greater understanding of the role of the community services sector in improving health outcomes.'* (Queensland Council of Social Service 2010, p.3)

The expectations of Medicare Locals from the social welfare sector are that they could be a source of flexible funding for health care delivery models to meet the needs of disadvantaged and marginalised groups, link with existing client co-ordination mechanisms and maintain service integration where policy and funding responsibilities are shared across national, state and regional levels. This suggests the strategic value of engaging in Year Two with the *headspace* program (for youth) and other Illawarra Division of General Practice programs such as its clinical psychology services to explore how to manage resources that are essentially 'item-driven', rather than flexible for the purposes of interagency work.

Other strategies to manage the risks to health system (and other agencies') levels of engagement due to external pressures are to promote the model more widely through another workshop in Year Two, and using training and information dissemination strategies. Participants suggested building in safeguards by strategically networking along with demonstrating more flexibility in the selection criteria, the selection of the Team members and the exit strategies for the families. The project also needs to strengthen and simplify its internal and ongoing evaluation processes.

4.4 Consolidating the lessons of Year One and promoting the model more widely

It may be useful to continue and possibly broaden the scope of the Steering Committee online survey, with suitable refinements to the questions for Year Two. For example the networking relationships part of the survey could be refined by deriving an 'integration score' that can be reviewed, further refined as a diagnostic tool and tracked over time as various national reforms and health-related changes take place.

Training in the model has been proposed and 'showcasing' it more in response to requests for more detailed information from like-minded models in other jurisdictions has

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[6] See the functions of Medicare Locals at:
http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr10-nr-nr164.htm

started already. This will use scarce resources in the process of disseminating advice and support to other settings. Applications for supporting joint ventures and tailoring the approach to other settings will also take resources from the 'core business' of supporting the families. Promoting the approach will be important in Year Two, but will have risks to an effective but somewhat under-resourced project.

4.5 Strategic selection of eligible families

Some eligible families will be likely to have members with one or more chronic health conditions. With the Coordinator's partial access to Health's CHIME data base already in place, and with continuing attempts at improving the linkage to hospital records, it could be possible to look back at the pattern of health service usage before and during the SS ICM intervention. This may create useful information for SS ICM and the Local Health Network in the area of claiming effectiveness in reduced hospital utilisation.

In practical terms and given the complexity of the tasks involved, the manager of Health's severe chronic disease management program (*Connecting Care*) could be approached to assist in achieving these data linkages. The approach would have two aims, the first being to assist the in-house evaluation of SS ICM outcomes and the second would be to strengthen the links (and gain access to 'in-kind' resources) to a relevant 'integration' program aimed at reducing hospital utilisation within the new Local Health Network.

4.6 Strategic selection of the Teams

Effective teenager engagement, and in particular the lack of programs for the positive engagement for teenage boys was identified at all levels as a 'systemic' deficit that limits the effectiveness of the model. Steps were taken through the Steering Committee to commission new local programs, given some referrals to services and assessments were being made out of the area.

Some discussion has taken place within the Steering Committee of the relative risks and benefits of including services for adolescents connected to the Illawarra Division of General Practice, in particular the *headspace* program and the Clinical Psychology Service. The limiting factors inherent in the Medicare-based fee for service model have been a realistic concern, but the involvement of these services on Teams has already begun. The advent of the Medicare Local as an umbrella structure for these services may make this option for expanding the Team participants more viable and valuable later in Year Two.

4.7 Strengthening an ongoing and built-in evaluation process

The evaluation is small in scale and apart from conducting surveys and independent interviewing of the participants, is more like a strategic advice function. It does not cover family-level information on their experiences and their views of the outcomes for them. Although essential, this level of inquiry is not in scope due to the ethical, logistic and resource issues involved, but could be addressed through building this level of inquiry more systematically into the role of the Coordinator and within the participating agencies.

The results in the first year are therefore primarily at the level of the structures and interagency processes that were established, not family-level outcomes. It will be important to develop a more formalised and 'built-in' outcomes monitoring process in Year Two, for understanding both the interagency impacts and the family and client-level of outcomes.

The assessment of outcomes for the families that have exited the model will be needed in the next phase. This should be done by the Coordinator as a continuation of examining the best ways of monitoring and following up the families who have exited after their 6 months, to see if the SS ICM intervention was perceived as being helpful to them. This opens up opportunities for outcome measurement to become more sophisticated over time.

The Common Assessment Criteria Form is the basis for outcome measurement. It says that to be selected for the project, families must have children of school age or younger present and not be 'case managed' under any other program. Priority is be given to referrals where the family are tenants of Housing NSW living in Port Kembla, Warrawong, Lake Heights, Berkeley and Cringila. Currently if there is unused capacity in the SS ICM project, referrals of families living in Dapto are considered.

In the meeting on September 2010 the Panel members developed refinements of the criteria – primarily for assessing requests to extend a family's involvement beyond six months:

1. Does the family still meet the criteria at entry, i.e. is domestic violence still present? Is the tenancy still a problem? Are the children at risk?
2. Why hasn't the team been able to progress any of the goals in the 6 months ICM period?
3. Does the team have a plan to address the outstanding issues?
4. Are there any additional actions required from SS ICM to progress?

It was agreed that if the Team's request met the criteria to extend, and an appraisal of the client's readiness and engagement for change was positive, then the request could be approved for a further 6 months.

This example shows how the Common Assessment Criteria are already being refined and how that refinement might evolve into better tools for measuring outcomes. It also shows how the project itself is modelling the flexibility expected of its participants. Measuring outcomes in the community based on a case study of integrated case management would be interesting and timely new ground for evaluation and useful to promote the model as it evolves further. The challenge would be to keep the process simple and efficient for the participants.

The evaluation of the next phase need not be *independent*, and it should be kept as simple as possible by using a set of key indicators of family-level outcomes. At the interagency level a simple tool in the form of a 'relationship index' derived from the Steering Committee regular on-line survey, could be derived, tested and refined over Year Two.

At the level of the project as whole, a set of 'headline indicators', based on the Regional Governance Framework/Regional Coordination Project reporting, could be selected by the Department of Premier and Cabinet and used to improve the interagency processes. It may be possible to build these evaluation elements into each agency's own planning and allocation systems. These are outlined in Appendix 4.

5   Recommendations for Year Two

The comments from the Steering Committee members summarise the most useful next steps after Year One that are relevant to the questions of sustaining the model, strategically using its lessons to date (both locally and in planning at other levels) and in simplifying some functions including the evaluation:

1. Promote the model through the existing regional and central governance structures.
2. Promote the model through inter-agency training opportunities.
3. In the next period work on how to consolidate the tools for integration and role of the Coordinator at the system level.

Its relative complexity, the small scale, its similarities to a host of other initiatives and the long timelines involved in seeing outcomes, all leave the model vulnerable to losing its 'visibility' in the context of larger scale changes in the participating agencies' organisational and program environments. Not being a 'program' in its own right (i.e. with a designated and protected budget) is a key design feature, but is also a factor that increases its vulnerability because the project relies on a good understanding of its strategic value in system-level change.

The Health sector will remain the biggest challenge to integration with its own models in mental health, drug and alcohol, midwifery, child protection and chronic disease management, all aiming to address family/service user/client complexity on an intervention continuum from self-management to more intensive levels of case management.

5.1   Sustaining the model

The Steering Committee has recognised that improving the sustainability of the model involves ensuring that the participating government Departments and agencies understand both the rationale and the flexibility that is required for the model to work. With the regular changes to organisational structures and the natural turnover of staff, there is an ongoing task for the Coordinator to explain the model, how it works and who it is aimed at.

The 'de-bugging' of the interagency agreements and understandings is very complex and takes up resources and time, so clearly documenting (perhaps in a MOU) and more widely disseminating the lessons to date will help to consolidate the model in the local service system. This documenting will also assist participating agencies to understand and manage any risks to their mainstream practice and assist other interested parties, and even other jurisdictions, to make use of its lessons.

To offset the tendency to over-burden the Coordinator with tasks that might be more usefully handled at the family contact, agency or system levels, the characteristics of eligible families (i.e. emphasising the SS ICM system level aims and strategic use of the selection criteria) should be clearly described and as much as possible built into the continuum of service responses available for each agency.

> **Recommendation 1:** *Each participating agency to build the SS ICM headline indicators (as well as its aims and selection criteria and its expected levels of participation) into its own client management, risk management and planning systems. With a focus on risk management, each participating agency should be encouraged to assess what 'building in' will mean for its policies, protocols and processes.*

5.2   Strategic use of the lessons to date

On the evidence reviewed here, improved collaboration between agencies is occurring both "top down and bottom up". Horizontal integration is working because of the current levels of shared understanding within the Teams, where members are addressing those issues and problems that can *only* be solved in partnership. The Panel interviews indicated that other agencies' middle management is using the collective 'family case management' capacity to respond to the complexities of the clients' circumstances and system 'rigidities' are being addressed.

Because of its system-level aims, there is a continuing need to strategically manage demand for the model as the number of referrals being received has to remain manageable, and the entry criteria have to be clearly articulated and understood in order to offer the model to those families most able to benefit.

Some agencies are concerned with raising expectations that cannot be met, or with moving too far or too fast with the necessary 'de-bugging' of their processes and templates, given SS ICM is not an 'established' program. Others are concerned that even though they feel they understand the model and its processes, they have difficulties in getting their own 'most difficult' clients/families into the model.

These dilemmas suggest that as well as building consistent understandings within agencies, there is also a need to strategically manage up, using the coordinating and planning structures of the health, justice and human services agencies by identifying service and training gaps and recommending how allocative and dynamic efficiencies might be achieved by promoting new models and using common and shared training opportunities across agencies.

In using the documentation after Year One it is possible to strategically situate SS ICM as part of a 'virtual network' or hierarchy of models promoting 'integration' such as Family Case Management models under the Keep Them Safe initiative, the Integrated Crime Management model, as well as the growing number of coordinated or integrated care models in the health sector, in both the Local Health Networks and the proposed Medicare Locals.

An example of the hierarchy of integration might be presented as SSICM being a tertiary model aimed at change at the system level, elements of the KTS models are promoting integration at the secondary level within and across agencies with providers as the focus, and the primary level includes models that operate at the level of changing the service delivery experience of the families.

> **Recommendation 2:** *The Steering Committee continue to pursue training opportunities for the participants. This should be through another workshop with the Teams in Year Two and through approaches to training providers. The training strategies can use the relevant SS ICM guidelines and other documented material, and the lessons to date and other resources identified in the evaluation, in each agency's own (and shared inter agency) staff and management training materials, courses and programs.*

Collaboration between agencies is occurring both "top down and bottom up". Horizontal integration is working because of the current levels of shared understanding within the Teams, where members are addressing those issues and problems that can only be solved in partnership. Middle management is using the collective 'family case management' capacity to respond to the complexities of the clients' circumstances and system 'rigidities' are being addressed.

The task of maintaining the momentum to date into Year Two is likely to be a challenge. Given the extent of expected organisational changes (particularly in the Health sector) during the first half of 2011 there may be opportunities to strategically use the investments and lessons learned to date to positively influence those changes.

> **Recommendation 3:** *The SS ICM Guiding Principles document, along with any selected and relevant material from this Year One report, should be turned into an accessible and short Briefing Paper with 'practice implications' drawn out for the local service sector from the lessons learned to date through the project.*

5.3 Using planning opportunities and common information

Because it is recognised in the Regional Governance Framework and is more broadly based in local interagency processes than the many single agency initiatives that exist, the project holds the potential to more broadly influence the way the human services and health agencies in the Illawarra work together. The lessons to date therefore present opportunities to make wider and very practical investments in guiding changes to service delivery systems in the near future.

Formalising communication 'up' through the Justice and Human Services Senior Officers' Group with firm (and evidence-based) recommendations on the (say) three most important gaps in service provision, would be a direct way to influence cross-program and inter-agency planning.

> **Recommendation 4:** *Workers and managers from both government and non-government agencies have collectively identified important service gaps and the capacity of the SS ICM Steering Committee should be used to assist the service sector to respond. For example, for boys aged between 8 to 14 years who are requiring intensive intervention at the tertiary level (essentially adolescent psychiatry), there are few opportunities in the local environment to address their needs.*

There is already a negotiated arrangement for the Department of Premier and Cabinet to be a repository of the common information on the families after case closure. There was also recognition of the need to consider longer term engagement with families past the 6 months of the SS ICM intervention, due to the complexity and long term nature of the families' problems.

The maintenance and upkeep of client files and information supporting the Team activities varies, meaning that understanding what has been achieved in the interagency activities may be limited in some agencies unless they can hold (or get access to) a common case summary. Because the Teams are composed of a limited number of the participating agencies, all agencies need to have a system of 'flags' so they can identify families or family members who have been involved with the model. This will also assist with longer term follow-up and/or assessment of outcomes for the families who have had a common case plan with a set of achievable goals.

> **Recommendation 5:** *The maintenance and updating of a family/client 'register' or a system for flagging SS ICM involvement should be formalised in the form of more standardised agency information and processes to give access to a common (but simple) case summary.*

5.4 Build in an ongoing evaluation process

A useful evaluation, but one of suitable scale, can be based on the use of the goals in the case plan that can act as a "common currency" between providers and the families and that can be reviewed at case closure and/or at subsequent contacts of the families with individual agencies. This would be a way to examine family level outcomes where the family's agreed goals become a useful tool for outcome measurement.

Examining the outcomes for the families will be more useful (but may be harder to achieve) in the longer term. Later follow-up and data collected for the purpose of measuring the outcomes for the families may be better done by individual agencies that still have routine contact (rather than by the SS ICM project. Evaluation at this point is more about the experiences of the 'process' for the families looking back to see what they say helped or hindered them. One aim is to inform how it is best to engage them and how to tailor the plan to meet their needs better than any single agency can do on its own.

One question that still needs to be asked and answered is whether it is practical to build a cross-agency 'data repository' function to support each agency's participation and capacity to use evaluation findings. This may be only justifiable if it were a model for wider application. Instead of one 'central' information system this could be brought together from many information systems that follow agreed standards so that summary information from a wide number of service providers in a distributed network could be combined (for example in a shared group inside HSNet) in order to allow participants to have secure information and an ability make their own judgments about outcomes.

> **Recommendation 6:** *The project should examine the most practical ways of monitoring and following up the families who have exited after 6 months to see if the SS ICM intervention was perceived as being helpful to them, in order to open up opportunities for more sophisticated outcome measurement.*

The findings from the first year of SSICM, in particular the on-line survey, suggests it is possible to build and support an evaluation system that can routinely capture a manageable set of key indicators that can help each agency to plan and deliver support. The aim would be provide a good picture of how well the service system is doing, not only how many services of different types are being provided.

The questions in an on-line survey should be directed at more than just the *frequency* of interagency contacts, but be directed at assessing the usefulness and quality of those contacts. This information may lead to better tools for the system-level improvements that SS ICM aims to achieve. This recognises that more frequent contacts between agencies may not be sufficient if the quality of those contacts is judged as poor.

> **Recommendation 7:** *Use an enhancement of the on-line survey tool to ask simple questions of all participants about service coordination and collaboration and the quality of interagency involvement in various activities and generate an aggregate 'relationships index' for the local system (see Appendix 4 and Figure 1 p.8).*

More standardised and shared information on the families collected in the initial and ongoing processes of assessment can form part of a continuous client record inside each agencies' client information systems. If the same data elements are collected at different points, then the 'change scores' can be used for the purposes of measuring the outcomes of services or interventions. Supplementing the family-level information with interagency and relationships information should give a more comprehensive picture of the project's achievements by the end of its second year.

References

Adair C.E., Wild T.C., Joyce A.S., McDougall G.M., Gordon M.D., Costigan N. et al. (2001) *Development of a measure of perceived continuity of care for persons with severe mental illness*. American Journal of Epidemiology 2001;153:S101.

Adair, C.E., L. Simpson, J.M. Birdsell, K. Omelchuk, A.L. Casebeer, H.P. Gardiner et al. (2003) *Performance Measurement Systems in Health and Mental Health Services: Models, Practices and Effectiveness. A State of the Science Review*. Alberta Heritage Foundation for Medical Research.

Adair C.E. (2009) *Concurrent Substance Use and Mental Disorders in Adolescents: a Review of the Literature on Current Science and Practice*, submitted to the Alberta Centre for Child Family and Community Research, February 6, 2009
https://www.onehealth.ca/r_alberta_nwt/video_conferences/E101014-HO.pdf

Boorman, C. and Woolcock, G. (2002). '*The Goodna Service Integration Project: Government and community working together for community well-being in Goodna'*. In T. Reddel, (Ed.) Governing local communities: Building state and community (pp. 57-81). Occasional paper series no, 4 Brisbane, Australia: School of Social Work and Social Policy, University of Queensland.

Canadian Health Services Research Foundation (2009) *Networks Leadership Summit IV: The Power of Networks in Times of Change*, Banff, Alberta January 14, 2009.

Eagar K, Pirkis J, Owen A, Burgess P, Posner N and Perkins D (2005*) Lessons from the National Mental Health Integration Program*. Australian Health Review. 28 (2): 189-200.

Eagar K, Owen A, Masso M and Quinsey K (2006) *The Griffith Area Palliative Care Service (GAPS): an evaluation of an Australian rural palliative care model.* Progress in Palliative Care. 14 (3): 112-119.

Eagar K, (2010) *Your Integration ids my Fragmentation.* Australian General Practice Network National Forum 2010, 4-6 November 2010, Perth.
http://chsd.uow.edu.au/content/groups/public/@web/@chsd/documents/doc/uow091319.pdf

Farland T (2009) Regional Coordination Program - Governance Framework (working draft) Department of Premier and Cabinet

Fine M. et al. (1996) *Demonstration Projects in Integrated Community Care. The First Full Year*. Evaluation Report, July 1995-June 1996. Social Policy Research Centre, University of New South Wales for the NSW Ageing and Disability Department.

Fine M, Pancharatnam K, and Thomson C (2005) *Coordinated and Integrated Human Service Delivery Models. Final Report*. Social Policy Research Centre, University of New South Wales. SPRC Report 1/05. ISSN: 1446-4179; ISBN: 0 7334 2186 5 (original report dated March 2000)

Fine M. (2001) *'Coordination through Collaboration. The New South Wales Demonstration Projects in Integrated Community Care*' in M.P. Mandell (ed) (2001) Getting Results Through Collaboration: Networks and Network Structures for Public Policy and Management, Quorum Books, Westport, CT. and Greenwood, New York: 207-219

Freeman, G., Woloshynowych, M., Baker, R., Boulton, M., Guthrie, B., Car, J. et al (2007) Continuity of Care 2006: What have we learned since 2000 and what are policy imperatives now?, London: National Coordinating Centre for Service Delivery and Organisation.

Head B. (2010) *How can the public sector resolve complex issues? Strategies for steering, administering and coping*, Asia-Pacific Journal of Business Administration, 2 (1): 8 – 16.
http://www.emeraldinsight.com/journals.htm?articleid=1853500&show=abstract

Hilferty F., Mullan, K., van Gool K., Chan S., Eastman C., Reeve R., Heese K., Haas M., Newton B., Griffiths M. and Katz I. (2010) *The Evaluation of Brighter Futures, NSW Community Services' Early Intervention Program Final Report.* Report for Community Services, Department of Human Services, NSW Social Policy Research Centre, University of New South Wales, September 2010

Keast R,. Mandell M., Brown K. and Woolcock G. (2004) *Network Structures: Working Differently and Changing Expectations* Public Administration Review, 64 (3): 363-371
http://www.jstor.org/stable/3542601?seq=7

Kiresuk T and Sherman R (1968) *Goal Attainment Scaling: A General Method for Evaluating Comprehensive Community Mental Health Programs* Community Mental Health Journal 4, (6)
http://borgermoede.com/uploads/f82aa3ab89e16681f2acd847ebbeb925.pdf

Kodner D (2009) *All Together Now: A Conceptual Exploration of Integrated Care* Healthcare Quarterly, 13 (Sp): 6-1

Kodner, D. and C. Spreeuwenberg (2002) *Integrated Care: Meaning, Logic, Applications and Implications - a Discussion Paper.* International Journal of Integrated Care 2(3).

Kuipers P, Humphreys J, Wakerman J, Wells R, Jones J and Entwistle P (2008) *Collaborative review of pilot projects to inform policy: A methodological remedy for pilotitis?* Australia and New Zealand Health Policy, 5:17

Leutz W (1999) *Five laws for integrating medical and social services: lessons from the United States and the United Kingdom.* Milbank Quarterly, Vol.77, pp.77-110

Leutz, W. (2005) *Reflections on Integrating Medical and Social Care: Five Laws Revisited.* Journal of Integrated Care, 13, 5: 3-12. October 2005.

Mandell M and Keast R (2009) *A New Look at Leadership in Collaborative Networks: Process Catalysts.* Chapter 9 in: Public Sector Leadership: International Challenges And Perspectives, Raffel,J et al. Eds., Edward Elgar Publisher, Cheltenham, UK.

Mandell M and Keast R (2007) *Evaluating Network Arrangements: Toward Revised Performance Measures* Public Performance and Management Review 30 (4):574 - 597

Masso M, Fildes D, Quinsey K and Matete S (2007) *GAPS revisited: follow up evaluation of an Australian rural palliative care service.* Progress in Palliative Care. 15(5): 233-239.

Masso M and Owen A (2009) Linkage*, coordination and integration – evidence from rural palliative care.* Australian Journal of Rural Health, 17 (5): 263–267.

McDermott, S., Bruce, J., Fisher, K.R., and Gleeson, R. (2010) *Evaluation of the Integrated Services Project for clients with challenging behaviour: Final Report*, SPRC Report 5/10, prepared for Ageing, Disability and Home Care, Department of Human Services, NSW, Social Policy Research Centre, Sydney.

Muir, K., Katz, I., Purcal, C., Patulny, R., Flaxman, S., Abello, D., Cortis, N., Thomson, C., Oprea, I., Wise, S., Edwards, B., Gray, M. and Hayes, A. (2009). *National evaluation of the Stronger Families and Communities Strategy 2004–2009*, Occasional Paper No. 24, Department of Families, Housing, Community Services and Indigenous Affairs.
http://www.fahcsia.gov.au/about/publicationsarticles/research/occasional/Documents/op24/exec.htm

National Family Preservation Network (2006) North Carolina Family Assessment Scale for General Services. Sample Scale and Definitions. http://www.nfpn.org/images/stories/files/ncfas-g_scale_defs.pdf

NSW Government (1995-1996) Integrated community care for older people and people with disabilities. Community Solutions. Office on Ageing, Social Policy Directorate/Ageing and Disability Department

Owen A, Green J, Senior K and Eagar K (2004) *Promises and pitfalls – results of the NSW Comprehensive Assessment System Pilots*. Centre for Health Service Development, University of Wollongong.

Parker, G, Corden, A. and Heaton, J (2010) *Continuity of care: Findings of a conceptual review and synthesis of the NIHR SDO programme of research*, Research Works, 2010-02, Social Policy Research Unit, University of York.

Parker G, Corden A and Heaton J (2009) *Synthesis and conceptual analysis of the SDO Programme's research on continuity of care*. Report for the National Institute for Health Research Service Delivery and Organisation programme. June, 2009, prepared by Social Policy Research Unit, University of York http://www.york.ac.uk/inst/spru/research/pdf/Continuity.pdf

Perkins D, Owen A, Cromwell D, Adamson L, Eagar K, Quinsey K and Green J (2001) *The Illawarra Coordinated Care Trial: better outcomes with existing resources?* Australian Health Review. 24 (2): 163-173.

Pluye, P., Potvin, L., and Denis, J. (2004). *Making public health programs last: Conceptualizing sustainability*. Evaluation and Program Planning, 27: 121-133.

Popp K, Dolinski C, Adair C, Tough S, Casebeer A, Douglas-England K, and Morrison C (2005) *How do you evaluate a network? A Canadian child and youth health network experience*. The Canadian Journal of Program Evaluation. 20, (3): 123–150

Powell Davies G, Williams AM, Larsen K, Perkins D, Roland M, Harris M. (2008) *Coordinating primary health care: an analysis of the outcomes of a systematic review*. Medical Journal of Australia 2008;188(8 Suppl):S65–8.

Queensland Council of Social Service (2010) *Forging New Links with the Community Services Sector to Build a Better Health Care System*. Joint COSS response to the Department of Health and Ageing Health – November 2010. http://acoss.org.au/images/uploads/Joint_COSS_response_Medicare_Locals.pdf

Reid, R, Haggerty, J and McKendry, R (2002) *Diffusing the Confusion: Concepts and measures of continuity of healthcare*, Ottawa: Canadian Health Services Research Foundation. Final Report, March 2002.

SESIH (2010) *Position Description; Chronic Care Partnership Managers*. South East Sydney Illawarra Health, Regional Severe Chronic Disease Management Services, June 2010.

Social Policy Research Centre and the Australian Institute for Family Studies (2010) Keep Them Safe: A Shared Approach to Child Wellbeing. Evaluation Framework, March 2010. http://www.dpc.nsw.gov.au/__data/assets/pdf_file/0009/82926/Outcome_Evaluation_Framework_Results_Logic_small.pdf

Suter E, Oelke ND, Adair CE and Armitage GD (2009) *Ten Key Principles for Successful Health Systems Integration* Healthcare Quarterly, 13(Sp) 2009: 16-23. http://www.longwoods.com/content/21092

Thomson C et.al. (2006*) Families First, Area Review Illawarra. Final Report*. SPRC Report 2/06, University of New South Wales Consortium, January 2006.

Thomson C et.al. (2006a) *Understanding the Local Service Network Project. Families First, South East Sydney Final Report*. SPRC Report 6/06, University of New South Wales Consortium, January 2006.

Turrini, A., Cristofoli, D., Frosini, F. and Nasi, G. (2010), *Networking literature about determinants of network effectiveness*. Public Administration, 88: 528–550.

Urbis Keys Young (undated summary by DP&C) *Evaluation of the Integrated Case Management Projects* funded under the Community Solutions and Crime Prevention Strategy.

APPENDIX 1: Review of useful lessons from similar projects

Lessons about integration

More recent review articles in the international literature have aimed to 'sort out' what is currently meant in practice by the concept of 'integration' in general and 'integrated case management' in particular.

The work of Walter Leutz (1999 and 2005) summarised the lessons from large scale trials and demonstrations and has been influential in understanding the complexity involved. It does this by describing integration issues in relatively simple terms as a series of *Laws of Integration*:

1. *You can integrate some of the services for all the people, and all the services for some of the people, but you can't integrate all of the services for all of the people*
2. *Integration costs before it pays*
3. *Your integration is my fragmentation*
4. *You can't integrate a square peg and a round hole*
5. *The one who integrates calls the tune*
6. *All integration is local.* (Leutz 1999 and 2005)

The *Laws* have been extensively quoted in evaluations as a way of understanding what can and cannot be realistically achieved in the interagency context. They emphasise that implementation is always local and has to fit the context, and as a corollary, the key lesson is that larger policies should facilitate, rather than dictate, the structure and pace of local action.

The *Laws* are expressed at a high level of generality but they help to adjust the expectations of policy-makers, program managers and front-line workers. However, the analysis of the detailed implementation of integration efforts is where important lessons can be drawn out, so when the concept of 'integration' is unpacked, a complex and 'nested' mix of concepts, mostly to do with the service *system* emerges.

A summary report called *All Together Now: a conceptual exploration of integrated care* was prepared by Dennis Kodner, an editor of the International Journal of Integrated Care (Kodner 2009). The paper reviews a large body of work carried out on integration, mainly in the health sector and includes a useful checklist of the 'typical range of integrated care methods and tools' (see page 23 above).

The report by Kodner (2009) adds a measure of clarity to what is described as a '*global buzzword… that has helped drive and shape major policy- and practice-level changes*' (p.7) and would be a useful resource for training purposes. It captures the essential aims of models like SS ICM in an accessible form of language.

> "*Integrated care is like a country. It demands a culture of its own, one that spans differing organizational and professional mindsets, eliminates boundaries and biases, and creates a shared space to facilitate much-needed inter-agency collaboration and interdisciplinary teamwork on behalf of the patient.*" (Kodner 2009, p.13)

In the same special issue of *Healthcare Quarterly* as the Dennis Kodner summary paper, Esther Suter and colleagues (Suter et al. 2009) described ten key principles for integration, based on a systematic literature review to guide Canadian decision-makers

and others to plan for and implement integrated health systems integrated health systems:

1. Comprehensive services across the care continuum - cooperation between health and social care organizations, access to care continuum with multiple points of access, emphasis on wellness, health promotion and primary care;
2. Patient focus - patient-centred philosophy; focusing on patients' needs, patient engagement and participation, population-based needs assessment, focus on defined population;
3. Geographic coverage and rostering - maximise patient accessibility and minimise duplication of services, rosters - responsibility for identified population right of patient to choose and exit;
4. Standardized care delivery through inter-professional teams - across the continuum of care, provider-developed, evidence-based care guidelines and protocols to enforce one standard of care, regardless of where patients are treated
5. Performance management - committed to quality of services, evaluation and continuous care improvement; diagnosis, treatment and care interventions linked to clinical outcomes;
6. Information systems - state of the art information systems to collect, track and report activities, efficient information systems that enhance communication and information flow across the continuum of care;
7. Organizational culture and leadership - support with demonstration of commitment, leaders with vision who are able to instil a strong, cohesive culture;
8. Physician integration – doctors as the gateway to integrated healthcare delivery systems, pivotal in the creation and maintenance of the single-point-of-entry or universal electronic patient record, engage in leading role, participation on Board to promote buy-in
9. Governance structure - strong, focused, diverse governance represented by a comprehensive membership from all stakeholder groups, organizational structure that promotes coordination across settings and levels of care
10. Financial management - aligning service funding to ensure equitable funding distribution for different services or levels of services, funding mechanisms must promote inter-professional teamwork and health promotion, sufficient funding to ensure adequate resources for sustainable change.

An international review of the factors important in coordinating primary care that was published in the Medical Journal of Australia described a similar range of methods and tools for integration to that described by Kodner (2009) and the lessons from the Suter et al. (2009) review (Powell-Davies et al. 2008).

The justification of integration efforts is also to improve the experience of *continuity* for the small proportion of clients/families that is expected to benefit from having their service responses organised under models like SS ICM.

A similar accessible style of summary report to those by Kodner (2009) and Suter et al. (2009) was published by the Social Policy Research Unit of the University of York in the UK in the health and social care area on the concept of 'continuity' (Parker et al 2010). It also summarised complex material, particularly the program of work by Freeman and colleagues (Freeman et al. 2007) to clarify the policy goals and for training purposes. In this summary report *continuity of care* was defined as an attribute of service delivery experienced by service users, but also as an outcome as well as a process of care.

> *Hence, there was emphasis on the need to measure both patients' experiences of continuity using these different dimensions, and the difference continuity makes to their health outcomes as well as satisfaction with care*. (Parker et al. 2010, p.3)

In a paper prepared for the Canadian Health Services Research Foundation, Reid et al. (2002) had previously reviewed the concept of *continuity* using a series of previous Canadian reviews, particularly those with a focus on measurement to improve healthcare performance (Adair et al. 2001, 2003). They came up with three categories that are useful to guide data collection and analysis in SS ICM and elsewhere:

- *"**Informational** continuity means that information on prior events is used to give care that is appropriate to the patient's current circumstance.*

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- ***Relational** continuity recognizes the importance of knowledge of the patient as a person; an ongoing relationship between patients and providers is the undergirding that connects care over time and bridges discontinuous events.*

- ***Management** continuity ensures that care received from different providers is connected in a coherent way. Management continuity is usually focused on specific, often chronic, health problems.*

   More emphasis is needed on the development and application of direct measures of continuity from the patient's perspective and to measure continuity across organizational boundaries." (Reid et al. 2002, p. i)

Informational and management continuity are more relevant to the aims of SS ICM and relational continuity is going to be less relevant as it relates to the ongoing relationships with particular providers; and SS ICM is a time-limited intervention.

The authors point out that there are no standardised tools that measure the transfer and use of information and the choice of continuity measures will depend on the context (see p.iii). Measures have focused on mechanisms thought to foster continuity rather on the direct experience of patients and providers. Therefore measures of informational continuity can come from a survey of the Teams on the availability of documentation, the completeness of information transfer between providers, and the extent to which existing information in the system as a whole is acknowledged or used.

Measures of management continuity should focus on the attendance of the designated agencies at case planning and review meetings and whether the right follow-up visits are consistently made when the case plan crosses organisational boundaries. Other measures of management continuity would be whether joint management protocols are both used and perceived as useful (the screening checklist, case plan, case closure and review protocols). For providers, it is the experience of having sufficient information and knowledge about a patient to best apply their professional competence and the confidence that their care is recognized and pursued by other providers.

There are limitations to the range of instruments to measure continuity, particularly instruments (whether medical or contextual) used by providers to measure consistency of care across organisational boundaries. There is still a general consensus in the literature that it is premature to recommend continuity measures for use as wide-scale performance indicators.

In the Australian context, successful ways to create a shared 'space' of interagency collaboration and interdisciplinary teamwork were examined in a case study on the *Service Integration Project* (SIP) in Goodna in Queensland (Boorman and Woolcock 2002, Keast et al. 2004, Head 2010). They highlighted the importance of collaborative networks, requiring leadership that focuses on developing a '*pool of shared meaning*'

and the role of a '*process catalyst'* to support the new model. The Queensland SIP model was described as successful, but the report authors concluded that:

> *'there are few definitive outcome measures commonly used by government agencies that can conclusively demonstrate these changes.'* (Keast et al 2004 p.370)

A useful set of facilitators and barriers to effective service coordination were described in Section 5 of the evaluation of the *Stronger Families and Communities Strategy*, funded by the Department of Families, Housing, Community Services and Indigenous Affairs as part of the Family Support Program (Muir et al 2009)[7].

The model was designed to support service coordination. Based on the interviews with stakeholders, the aims of networking, collaboration and coordination were effective within the multiple sites because of:

- dedicated funding available for it
- the shared focus around the early years
- the role played by the Facilitating Partner in establishing, facilitating and maintaining connections between service providers
- role of the Steering Committee (which grouped stakeholders together)
- commitment from the community-based service providers.

The report notes that although some services were already willing to work together, or had in fact been doing so prior to program, the support provided by the program '*translated willingness into practice and provided a structure and support to strengthen pre-existing networks'*. It concluded that:

> *It is important to point out that, irrespective of the successes in service coordination and collaboration, relationships took considerable time to establish and partnerships were not always conflict-free. They required a significant investment of time and resources and a commitment to both formal and informal processes and policies.* (Muir et al. 2009, Section 5.3)

In the services relevant to SS ICM there was a summary of lessons in a useful Canadian review of the literature and practice on *Concurrent Substance Use and Mental Disorders in Adolescents*:

> *Concurrent disorders in adolescents are enormously concerning and challenging, but there is much that can be done to reduce their frequency and impact on current and future generations. (Adair 2009, p.98)*

The key points reflected the 'big picture' for service systems and policy:

> *Progress has been slow on changing health systems to respond to both adult and adolescent concurrent disorders, but processes to support change for adult services are more advanced.*
> *Many child and youth mental health policies stress the obvious need for change to respond to the evident needs for intervention for adolescents, though few address adolescent concurrent disorders specifically.*
> *Some innovative approaches are being proposed and some initiatives for broad, comprehensive population health approaches … in youth are being launched.*

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[7] See this report and other related reports on the Communities and Families Clearinghouse Australia (CAFCA), part of the Australian Institute of Family Studies. http://www.aifs.gov.au/cafca/about.html

> *Effectiveness research and knowledge translation and exchange initiatives are needed to support policy and practice change. (Adair 2009, p.96)*

The practical implications for the SS ICM model in the Illawarra from the international literature and in particular the case study in Queensland are:

- the importance of a broadly-based policy capacity to promote system change (in this case beyond each agency through the NSW Regional Governance Framework);
- building coordination capacity (through the Steering Committee, the intake Panel and the role of the Coordinator); and
- the strategic use of partnering to improve implementation capacity (through the Teams formed for each family).

These linked elements are described in Section 3 above though the participants' views on the SS ICM model and are helpful in identifying relevant agency-level outcome measures. In summary, the review of lessons for SS ICM from other projects indicates where to invest evaluation resources in Year Two and the way to tailor the methods to fit the scale of the project.

Indicators for interagency and family level outcomes

Improving integration and continuity for the participating agencies and for the service experience of the families was recognised as part of the wider system role of SS ICM as a *Headline Initiative* under the NSW Regional Governance Framework (RGF) in 2010. SS ICM's indicators of interagency outcomes should ideally promote a level of consistency with other initiatives supported under the RGF. The draft *Evaluation Framework* for the NSW *Keep Them Safe* initiative (KTS) is an example of how more consistency across programs might be encouraged.

The overall evaluation of KTS was commissioned by the Department of Premier and Cabinet and a draft developed by the Social Policy Research Centre and the Australian Institute for Family Studies in March 2010[8]. It included the aim of improving collaboration between agencies and building a workforce '*that executes their responsibilities and works collaboratively with other professionals to achieve the best outcomes for children and their families*.' (p.6)

Question 8 under the overall KTS draft framework is relevant to the SS ICM interagency outcomes questions: '*To what extent are agencies and professionals working with families working collaboratively'?* (p.15). The draft framework identifies some shared outcome measures from administrative data sets, but does not recommend specific routinely collected indicators that could be used to assess improved collaboration or other interagency outcomes. This is essentially because of the complexity of each of the agencies' systems and the resources that would be involved in efforts to harmonise their outputs into a single coherent reporting framework.

The *Family Case Management* component of the KTS evaluation is more specific in what it proposes and has some relevance to the SS ICM evaluation. The indicators of interagency level outcomes would be well covered by straightforward descriptions of where the difficulties of service access and specific gaps in the range of interventions, for example in the efforts to access a range of appropriate services to help adolescent boys.

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[8] Social Policy Research Centre and the Australian Institute for Family Studies (2010). See the Evaluation Framework and the Overarching Results Logic for Keep Them Safe at: http://www.dpc.nsw.gov.au/__data/assets/pdf_file/0009/82926/Outcome_Evaluation_Framework_Results_Logic_small.pdf

In addition, the on-line survey of the participants on the Steering Committee could be extended to the lead agencies for the Teams and the Panel members. This mainly provides a set of useful comments (see Section 3) and could be supplemented by more specific questions in a revised on-line survey about their views of changes in integration and continuity (information, relationships and management) that they would attribute to the project. Repeating the 2010 Steering Committee surveys in Year Two would indicate any changes against the 'baseline' of Year One

Family level outcomes could be measured by the lead agency in each Team using a goal attainment scale for the identified goals in each family's case plan and/or the lead agency participant in each Team could use either a simple generic format (see the GAS below) or one of the recommended KTS tools – e.g. the North Carolina Family Assessment Scale for General Services (NCFAS-G). It would be possible to get advice on its practicality from KTS projects that are using this tool, and a caveat on its use is that it is not freely available in the public domain.

The NCFAS-G assists workers to assess families in eight domains of family functioning: Environment, Parental Capabilities, Family Interactions, Family Safety, Child Well-Being, Social and Community Life, Self-Sufficiency, and Family Health. The scale provides assessment ratings of problems and strengths, both at intake and at case closure[9]. (National Family Preservation Network 2006).The tool was designed for use by programs offering secondary prevention and/or differential response.

The assessment and measurement of family functioning in family based child abuse and neglect prevention/intervention programs is known to be difficult and resource-intensive. if used across programs and projects and supported by centralised training resources, the NCFAS-G may be an appropriate tool to help develop better targeted services to families and evaluating service outcomes in the longer term.

At a more practical level, the interagency level the ongoing evaluation could use feedback from the Teams (for example in a second workshop) and a simple survey of the participating agencies on the Steering Committee, the lead agencies for the Teams and the Panel members. Questions could cover the information, relationships and management dimensions of continuity as a way of measuring progress towards a more integrated local system

Measuring family level outcomes

At the most straightforward level it would a simple evaluation strategy to use the goals in the case plan and ask each Team leader to judge the extent to which they have been achieved at case closure on a five point scale as used in Goal Attainment Scaling (Kiresuk and Sherman 1968). The best indicator of outcomes would be those families who exit with their case plan goals met.

There are similar measurement issues for programs under the KTS, as few families may be in a good position to assist due to their disadvantaged circumstances and mobility, where it will be less possible to measure the post intervention outcomes, and there is no realistic possibility of measuring outcomes against a control group. A realistic approach could be to examine the previous six months of service contacts as a comparison.

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[9] See a description of the NCFAS-G tool at http://www.nfpn.org/articles-mainmenu-34/97-ncfas-g-an-assessment-scale-for-low-to-moderate-risk-families.html and examples of the questions used at http://www.nfpn.org/images/stories/files/ncfas-g_scale_defs.pdf

APPENDIX 2: Consolidated views of Panel members

The aim of the six interviews was to understand the role of the Intake Panel and its core elements and the competencies/permissions required to make it work. This included the role of the Coordinator and the sustainability of the model.

The Panel interviews were checked for accuracy with the informants and the issues raised have been grouped under the headings below with minor editing for ease of reading.

1. What is the main role of the Intake Panel in this pilot?

The main role is in selecting the most difficult ('hardest of the hardest') families, but with an ability to exercise good judgement that they will have a capacity to benefit from the considerable amount of inter-agency work involved.

Keep close watch over the guidelines; the ability to 'just say no!' - plus the ability to ask extra relevant questions relating to the service system:
- Ask what it is that makes this family an exception to the usual single program or departmental 'crisis' cases.
- Ensure the families both meet the selection criteria *and* have the capacity to benefit from the model of *integrated* case management.
- Ensure transparency of the process for the referrers and the Steering Committee.

(The Panel) ensures compliance with SS ICM referral criteria and relevant decision-making regarding entry into the program, and to consider requests for extended involvement. The latter requires the development of criteria to cover decision-making in response to these requests.

It provides a point of liaison between clinicians and the Steering Committee; a consultation role when problems are encountered by Teams; a consultation role when problems are encountered by the Coordinator or Steering Committee - for example when the entry criteria need to be reviewed / refined.

The (Panel process) needed someone with local knowledge and a lot of experience so they would be able to have good quality clinical input into the pilot.

It is based on panel members' long history of local working relationships and a capacity to understand the system in its totality.

The Panel is designed around knowledge that can span the local service system – it is a multi-agency panel that considers the paperwork as well as having the attendance of the person making the referral, so it has rich sources of information to understand and interpret the referral.

We bring our own way of working into the inter-agency space. We have good experience with integrated methods as we are expected to be preventive, pro-active and analytical.

Once through the gate-keeping function at the level of the Panel, the family's Team has to be formed, based on the knowledge of local service arrangements and keeping in mind that not all the agencies have the capacity to lead in this model.

The Panel has authority given to it through the Steering Committee, coming from the SOG and ultimately from the DPC regional governance arrangements.

Stakeholder Panel Reps having operational authority to delegate and ensure identified clinician skills and time can be dedicated to the necessary tasks of the Panel.

There is a role of the Panel in 'testing how rigid we are' at the system level. This is done by the multi-agency group being the place where the discussion of the families' capacity to benefit takes place and the questions are asked about whether SSICM is the right place for them and if the family needs this level of intervention.

2. *How is it different to other work you do in this housing-related DV, juvenile justice, etc area?*

The breadth of the scope in integrating health, family violence, social and housing, criminal/juvenile justice domains makes it different to what has been tried before.

Once accepted into SSICM, the family then attends the Team meeting to discuss the goals and to 'sign off' on what the goals are, as agreed from their viewpoint. This is like a regular participatory care planning model, but the interagency/multi-agency sign-off by the family is different.

SSICM is different in being in the area of the Government Departments, and it does not hold funds for brokering the packages of support services – just pooled funds for covering the 'project coordination' costs.

The Steering Committee gives permission to commit time and resources and as a body oversighting the Panel and the project it has the more senior people on it so that the commitment is there – so it gets beyond what you can do with a MOU that is signed off at higher levels.

It is testing the Government service system, to challenge its rigidities, tackle problems, looking for service gaps and proposing other solutions as well as giving access to SSICM.

It mandates more flexibility than in routine practice and is outside the current scope of most of the bureaucratic procedure manuals.

So like most programs the way to get in is through tight criteria, but once in the requirement is for maximum flexibility to meet the aims of the jointly agreed plan.

The aim is not one 'single' common (shared) plan but a better fit of each agency's care plan into an agreed 'integrated' approach, and with associated monitoring and management-level interventions to help with 'navigation' through the system and to change the approach as needed.

How it is different:

- Operational authority enables capacity to ensure targeted clinical service provision from stakeholder agencies especially Government Organisations
- Involvement of ALL health related services and other departments. The value in SSICM is that it is 'operationally authorised' and there is a clear recognition from all sides that we agree to resource this family in this way.
- Capacity to enhance interagency networking and therefore to, hopefully, enhance the continuum of care offered to and received by clients

- Clients' awareness and consent to a coordinated Plan, which is within the authority and agreement of all participating services - hence there are times when normal agency requirements of their workers are 'subordinated' to the primacy of the SS ICM Plan, esp. Centrelink etc.
- There is a requirement that different/more complex rules apply to the information that is being shared, such that traditional clinical-level restrictions on the confidentiality of information do not apply. This is potentially significant in the period before a family is accepted into the program.
- Names, addresses and details are sent around to agencies so as to be able to confirm current agency contact. For example, a Health Panel member requires unrestricted access to Health client details/files held in CHIME so they can be fed into SS ICM. This is a Unit Head, rather than individual clinician level of access which had to be approved by the Line Management.
- The role on the Panel needs a capacity for a clinician-level of judgement but supported by operational authority at a higher level.

Other elements that make the SSICM project and its criteria different to other programs and projects:

- The model is locally derived, not centrally determined and then 'handed down';
- Senior managers have created the expectation for their staff that they will cooperate and engage with the project
- Senior managers have given permission to bend the rules to operate under the model for the small number of families managed this way 'by exception'.

This model mandates a team approach with suitable structures and supports provided by the Coordinator to make it happen – which is OK at the current scale but hard to see being widened in scale because of the requirement for resources for minutes, organising meetings, keeping records.

The project and its entry criteria are quite well designed but need to be better understood[10]. They are not about the families' level of absolute need; nor about their relative need or their urgency or the depth of a current crisis.

They are also not only about the universal requirements for prevention in the child protection area, like *Keep Them Safe*. That is why it so important to keep clarity within the Intake function of the Panel. The key criteria are based on the 'case' being 'hard' for a number of key reasons:

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[10] M. P. Mandell, Ed. (2001) Getting Results Through Collaboration: Networks and Network Structures for Public Policy and Management, Quorum Books, Westport, CT.
Fine, M. (2001) *'Coordination Through Collaboration. The New South Wales Demonstration Projects in Integrated Community Care'* in M. Mandell (ed) Greenwood, New York: 207-219
Myrna Mandell and Robyn Keast (2007) Evaluating Network Arrangements: Toward Revised Performance Measures Public Performance & Management Review Volume 30, Number 4 / June 2007 Pages: 574 – 597
Robyn Keast, Myrna P. Mandell, Kerry Brown and Geoffrey Woolcock (2004) *Network Structures: Working Differently and Changing Expectations* Public Administration Review Vol. 64, No. 3 (May - Jun., 2004), pp. 363-371
Myrna P. Mandell and Robyn Keast (2009) *A New Look at Leadership in Collaborative Networks: Process Catalysts.* Chapter 9 in: Public Sector Leadership: International Challenges And Perspectives, Jeffrey A. Raffel, Peter Leisink, Anthony E. Middlebrooks, Eds., Edward Elgar Publisher, Cheltenham, UK. http://www.jstor.org/stable/3542601?seq=7

- The intensity of the families' use of government services;
- The complexity of the issues facing the family (i.e. current focus is on housing security, domestic violence and child safety/risk of significant harm); and
- The likely benefit to the family from having a multi-agency response; and
- The potential for re-shaping or "massaging" the local service system

So the criteria have to be continually discussed between the Panel and the attending referrers so as to explain them and provide the rationale as to why the family is accepted, or why not.

How it is different is we don't do the 'integration' bit across agencies, but SS ICM gives a legitimated way for us to contribute into that interagency area, based on the type of information we know about as a result of our work.

(Our staff know how to) sort out problems … and they get to know the spectrum of high need through to regular … clients, so being able to refer to (the next level) for possible help via SS ICM is useful.

(However) there are many more families we see need help they can't get and not many of them make it through the Panel into the ICM space even though we put a lot of work in trying to put the case forward. In spite of the relatively small numbers, the pay-off is worth it in terms of the relationships with the other agencies.

The aim of the project is not primarily about whether case management works, which we know enough about already. It is about setting up the teams and the lead agency roles and working out which agencies have the capacities and skills to work effectively in the 'interagency' space. For some agencies it is less 'natural' and the skills and experience are hard to find.

Also it is not primarily about examining the outcomes for the families, which will be longer term and require later follow-up and data collected for that purpose of measuring the outcomes for the families. It is about the 'process' for the families at this point – how to engage them and tailor the plan to meet their needs better than any single agency can on its own.

3. How is it the same?

Local knowledge equals knowing who the workers are who can do the translation of the 'culture and language' of this type of social model between the health workers, the other workers, the managers and the families.

It is similar in the way it is tackling a familiar problem created by the retreat from generalist models into specialist areas – this has led to some loss of capacity around knowledge of the local service system. SSICM reinstates that interagency space based on the SC and the Panel members having a long history of working relationships and a shared capacity to understand the system in its totality.

How it is the same:

- The aim being to enable the most efficient interagency service provision to clients requiring and/or receiving multiple agency service provision.
- In a very busy clinical workload the level of SS ICM work adds in another job to be done, but this is not unusual.

There are two similar projects with a similar target group about to start that can illustrate the differences:

- Homelessness Action Plan Domestic Violence Support Project – with the Wollongong Women's Refuge holding a SAAP budget for DCS and with an MOU in place. It will be over 3 years and have about $3m for supporting 30 women per year in private rental and social housing. It will employ a coordinator and will broker a form of coordinated case management with funds for covering the brokerage costs and the costs of a coordinated package.
- Staying Home - Leaving Violence Project – funded from DCS (about $150k per year) and expecting to help 30 families a year where the focus is on safety and justice issues. It has a State wide and a local MOU for a local coordination group.

(From the Police viewpoint) a lot is the same and SS ICM fits in well with our *Integrated Crime Management Model*. Inside the Local Area Command, the Crime Management Unit (CMU) has the role of problem solving and prevention as well as investigative and analytical support to the detectives in the Investigations Team.

CMU covers domestic violence, youth and Aboriginal liaison, crime prevention, warrants and summons, licensing, firearms and security, and the Intelligence Cell is how we look up and supply any relevant data to SS ICM. We will know about any history, can analyse event reports and any relevant information gathered through investigations. There is a fair amount of work in bringing together and sensitively managing that information.

We also have two 'civilian' DV workers with us who are funded and employed through the Women's Centre to engage with the women about DV – working on individual strategies, where to get help, making referrals to the DV Counsellors in Community Health.

This area of work takes pressure off the uniformed Police to manage the victims' social problems like accommodation, income support, finding a place in a refuge, follow up to see how things are going. Police have a big enough role in organising a response to violence, enforcing AVOs, preparing matters for Court.

The CMU has a number of methods it brings together that we can contribute, either on a SS ICM Team or independently of the project itself as a part of someone else's plan. This involves a number of strategies that can be used as needed by the matters in question; checking on bail conditions and AVO compliance, enforcing curfews, pro-active searches, youth-focussed interventions around under-age drinking, licensing matters.

Because (our agency's) roles are not about case management as such, the SS ICM model gives us access to better networks for handling complex … families who are at risk ... The work is similar to when we have to assemble the evidence to make a case for (priority action) where we need to have a full picture of the applicant's circumstances.

The reason for 3 Health Panel members is that no single part of Health can speak on behalf of the other parts, apart from the CEO. The same problems exist in all integration pilots – the Health sector is fragmented in itself and still needs to find a way to successfully work with these families.

It is shining light on the problems and service deficits e.g. in Mental Health and with interventions for young adults/adolescent males – with the requirements being to find a practical way to work on them, not just complain about them.

Also Health are not case managers, and the inter-agency role is now relatively rare in Health (compared to earlier times), as the various teams involved take on specialist roles with the families (compared with the flexibility of the Family Support Worker roles in the NGO sector).

4. ***What permissions and protocols are required to work effectively in this interagency space? What cooperation is required, with authority/direction from above?***

The relationships existed before, but now we have a 'safe space' where the rules are a bit different and we have permission to be more frank with the other agencies, and help to be more flexible. The signed permissions and consents mean the clients can be confident we are working together with them, not just each other.

Where the roles sit and where authority comes from is the Senior Officers Group (SOG), with influence from the Regional Coordination Program and Regional Governance Framework – with the central DPC role being mainly in policy and persuasion in encouraging the agencies in moving more 'across' their program boundaries to help the system not have so many 'cracks'.

The senior operational people report to the Senior Officers Group and the role of the less senior managers is to show a high level of commitment to solving problems.

The project's authority comes from the SOG owning it and then using the Steering Committee in oversighting the larger service system, and asking why things work or don't work. The SOG gets reports from the Steering Committee and the Coordinator manages the work of the Panels and the senior managers then have the job to back up their members of the Team to implement the joint plan for the family.

The Steering Committee needs the ability to cut through the red tape - ensuring the criteria are tight to enter the gate to the shared 'integration' space, but once inside the gate there is a requirement of maximum flexibility at the Team level.

The senior managers on the Steering Committee have to face up to the rigidities in their own systems – the model requires them to not just have the SC role as an add-on, but to dedicate time to fix problems when time is needed. They are expected to ask if any apparent barrier is real or artificial; is it work load driven or the result of only being able to deal with crises after they occur?

The Steering Committee also has to sell the model 'up the line' of governance arrangements as well as 'down the line' to the teams so the concept of the integration model and team approach is more widely understood because it is more work - but the trade-off is that it is well suited to these complex families.

The Steering Committee role is for senior management to encourage the Team's work by being able to say 'get involved' and when there is any reluctance because of the work load, to be able to say 'tough luck, you are the lead agency'.

- Essential that all stakeholder service providers, esp. Government Organisations, have operational authority and/or time delegation to give to the process.
- As a Panel member you are a representative of your Line Manager and that implies a good quality of communication and a strong relationship. Under the existing rules and structure in Community Health the capacity for this has gradually dwindled as the structures have changed, middle managers are uncertain about their jobs and resources have become scarcer.

The senior managers have empowered the Team members to make decisions 'on the ground' and that way, once the plan is agreed with the family, the Team members do not have to keep referring up the line for permissions to bend the rules to operate under the model and have the right level of dialogue with other agencies.

So the next level of public sector management above the Team member needs to reward and motivate them in this model – which is unusual in the larger and more complex bureaucracies. So e.g. within DCS the model requires more flexibility from child protection staff beyond what is expected in KTS – and some recognition and reward for seeing that the 'integrated' plan is going to have potential for being more than the 'sum of the parts'.

The model needs permissions from above (especially in Health) to work outside the usual models and 'silos' with these families. The Panel depends on Health reps sorting out their own protocols and having a 'champion' – e.g. Domestic Violence, Women's Health and Mental Health all had to be involved in the Panel because Health is the most fragmented/complicated sector.

In Health there are many systems and separate records to bring together (CHIME, D&A, MH, ED, electronic Health Record) – it may take 2 weeks to bring the information on the family together; whereas in the Police system they can get one screen shot to cover the history of their encounters with the family.

This project comes from the 'bottom up' and has its origins in longer term local understandings at the senior management levels of the population, the southern suburbs area and the types of problems of the families in particular. It was initially proposed by Wollongong Council, so it not a 'foreign notion'. In that way it is different to centrally proposed programs like *Keep Them Safe*.

It helps to have some history and experience as well as the right level of support. In 2007 the (then Police) Superintendent got together with Wollongong City Council to put forward the idea that eventually started up in September 2009. The idea survived through two subsequent (Police) Commanders because there was experience from other places in Western NSW where there had been riots and a need for a different way of doing community-level policing.

5. Are there any benefits to you of the Panel and/or Steering Committee work in practical terms?

It is in 'testing the Government service system', tackling its rigidities and looking for its holes – it is not just about applying a set of criteria but looking closely at blockages, asking what has been tried and what didn't work and then trying again with something different.

Benefits come to the service system, not so much to the families at least in the short term, although the Coordinator reports good anecdotal evidence of satisfaction because of the work that goes into engaging the families with their plans. Their needs were not being met because of the requirements of the 'core business' side to the Government service system – and a retreat from the interagency space. We now have an expensive way to reinvent that interagency space – but with clear criteria for who gets in and what interventions are offered to them.

Every agency has their own 'boxes to tick' in terms what they might get out of engaging with SS ICM for their own 'clients', like Community Services dealing with the 0-5 year

olds, DET dealing with school age kids and Housing being concerned to resolve rental arrears with the adults in the family who are (their) clients.

The families will have been around the cycles a few times and generally have no hope, so the idea is to share the 'no hope' around in a creative and useful way - through what is agreed is a best practice model in this intersectoral space.

The interagency space gives permission for us all to talk about the risks involved around the boxes we each have to tick and how that all might be part of one plan. We are all dealing with the families in some way already, so in one sense it is not more work, just different ways of doing the job with this particular selected group.

The Panel is an extension of what we do at the complex end and one of the benefits has been to improve our contacts with the other agencies at the face to face workers' level, for example the specialists know the Community Services workers better and that generalises to our other contacts with them. We are using Illawarra Family Services and Police youth liaison more now.

The SS ICM model operates as an extension of some of the more useful prevention work we do. For example with the parents of kids in trouble we can organise compulsory attendance at a workshop where people from Area Health and *Headspace* might give a talk and offer practical advice on how to manage better, where to get help, and so on. A model that operates across the agencies at different levels under a prevention and harm minimisation framework is a benefit.

The down-side is the very intensive resource use that puts more pressure on the staff who are part of a Team. We have contacts with 7 of the families and that means 2 or 3 meetings a month for each of the SS ICM families. It takes a lot of hours out for the (staff) attending meetings and in doing the necessary follow up.

'*Networking*' the Teams is so as to get the shared understanding of the 'integration' goals and how the criteria are tight to get entry to the shared space, but once inside there is a requirement of maximum flexibility.

The Panel and the Steering Committee act as the gate keeping role for keeping to the criteria around DV and a long history of trouble. They apply the criteria so that the panel is not just responding to particular Departments' crises.

It helps to have continuity on the Panel (a quorum of 4 seems to work) so as to keep clear about the criteria and to have a 'devil's advocate' role to be able to say 'no'.

Having the additional advice on how to manage social problems like housing and finding refuge accommodation is good for the small number of families we are talking about in SS ICM. The two DV civilian staff employed through the Women's Centre now have a SS ICM channel to be engaged with the families, along with other agencies.

SS ICM has the potential to make an impact with the families, but it is hard to evaluate, especially short term. If we can keep a kid in school, then in three years his or her prospects will have to be better, but how to measure that effect is still a question for us to work on in our monitoring.

The SS ICM model implies we will recover our costs of coordination and monitoring in the longer term by each agency making 'savings' through the prevention of later problems, and that could be worked out by simple calculations on a family by family basis.

But to put it all in perspective the initial gains come from each agency working better with other agencies and the longer term outcomes for the families are what we have to be realistic about and try to look back on from later. That should work as long as we are set up for evaluation so as to be able to re-visit the families at that later time.

6. *Referral criteria and assessing the 'readiness' of the family*

The documentation covers the reasons for the referral, the recommendations and any comments on what the family needs, the services involved to date and assistance received, any 'treatment' plans, and the risks (housing, domestic violence and child safety).

The criteria are not urgency or crisis-driven per se – and should not be just about forcing agencies to provide 'more of x, y or z'. The referral has to be tested by considering the families' capacity to benefit – i.e. it may be that routine case management is still appropriate, as well as prevention in the families' issues of housing, child safety and domestic violence.

The criteria are not (too) specified as such as, the decision depends on a lot of local knowledge in the Panel in order to match the family with a Lead Agency and a Team based on what contacts (good and bad) that they have already had with the system, and their practical problems that will benefit from a SS ICM 'integrated' approach.

There is a new section on the Intake forms used for making the Panel's assessment including the 'readiness' dimension that, as well as finding out what has already been tried, asks about the family's 'capacity to benefit' from the ICM approach.

The paperwork comes in and is initially reviewed by the Coordinator to and referrer attends in person and puts up their case. Initial review is to check if the referral is out of area or does not have any DV or tenancy risks.

Referrals come from a big range of agencies and most of them have lots of families in crisis. For example the case discussed today already had 8-10 'case managers'.

The role is to inquire about what else has been tried to date with the family and to make sure the information is as complete and up to date as possible by an email round up after they are accepted by the Panel.

There has to be evidence that other approaches have been tried and haven't worked to date. If there is a way that an agency making a referral (or another agency) could have done things differently to good effect, on the Panel we are likely to push the referral back for another go at routine practice.

One decision point is to determine if the families' capacity to benefit from the model is clear and whether this is the right *timing* for offering the model to this family.

- There is an ongoing discussion about the client's readiness in the context of the entry criteria, with no parameters being completely developed as yet. The *Common Assessment Criteria Form* attempts to build in a more longitudinal view as part of the decision-making and gate-keeping on this more 'protected' interagency space.
- 'Readiness' versus compulsion is an ongoing issue where agencies may have a set of requirements that may be of an involuntary nature – court orders, probation, payment of rent or benefit arrears/debts/fines.

- (I) personally feel that referring agencies need to accept responsibility for reviewing their client's readiness and motivation for functional/behavioural change, beyond just the practical benefits such as housing.

Other aspects discussed in making Panel decisions include:

- The level of agency concern for client involvement in SSICM as a 'last resort'.
- The Panel is informed about what has already been tried before and the decision requires view there is a potential for more effective intervention through interagency involvement plus a review of the level of need, especially of the children at risk.
- ALL resident adult carers need to sign consent.
- Clients' capacity to self-manage their way around the system – this is currently expressed as 'unable to independently plan for their own needs'.

The decision making is complex and 'issues-based' and the immediate task is to accept or decline and if accepted to identify a potential Lead Agency.

Beyond the formal criteria there is also strategic thinking and planning around the family's situation and capacity to benefit to get the right mix of providers and agencies signed up on the Team level.

The strategic thinking depends on the Panel's use of its joint knowledge of the family's problems and the match to the available system/agencies' resources. The family coming to the planning meeting is where there is agreement reached on what the Team will work on.

The allocation to a Team depends on judgements made by the Panel based on who has the capacity and skills e.g. the Police and Housing are not consistent enough attendees and do not volunteer, so best for them not to be in the role of Team leaders.

This is a question about how to a Lead Agency can get a useful Plan for a particular family and involves good judgement about what will work best over a long timescale. That includes a period of intensive interventions (generally six months) through to cessation of the SS ICM role and making subsequent links for following up.

Another way of seeing it is as a period of intensive navigation support, a maintenance phase and then work on the prevention of 'relapse'.

7. What follow up and/or oversight of the case takes place?

Oversight is mainly through reporting back to the Steering Committee via the Chair and the Coordinator, plus discussions by the Coordinator of the Panel decisions with the Teams. The Coordinator communicates the Panel decisions to the Teams.

The Panel makes the decision at the entry point, after which the Team works with the family and (my perception is that) the Panel *really* finds out what is happening during formal review processes. (This is) not by the Panel in any formal sense of evaluating the results – more by feedback on progress via the Coordinator and through the Steering Committee. We do not expect to see quick outcomes for the family or a big 'mission accomplished' result.

We also have lots to learn about organising 'exit' from the SS ICM as the next step of managing the families' support back. Managing their entry back into regular business has not featured so strongly yet.

So in the SS ICM model the readiness to address the DV issues may be when the family is exited from the model due to the stability of their tenancy or the resolution of the child at risk issues, and then they may not be formally referred for DV counselling, and/or they may no longer have any real incentive to attend to those types of issues.

There are no 'controls' for the project so we can't say what might have happened without the model, so there will be a need to look at what might be useful outcome measures in the next phase.

In practical terms these points mean more attention (is needed) to 'exit' criteria and planning as well as the 'entry' criteria, especially in relation to DV:

- A plan is needed for motivating the families for change when coming *out* of the program – what will they do next when they step down to less intensive interagency involvement?
- Given DV issues are part of the core criteria we should expect to see a referral for DV work on exit. But it may be that the Lead Agency or Team does not have members who are really cognizant about DV services in the community.
- The model does need longer term follow up (e.g. 6 then 12 months after exit) of the outcomes for the families if it is going to be able to be shown to be effective at that level.
- The incentives for the family on entry as well as exit will likely be driven by practicalities like money and housing security – once these are sorted out there may be less incentive to change other things, e.g. relational dysfunction, for the longer term.

8. Skills and experience required by the Panel

Awareness of the realities of people's lives in these families – especially around the impacts of DV. A good therapeutic model is not enough. Need to have a *feeling* for the timing of the SS ICM intervention and whether this will be useful

Panel members bring knowledge of the breadth of the service system – justice, health and housing/social services – they need to know what has been tried before in order to decide whether the family needs the SS ICM level of intervention.

- Ability to talk frankly and explicitly to form a wholistic view of the family and the issues they face.
- Sound understanding of the service system government, non-government and private.
- Corporate knowledge of the way services work, relationships between agencies and an idea of where the gaps are – i.e. the Panel has identified a gap in finding good interventions/services for adolescent males and the shortage of employment options plus the problems created by incentives to keep young adults at school longer - especially with training opportunities reduced through TAFE.
- Strategic thinking and planning around the family's situation and capacity to benefit to get the right mix of providers and agencies signed up.
- Understanding of the difference between *wholistic* case management, as practised by some agencies, and *integrated* case management; i.e. wholistic case management focuses on the needs of the family (not just the individual) and seeks to facilitate the provision of coordinated services from a range of services; while integrated case management focuses on the integration of systems and disciplines to facilitate more effective and coordinated service delivery.
- Ability to be "inquisitive" as to what might work better or differently.

Appropriate delegation all the way down to the level of the Teams and individual workers is vital. (This requires) operational authority, clinical knowledge and a broader vision, including a longitudinal view, in order for there to be an effective review of this Project.

9. Skills and experience required by the Teams

The issues more relevant to the integrated case management Team, when they are drawing up the case plan, are:

- Ability to respond flexibly to a family's multiple set of needs via a form of 'informed risk taking' – i.e. being able to analyse the risks for our own organisation of taking a different approach for this small high cost segment of the clients we see.
- Understanding our own agencies' limitations and the commitment to move beyond a narrow view of our own agencies' roles.
- Knowing about the service system and how to get a broad range of interventions coordinated under an agreed structure.
- Current involvement with the family is important.
- Understanding of the SS ICM model.
- Capacity of the Lead Agency to make a plan and to allocate time – requires good support from the Coordinator and from line management.
- Capacity of the Lead Agency to coordinate and mobilise the involved Teams
- 'Readiness to change' is an issue in the selection of the families and the Team members, and to consider again on exit

The skills are broad and multi-disciplinary and similar to what we expect to happen under (the Police) *Integrated Crime Management Model*. The philosophy in this Unit is that people will have specific roles and training but also training in others' roles as well; so in youth liaison we should also know about DV and what happens in the analysis of local intelligence.

We don't see ourselves as 'case managers' in the same sense that it is used by some other human services. The approach fits with our own model. Inside the Local Area Command we identify high risk DV offenders and come up with case plans to prevent recurrent victimisation. We just don't see that as sophisticated 'case management'.

Where we can help on a Team is in the analysis of intelligence where we try to make sense of problems beyond the case by case level by looking at links and common factors. These links might be over time, like offenders' roles in multiple crimes, or by looking at particular locations where there may be opportunities for prevention by tackling environmental factors, and working with other agencies that can reduce the likelihood of crime occurring.

10. The Coordinator's role

SS ICM was fortunate in finding someone competent at working in the multi-agency space and across Government and non-government agencies. The role also benefits from familiarity with this particular set of health and social issues – it is an area that spans police and criminal justice, youth, domestic violence, mental health and drug and alcohol – so finding the right person with this mix in their background is not easy.

The Coordinator skills are not so easy to assemble in one person's role as they are about knowledge of the content area and about negotiation across the service delivery, program and policy levels.

The role needs a sophisticated understanding of the service system as well as its component agencies/departments. This is a 'high level' form of 'case management skills and the competencies are to maintain the right level of dialogue within and across the different agencies. It also needs a measure of comfort with, and understanding of, the circumstances of the families.

The Coordinator has been excellent and my perception of the role is significantly influenced by current practice. I see (them) as the 'coordinator' i.e. the central reference point for all system 'players' with capacity.

The role is to help communication between the Panel members and between the Panel and the Teams by writing up decisions and trouble-shooting the right information for making decisions and getting the Lead Agency and Team arrangements sorted out.

The Coordinator communicates between the Panel and the Steering Committee and communicates the Panel decisions to the Teams.

The Coordinator needs a clearly identified authority separate to any other 'part' (e.g. Health, JJ, Police…) of the system, and needs to use that authority to liaise with the Panel, the Lead Agency, the Teams, as well as the Steering Committee.

With the Panel the skills are a mix of administrative support, getting people together and getting the information moving in the right way, intervening at different levels as needed to sort out problems. It is like a relationships manager role across the agencies - working at the level of finding and maintaining the right links and keeping the focus on the overall strategy - using common tools and templates and explaining the model.

The role of Coordinator is to assist the Panel processes with assembling the paperwork, organising the right people to be at meetings and recording decisions and to keep the focus on the interagency space. It involves reporting up to the SC and SOG on how the Panel is going.

So the Coordinator works across the agencies at multiple levels, and it is important the role is not owned by any one of the agencies as then the role would become diluted over time - subsumed into routine other tasks and crisis management.

The Coordinator helps to maintain the commitment of the agencies to working more flexibly with the families by making sure the selection criteria are used to ensure all the agency-level strategies and useful referrals have already been tried before using the inter-agency strategies.
That means getting the history and current experiences with the family in one place to help the Panel decide whether they will benefit and whether this is the right timing for the inter-agency response.

Helping with the planning of the agencies' work and the families' problem mix; balancing the 'too hard' and 'too easy' families so as to get the maximum learning and mix of outcomes from the pilot.

- Highly self motivated, disciplined, time management skills, ability to collate and present the necessary information, ability to take this to the various meeting levels, minute taking skills to capture the depth of discussion etc.
- Skills in community development; capacity to communicate and remind; capacity to develop project parameters.
- The ability to draw out clear actions from complex meetings.
- The role needs the ability to 'not personalise' the processes – i.e. not using 'blaming'.

- Take a multi-agency 'helicopter' view that reinforces the model and its entry point criteria - plus help with the strategic thinking and planning around the family's situation and capacity to benefit from the model.
- Operate beyond the separate health worker and Departmental roles.
- Being able to follow up everything in a way that is timely and not too heavy-handed.
- The ability to build up trust with the Teams, and to have the ear of the managers, and use information to get things moving without causing friction, are all important.

11. Can the Coordinator role be built into the wider system? Can we standardise or generalise the role or replace it with something else?

This is hard. As for 'building in', the model is going to be hard to maintain against the backdrop of the different agencies' own models – and getting across that this model is for certain frequently encountered families who are the carefully selected 'exceptions', rather than for urgent cases of 'regular business' (where existing protocols should be tried, or tried again) has been a challenge.

The role of the Coordinator has be dedicated to the time required and the tasks, and be located at the 'system' level and in the interagency space. It is hard to see it working well if the role is rotated around between agencies or added on as a part of another job. In practice, if the role were to be located in one agency, then 'how can they test us out at the system level if we pay them?'

If there were no Coordinator role I don't think it would succeed. The Panel members would not be able to cover the role as it is also about working with the Lead Agency to formulate the Plan, organise Team meetings as necessary, getting consents worked out for sharing information, assisting the organisation of the exit strategy.

With the continued commitment of the Human Services senior managers' group we could keep up some of the role but would not have the authority for *all* of it, particularly in influencing other agencies' decisions. So for example we might have a duty officer doing mental health liaison in a DV case and they *could* have some influence but it would not be at the same level as in SS ICM.

Because of the skill mix needed for the pilot, instead of in a situation where it might be implemented more broadly, it will be harder to replicate the Coordinator role in routine practice.

Formalising or automating the Coordinator role too much may destroy it.

It is hard to see how it will be built in with the resources to pay for a lot of the skills that are required – as the skills are not all part of 'regular business' (except for generic social work under previous psycho-social models); they are not amenable to being paid under for under Medicare or existing programs as 'interventions'.

It would be difficult to work on a much bigger scale as the capacity to do so is not there, given the complexity of what we are managing and the differences in agency structures and boundaries and so on. The role seems about 'right' for the scale and the number of families in the model.

It is hard to see how SS ICM would work without the Coordinator role as we might then be back to dealing within the agencies on a family by family basis rather than being part of a bigger strategy.

The capacity within our agency to take on the Coordinator level of work is limited. Within our agency we have a big DV workload in the courts, evaluating cases, doing reports, referring to services, doing the victim follow-ups, plus the operational tasks and core duties of general policing. It makes sense to be part of the joint service responses and to be able to share the burdens, do common training.

The Community Health restructure has resulted in the diminishment of the 'Interagency role' which is why it has to be re-invented here through SS ICM, suggesting that the role should be able to be generalised, but with careful understanding of what makes the model work, so as not to lose the key ingredients.

- Middle management and team leader roles have been contracted back in Health, which combined with clinicians' busy caseloads means that staff has difficulty going to lots of meetings in the interagency space.
- Some agencies like Housing and Police do not see themselves as having 'case manager' roles
- The newer Health models such as in chronic care include ongoing support beyond the active phase of the program, but this is mainly about hospital avoidance, not social models of longer term prevention.

Since the restructure and as the levels of management and responsibilities have altered, the Clinical leadership of the Community Counselling Team has not been replaced. This impacts Community Health Domestic Violence services because there is no leadership to review the efficacy of interagency case management which can be time consuming and where the relevant statistical data does not always sit comfortably in the Health statistical data collection.

12. How could the model be improved?

With the higher level commitment to 'make it work' we expect to continue to get better over time. The Lead Agency and the Teams should get better at specifying the goals for the families, the Coordinator will go on improving the processes and refining the intake tools (e.g. getting better ways of explaining the criteria for referrals, understanding what we mean by capacity of the family to benefit) and the face to face workers will get better at securing the families' 'buy-in'.

We still need to explain the '*integrated* case management space' and its competencies better – how it is not the same as 'coordinated care'/coordinated case management or just better dialogue across agencies, although there are these elements involved by way of the expected results.

We expect to continue to get better over time – better at specifying the goals for the families, improving the processes and refining the tools (e.g. getting better ways of explaining the criteria for referrals, understanding what we mean by capacity of the family to benefit) and getting better at securing the families' 'buy-in'.

It is best to interpret this question about improving the process in a 'generic' as well as a 'nuts and bolts' way.

There are two different aims, one for the system and one for the clients, which may not necessarily be in accord, though the net result may be the same. Hence is the primary concern/aim the development of more effective interagency service provision OR is the main aim the improvement of client outcomes?

The managers at the next level to the workers making the referral should be involved in making the referral.

If the role is to be built into wider system there would need to be an identified project with all stakeholder agencies with a specified role and target group. Otherwise it runs the risk of getting 'lost in the complexity of need'.

Agencies have to be able to do their risk analysis so they understand what is involved for them in managing a small number of their clients 'by exception' inside the SS ICM model because it clearly can't be offered too widely or set up so that there is demand from clients for being managed this way.

So the potential for reversion to 'regular business' or the temptation to 'dump' complex or families in need of urgent interventions into the model is always there, especially with over-stretched agencies operating a lot of the time in crisis mode and without any case management function or capacity within their agency.

Can we standardise or generalise the model or replace it with something else?

This depends a lot on local circumstances, so the model works best where agencies have shared clients in the past and where there is a defined geographic area that contains agencies that understand each other's roles.

As for standardising, we are getting a more refined way of describing the entry criteria over time – fine tuning the guiding principles and the forms. The integration happens through a better fit of existing or new plans within agencies and being too standardised or prescriptive is a risk.

Once the processes are well established and documented (including outcome indicators for the families as well as the agencies) that will help generalise the model. It needs to be clearer about separating out the inter-agency aims from the client level aims – although the two areas are distinct, the model 'assumes' they are linked, i.e.
Agency Aim → Agreed Plan ← Client Aim

More explicit rules around the Area planning aspects of choosing the team members and the lead agency to match the family circumstances – e.g. is the GP counselling/ headspace/short term interventions funded by Medicare a good set of options? Is the quasi-legal area around family law and relationships counselling part of the model?

There are already training opportunities that could be used to promote the model including new programs under programs like KTS and existing agencies like the Education Centre Against Violence (http://www1.health.nsw.gov.au/ecav/).

A CALD case is yet to be involved and the model is well suited to refugees (SS ICM have had a refugee family referral but they were out of area).

Expanding the geographic area?

The SSICM model could expand to other areas with guidelines on the entry criteria, how to find a Lead Agency, consents and sharing data, how to compose a Team and make a good Plan, how to exit.

But any expansion of the geographic area is going to be hard to manage as there are so many different boundaries of teams even within Health, as well as with the other

Departments and it will take time to 'integrate' new clinicians and middle managers into the way the model works and for whom.

It would make sense to see a similar system in each of our housing 'hot spots'. There is little logic in the current boundaries and it makes sense to have more flexibility in the geographic zone for the project.

The risk in changing boundaries is in the way the different agencies are organised. So if there were one in the Southern Suburbs and one in Shellharbour, some agencies, like the Police Local Area Command, would have to cover the two areas' meetings with the same people.

The process could be made more effective and efficient over time but that would require it be fitted into an overall service system design. Costs could be reduced by expanding the model over time, but not by using more Panels - the key agencies would have to be on many Panels. Having one Panel for the larger area of the Illawarra makes sense but the focus is likely to remain on the Housing 'hotspots' within the larger area.

Building in Medicare-funded services?

Since the 2007 changes to Medicare allowing for more private counselling on referral from GPs, the assumption has been that fewer counselling resources are needed in Community Health. However the Medicare Care Plan has changed the mix of demand and Community Health counselling now looks after people who can't afford gap payments, have more complex problems and require longer term engagement.

If the pilot were to bring in more of the GP-related services, then there may be funding issues as a lot of background work goes on around the client and they cannot be expected to sign off for each service or pay gap fees.

The privatised community counselling sector is not funded for working in the interagency space and GPs can get reimbursed for a Plan, but contract counsellors are not directly funded for going to meetings and doing interagency-level work unless the 'client' is actually there and receiving therapy.

Furthermore this group of clients are likely to be frequent 'no shows' which does not fit the Medicare view of how services operate under fee for service models.

13. Measuring outcomes

'Success' is unlikely to be very evident. If we can help to keep a kid in school for two months, that might be considered success. Small steps can sometimes be big wins. In our terms it means we can be a little less crisis-driven and a bit more proactive and we are already used to having realistic expectations.

The model should be tracked over time with outcome measures for the clients/families and the agencies/departments in the longer term before we can make a call on the efficacy and effectiveness of the model.

I am not convinced that the evaluation form is able to give an effective review of the outcome for the clients/families, especially at six months. For instance, how is reduction in DV evaluated? There may be fewer Police call outs but this does not necessarily equate to less DV.

This could be addressed in practical terms by developing objective *SSICM Outcome Measures.* For example:

At the level of Client outcomes:

1. Reduced child at risk from family violence
2. Increased family functionality
3. Increased tenancy stability.

Those are different to the 'stakeholder' or Agency level of outcomes:

1. Increased and effective interagency networking and service provision
2. Enhanced continuum of care for clients where all agencies work more effectively

I'm aware that there is a subjective 'client satisfaction' process but I think we need a more objective process that gets at the actual experience of the client so we have better criteria against which the efficacy of the intensive case management is assessed.

The 6 month timeframe on assessing client outcomes may be unrealistic given the complexity of the issues. For example DV is *always* an issue in the mix of problems and therapy can't be really commenced until after the management of practical concerns is well under way, yet that generally falls outside the timeframe.

It would help to have two stages:

- The first six months would be to get most of the practical work done and interagency issues resolved, so the practical outcomes would be where the tenancy and financial issues are sorted out, arrears addressed, Centrelink issues resolved, etc.

- Therapy in a DV situation is more effective if the practical issues are not so pressing, and six months may be too short a time for dealing with the mix of issues in the families.

There are questions about where all the information goes once it is inside the SS ICM system (i.e. information from health records plus police intelligence and so on are all sensitive and not always factual) and hence there is need for ongoing review about who enters the data and where/how it will be stored on 'case closure'?

14. What is the real cost of the pilot?

We understand that the model is expensive and necessarily small scale at this stage as it has involved setting up the superstructure (SC, Panels, Teams, Coordinator roles, selection criteria, protocols and procedures and forms).

The resources needed for the 'set up period' have to come from somewhere and initially the integration work is always going to be expensive. It does not require the most senior operational people all the time but they have to show a high level of commitment and the process has to more than signing off a MOU.

The testing of the model and the learning to date is what we are paying for initially, and subsequently that learning has to be shared more widely across programs. The aim is to get the joint planning into routine practice for the small number of families who will benefit from it.

(It) will not save money – (the) costs are in wages and time for Panels and the Steering Committee.

Families getting a better outcome will save costs – but not necessarily in the short term – and for the system as a whole it may not save costs on the budgets of the agencies because other types of needs will be able to be met by the resources not being used on the particular families in the longer term.

APPENDIX 3: Themes from the Workshop Findings

This material was prepared by the Workshop facilitator and Coordinator for incorporation into the evaluation. The same headings could be used as a comparison for a second workshop in Year Two.

1. Engagement - what do we want engagement to look like in 12 months?

- Children are consistently engaged in education and that parents understand their role in establishing this pattern.
- Voluntary engagement.
- Parents in control of their responsibilities.
- Engaging father is possible and safe.
- Engaging community groups such as PCYC.
- Engagement needs role models.
- Realistic expectation for families engage strengths, not just weaknesses – ABCD style initiatives base on individuals.
- Understand client's underlying personal and family values.
- Consult with young people and find out why they find it hard to engage and what would meet their needs.

Strategies to improve engagement

- Break down teens' resistance to "systems."
- Consistency across all agencies regarding parental responsibilities.
- Find fathers first (not always on scene) – poor participation.
- Connections with employers (for adolescents to see a future as well as role models).
- Case management planning through thorough consultation with families.
- Identify client's values at the outset and invite engagement from this point onward.
- Find the gaps in services for 12-17years.

2. Process - what do we want process to look like in 12 months?

- More strength based planning, more refined assessment tool.
- Less service driven.
- Service and relationship drive with family.
- Key worker relationship working with family.
- Lead agency leads the services.
- Realistic family expectations.
- Client advocate/support person unpacks the process and what it is all going to look like to the client prior to the first meeting, aimed to prevent client shock/overload.

Strategies to improve process

- List and document client's strengths on case plan.
- Case plans individualised to meet family learning styles especially literacy issues and disabilities.
- Ask client for solution and start there.
- Give them the support that allows them to explore.
- Thorough family consultation regarding planning and case development.
- More initial training in implementing the process of the SS ICM project.

- Reflective practice forums on process issues.
- Give the client permission to say "it's enough for today" at meetings.
- Move at a slower pace – reduce family anxieties.
- Family are the primary decision makers from the beginning.
- A clear case management/therapeutic framework approach e.g. solution focussed.

3. Case management - what do we want case management to look like in 12 months?

- Local knowledge.
- Family support services.
- Advocacy skills – engagement skills.
- Strong commitment to achieve identified family outcomes.
- Planned and flexible.
- Realistic.
- Working together in this way becomes more common.
- Case management is intensive and takes a lot of time and resources and should extend beyond 6 months.
- Consistent team members.
- Core skills of lead agency to case manage.

Strategies to improve case management

- Good communication that is open and reflective.
- Autonomous.
- Brokerage component.
- Each agency experiences ICM.
- Regular team meetings.
- Being able to navigate through own services.
- Build relationship with client.
- Lead agency should have capacity to case manage.
- Complex case management practice supported at managerial level.

4. Teams - what do we want good teams to look like in 12 months?

- Holistic decision makers rather than operational.
- Consistency amongst workers, agencies, attendance, accountability and responsibility.
- Minute taking at team meetings – information provided quickly after the meetings.
- Ongoing electronic communication between meetings with all group members.
- Consistency with lead agency.
- Government agencies to deliver, be accountable, have the same KPIs.
- Education on how issues are perceived differently for different agencies.
- Senior management representation on steering committee.

Strategies to achieve a good team

- People who have contact with the family.
- Managerial commitment.
- All team members committed to the process.
- Social/welfare background (complex needs).
- Balance of specific skills, expertise and power.
- Lead agency has case management skills.
- Follow through on agreements.

- Team members challenge each other's practice and have "hard conversations."
- Attendance at all meetings.
- Open and regular communication between team members.
- Feedback to own agency to reflect on practice changes needed.

5. Training/resourcing needs - what do we want training/resourcing to look like in 12 months?

- Case Management subject through Charles Sturt University.
- More money in drug and alcohol services in Health, no increase in budget since 1999 and therefore little capacity to improve.
- No point in one off training.
- Need money for integrated training which might look like – practice forums, action research processes, local. Must include managers.
- How to engage boys and fathers.
- Advice from experts on how to engage teens who are resistant to "systems", i.e. how can we engage them when they do not want to work in the process in the way that it is offered.
- Training in a clear philosophical/therapeutic approach to client engagement and case management.

Strategies to improve training/resources

- Trauma informed decision making.
- Local or ECAV training in complex trauma links across services.
- Forums where managers workshop specific issues raised in first 6 months of SS ICM.
- Regular training – practice forums beyond 6 months.
- Reflective practice model added to SS ICM – teams training together as well as practicing together.
- Managers who are informed, sensitive, flexible decision makers 'Risk Takers" in spite of agency imposed constraints and supported to be so.
- Ongoing commitment (ICM) to engage with all agencies and educate and consult with government and non government in both short and long term engagements.
- Middle management responsiveness to complexities of clients.
- Services should be tailored to the client not the agency.
- Flexible within policies.

CLOSE

The focus is initially on the Southern Suburbs of Wollongong, but the project holds the potential to more broadly influence the way the human services agencies in the Illawarra work together. It therefore represents an opportunity to make a practical investment in future service delivery systems change.

This workshop was part of the broader evaluation to occur for the project which includes ongoing monitoring and then formal evaluation by the Co-ordinator and formal evaluation by the external evaluators on behalf of the Steering Committee and Regional senior human service managers.

APPENDIX 4: Outline of Evaluation Requirements in Year Two

It is important that the evaluation remain relatively simple and that it operate at two levels; the families and the interagency processes.

Family outcomes

To address the family level of outcomes the Coordinator can assist the Teams to document their goals in measurable terms and engaging the Team members in assessing goal attainment. A process of evaluation based on the use of the goals in the case plan would be a practical way to examine family level outcomes. The routine use of more standardised assessment information at the intake point can include the family's goals and these are the basis for outcome measurement tailored to each family's mix of goals.

The project should examine practical ways of monitoring and following up the families who have exited after 6 months to see if the SS ICM intervention was perceived as being helpful to them. To be reliable, this direct engagement with the families at a later date, asking them to look back on their experience, would need to be independent of the project's participating agencies or the Coordinator. This also opens up opportunities for more sophisticated and valid outcome measurement.

Interagency outcomes

The interagency level of evaluation has been organised under the model's three components: the Steering Committee, the Panel and the Teams.

The online survey could be modified to also be administered to the Panel members as well as the Steering Committee and this would replace the extensive (and time-intensive) interviewing method undertaken in the Year One evaluation. Its aim is to be diagnostic of any problems or difficulties for the agencies if the information can be fed back in a non-judgemental and timely way.

The key questions are:
1. How well do you think that your agency works with …? Where the categories are: works closely with; occasionally works with; does not work with at all; not sure. This information can contribute to building an 'index' of the strength of the different interagency relationships and how they may change over time.
2. Did you find that this (Steering Committee or Panel) meeting was: very useful; somewhat useful; a waste of time. Are there any comments that you would like to make about this meeting?

The workshop with the Teams was a useful, essentially qualitative, way of gaining their perspective on the strengths and weaknesses of the model and the functioning of its processes to date. The second year focus was suggested as allowing more time for understanding and proposing ways of fixing problems.

The final level of reporting on the project is the summary statements that are used to go 'up' to the Department of Premier and Cabinet to fit into the Regional Coordination Program's template used to inform the Senior Officers and Departmental Heads about SS ICM as an example of a *Headline Initiative*. As the project matures or if it expands its use of resources, this level may require more 'hard data' as well as primarily descriptive material to explain its achievements.