



Final Report

How integrated are homelessness, mental health and drug and alcohol services in Australia?

authored by

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CONTENTS

LIST OF TABLES	V
LIST OF FIGURES	VI
ACRONYMS	VII
EXECUTIVE SUMMARY	1
1 INTRODUCTION	8
2 LITERATURE REVIEW	14
2.1 What is integration?	14
2.2 A typology of integration: construct	15
2.3 Measuring integration.....	18
2.4 Drivers and enablers of integration.....	21
2.5 Summary	22
3 RESEARCH METHODOLOGY.....	23
3.1 Sites.....	23
3.1.1 Victoria.....	23
3.1.2 Western Australia.....	24
3.1.3 New South Wales	24
3.2 Methods.....	25
3.2.1 Key stakeholder interviews	25
3.2.2 Case studies	26
3.2.3 The Integration Survey.....	26
3.3 Participants	29
3.3.1 Key stakeholder interviews	29
3.3.2 Case studies	29
3.3.3 The Integration Survey.....	29
3.4 Summary	32
4 UNDERSTANDINGS OF INTEGRATION	40
4.1 System and service integration	40
4.1.1 Coordinated networks	40
4.1.2 Connectedness.....	42
4.1.3 Client centred.....	43
4.1.4 Extension of professional boundaries.....	44
4.2 The serviceableness of integration.....	45
4.3 Summary	46
5 THE STRUCTURE AND FUNCTIONING OF INTEGRATION	47
5.1 Structure of integration.....	47
5.1.1 Extent of integration	47
5.1.2 Scope of integration	49
5.1.3 Depth of integration.....	54
5.2 Functioning of integration.....	61
5.2.1 Quality of the network	61

5.2.2	Participant perceptions	64
5.2.3	Critical ingredients for integration.....	65
5.3	Summary	71
6	CLIENT EXPERIENCES OF SERVICE INTEGRATION	73
6.1	Clients' views on the importance of integration.....	73
6.2	Client-level indicators of integration.....	75
6.2.1	Case management.....	75
6.2.2	Awareness of need	76
6.2.3	Care coordination.....	77
6.2.4	Duplicate information	77
6.3	Client access to services.....	77
6.3.1	Findings from the Integration Survey.....	77
6.3.2	Findings from interviews with case study participants	81
6.4	Client outcomes	84
6.4.1	Findings from the Integration Survey.....	84
6.4.2	Findings from interviews with case study participants	84
6.5	Summary	88
7	EVALUATING THE INTEGRATED SERVICE DELIVERY APPROACH	89
8	SUMMARY AND POLICY DISCUSSION.....	94
	REFERENCES	98
	APPENDIX 1: CASE STUDIES	102
A1.1	Homelessness Case Study (NSW): the Haymarket Foundation	103
A1.3	Health Case Study (NSW): the Homeless Health Service	107
	APPENDIX 2: CONGRUENCE AND RECIPROCITY	109
A2.1	Congruence	109
A2.2	Reciprocity	111

LIST OF TABLES

Table 1: Kodner and Spreeuwenberg (2002) Continuum of integrated care strategies	17
Table 2: Measures included in the <i>Integration Survey</i>	27
Table 3: Stakeholder profile, key stakeholder interviews	33
Table 4: Agency profile, case studies	34
Table 5: Number of participating agencies and services in the <i>Integration Survey</i>	34
Table 6: Agencies in the <i>Integration Survey</i> , by sources of funding and area of specialisation	35
Table 7: Services in the <i>Integration Survey</i> , by area of specialisation by assistance provided, funding sources, target population, service size and mean episode of care.....	36
Table 8: Characteristics of client participants, stratified by service domain.....	38
Table 9: Extent of integration scores for both observed and expected integration	55
Table 10: Indicators for level of service integration scores	55
Table 11: Total observed and expected levels of depth of integration by specialist homelessness, mental health and drug and alcohol services within the outer eastern metropolitan region of Melbourne	59
Table 12: Total observed and expected levels of depth of integration by specialist homelessness, mental health and drug and alcohol services within the City and South East Corridor region of Perth	60
Table 13: Dimensions of the Weiss Partnership Synergy Self-Assessment Tool.....	62
Table 14: Average partnership synergy dimension scores for Melbourne.....	63
Table 15: Average partnership synergy dimension scores for Perth: total group and total service domains	63
Table 16: Average satisfaction with participation scores for service participants, stratified by service domain.....	64
Table 17: Critical ingredients for integration	70
Table 18: Indicators of client integration measured in the <i>Integration Survey</i>	76
Table 19: Difficulties with access for total group and total service domains	78
Table 20: Difficulties with access for total group and service domains within Perth sample	79
Table 21: Difficulties with access for total group and service domains within Melbourne sample	81
Table 22: Comparison scores for benefits and drawbacks of participation among service participants	89
Table A1: Ingredients of integration: the Haymarket Foundation	103
Table A2: Ingredients of integration: Moreland Hall	105
Table A3: Ingredients of integration: the Homeless Health Service	107

LIST OF FIGURES

Figure 1: Keast et al.'s (2007) integration continuum.....	16
Figure 2: Ahgren and Axelsson's integration continuum.....	16
Figure 3: Adaptation of Browne, Kingston, Gridisa and Markle-Reid's (2007) model of 'Dimensions of Human Service Network Integration'	20
Figure 4: Extent of integration considered in the present study	48
Figure 5: Types of homelessness support provided by participating agencies, stratified by jurisdiction	51
Figure 6: Types of drug and alcohol support provided by participating agencies, stratified by jurisdiction.....	52
Figure 7: Types of mental health support provided by participating agencies, stratified by jurisdiction	53
Figure 8: Decision-making dimension scores stratified by study site	65
Figure 9: Frequency with which critical ingredients of integration are present across all service domains	67
Figure 10: Frequency with which critical ingredients of integration are present in partnerships with homelessness services	67
Figure 11: Frequency with which critical ingredients of integration are present in partnerships with housing services.....	68
Figure 12: Frequency with which critical ingredients of integration are present in partnerships with mental health services.....	68
Figure 13: Frequency with which critical ingredients of integration are present in partnerships with drug and alcohol services.....	69
Figure 14: Degree of importance placed on information sharing by client participants of the <i>Integration Survey</i>	74
Figure 15: Degree of importance placed on care coordination by client participants of the <i>Integration Survey</i>	75
Figure 16: Proportion of service participants reporting different benefits of participation, stratified by service domain.....	90
Figure 17: Proportion of service participants reporting different drawbacks to participation, stratified by service domain.....	91
Figure 18: Benefits and drawbacks to integration articulated by service participants in the <i>Integration Survey</i>	92
 Figure A1: The Haymarket Foundation (2009)	 104
Figure A2: Moreland Hall (2011)	106
Figure A3: Homelessness Health Service, St Vincent's Health Network (2011)	108

ACRONYMS

ANOVA	Analysis of Variance
AOD	Alcohol and Other Drugs
ATSI	Aboriginal and Torres Strait Islander
CALD	Culturally and Linguistically Diverse
CBD	Central Business District
CEO	Chief Executive Officer
CTOs	Community Treatment Orders
DoCS	Department of Community Services
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
LHN	Local Hospital Network (NSW)
MHDAO	Mental Health and Drug and Alcohol Office (NSW)
MOU	Memorandum of Understanding
NCADA	National Campaign Against Drug Abuse
NDS	National Drug Strategy
NGO	Non-Government Organisation
NSW	New South Wales
NT	Northern Territory
OEMHSA	Outer East Mental Health Service Area (Victoria)
PDRSS	Psychiatric Disability Rehabilitation and Support Services
QLD	Queensland
SA	South Australia
SAAP	Supported Accommodation Assistance Program
SHS	Specialist Homeless Services
VIC	Victoria
WA	Western Australia

EXECUTIVE SUMMARY

Aims and objectives

The homelessness, drug and alcohol, and mental health service systems are separate service structures in Australia. They have their own unique funding and governance arrangements and work in separate domains. The homelessness service system fits largely within a community services support framework, while drug and alcohol, and mental health services are embedded within their respective health systems.

Despite the fact that the homelessness, drug and alcohol, and mental health service systems are separate, they share many of the same clients and address similar problems among clients. Homelessness services, for example, provide support to clients who also have drug and alcohol, and mental health needs. Therefore, the homelessness, drug and alcohol, and mental health service systems interact. Service integration and effective working relationships between services across the homelessness, drug and alcohol, and mental health systems is, *a priori*, critical in achieving good outcomes for clients wherever they may be located.

Service integration has become a point of policy focus in recent years. Despite the focus on systems and service integration in the present policy environment and among practitioners, there has been no study, as far as we are aware, of the integration of homelessness, drug and alcohol, and mental health services in Australia that also considers the perspective of clients.

This study aims to fill this critical gap in the literature. The purpose of the present study is to increase our understanding of the extent and ways in which homelessness, drug and alcohol, and mental health services are working together to provide services to clients with particular emphasis on the needs of homeless people. The study also considers the barriers, costs and benefits of service integration and the perceived effectiveness of various integrated service delivery responses. It focuses at both the service level and at the level of the client and addresses the question as to client perceptions of the integration of services and the effectiveness of the services they are receiving.

The study addresses six research questions.

1. What do we mean by the term 'service integration'? What models and typologies of 'service integration' have been advanced in the existing literature?
2. How do key policy and practice stakeholders in the homelessness, drug and alcohol, and mental health sectors in Australia define 'service integration' and its role in the delivery of services to clients?
3. What is the current structure and functioning of service integration in selected networks within the homelessness, drug and alcohol and mental health sectors? How does the practice of service integration in Australia compare with the existing models?
4. What do clients and the practitioners who work with them, tell us about clients' experiences of service integration and coordinated care within the homelessness, drug and alcohol, and mental health sectors?
5. What are the views of homelessness, drug and alcohol, and mental health services about the pros and cons of service integration and its overall effectiveness, particularly in relation to the delivery of services for homeless people?

6. In what ways can the findings of this study inform the development of policy with respect to service integration and the practice of integrated service delivery for homeless people?

Research methodology

Our study is a cross-sectional, mixed methods study. It comprises three components: interviews with key stakeholders; case studies of specialist homelessness and health services; and, a multi-level survey (the *Integration Survey*) of specialist homelessness, drug and alcohol, and mental health services, the agencies they operate from and the clients they assist.

The study was conducted across three capital cities: Perth, WA; Melbourne, VIC; and Sydney, NSW to ensure that findings were not specific to one particular jurisdictional setting. The structure of the health and community service systems is largely determined at the State/Territory level despite the significant role the Australian Government plays in funding these systems. As outlined in the study's Positioning Paper (Flatau et al. 2010), structural forces are an important driver of integration (Williams & Sullivan, 2009).

Clients

The ultimate goal of a well-integrated service system is better client outcomes. It is common for clients to have a range of needs that require support from service providers from multiple systems or agencies. For example, clients presenting with homelessness and housing needs may also have drug and alcohol issues and/or require additional support with mental health issues. Likewise, clients of drug and alcohol and mental health services may have needs in relation to shelter and permanent housing. Clients from the three separate domains of service delivery: homelessness; drug and alcohol; and mental health services were asked to participate in the study in order to ascertain their experiences and attitudes toward service integration within the chosen geographical area.

Key stakeholder interviews

Interviews were conducted with 25 key stakeholders at both the Commonwealth and state level holding prominent policy and practitioner positions in WA, Victoria and NSW across the homelessness, drug and alcohol, and mental health service systems. These interviews aimed to document:

- The policy environment, including any whole-of-government approaches, at both the federal and state/territory levels in respect to the delivery of homelessness, drug and alcohol, and mental health.
- Stakeholder perceptions of integration—what it means, how it can be operationalised and implemented, and the benefits and costs of integration.

Case studies

Case studies were conducted in Melbourne, Perth and Sydney and aimed at developing an understanding of how integration is being implemented at the local level, focusing on responses that agencies themselves have developed to meet client need.

Interviews were semi-structured and included the following discussion prompts:

- Description of service/program and how it is linked into the broader organisational structure.
- Target client group and definition of client success.

- Integration mechanisms/strategies employed and the impact of these strategies on successful client outcomes.
- Linkages and partnerships with external services/agencies.
- Factors that facilitate and impede effective integration.
- Funding sources and reporting requirements.

The Integration Survey

The *Integration Survey* is a unique multi-level survey comprising an organisational or agency instrument, a service instrument and a client instrument. The *Integration Survey* covers all topic areas in the study with a particular emphasis on mapping the degree of integration that currently exists between agencies that provide homelessness, drug and alcohol, and mental health services within specified localities in Perth and Melbourne as well as gathering client-based data of relevance to the study. (We also attempted to implement the study in Sydney but faced a number of hurdles in doing so.) Measures used in the *Integration Survey* include a number developed in previous studies of integration such as the *Partnership Self-Assessment Tool* (Weiss et al. 2002) and the *Integration of Human Services Measure* (Browne et al. 2007) as well as others developed specifically for the present study.

The area chosen to conduct the *Integration Survey* in Perth was from central Perth through to what is referred to as the South-East Corridor. This is an area of high concentration of clients of homelessness services (particularly inner Perth) but also of drug and alcohol, and mental health services. The Perth site was chosen as representing a typical area in which homelessness, drug and alcohol, and mental health services operate in Australia. It is also typical in that services work together, follow protocols of engagement that exist in relation to different service systems and exist in a policy and practice environment that seeks greater integration, but do not operate within a formal integrated network entity.

The chosen Melbourne area was a more 'typical' suburban area of outer eastern Melbourne. This is an area of growing need but not an area of concentrated homelessness services. The area includes a large well-established single, multi-function agency, which developed as an integration response. Hence, the Melbourne site has a more structured network design. There is no sense in which the two regions, Perth and Melbourne, are comparable. Indeed, they represent intentionally quite different sites of analysis.

Key research findings

A typology of integration

Integration involves 'joint working' in one form or another and this can range from loose collaborative arrangements around referral of clients and good communication between staff in different organisations to coordinated delivery of services and full integration where the resources of different organisational units are pooled in order to create a new organisation.

Integration can be developed on a system-wide basis and be centrally funded and managed (system-level integration) or be generated at a service level involving the coordinated delivery of individual services within and/or across different sectors (service-level integration). It may also occur within agencies (vertical integration) or between agencies (horizontal integration) and involve a broad range of stakeholders including users, frontline providers, managers and policymakers. Ultimately, system-level integration and service integration is a means to the intermediate objective of

greater client integration (a seamless service system as perceived by clients of services) and the final end of improved client outcomes.

A typology of integration entails structural, functioning and output dimensions. In this study, we adapt the typology and associated measurement framework presented in Browne et al. (2007). We place particular focus on the clients of services and their perceptions of the effectiveness of services in meeting their needs in a timely and seamless fashion and the views of services managers as to the benefits, costs and barriers of service integration and their views as to the effectiveness of integration practices.

From stakeholder interviews and case studies, there were some differences between policy and practice stakeholders in how they perceived integration. For example, policy stakeholders placed a greater emphasis on particular models of integration. In contrast, practice stakeholders had a greater sensibility about integration as a means to an end—that is, using whatever strategies enabled them to achieve connectedness with other services and to meet the needs of their clients.

The structure and functioning of integration

Based on the *Integration Survey*, specialist homelessness, drug and alcohol and mental health services are all providing support in domains other than their direct area of specialisation. Evidence of such support suggests a degree of internal integration within the relevant agency, what we have termed vertical integration. For example, 40 per cent of specialist homelessness services provide mental health services and 35 per cent also provide drug and alcohol support.

We measured the depth of integration in the specified geographical areas using Browne's *Integration of Human Services Network Measure* (Browne et al. 2007). On a scale from no integration through to excellent integration, Melbourne service managers reported a good level of interaction, joint planning and communication between services across the defined geographical area consistent with an active program of communication and information sharing. In Perth, services reported a lower, moderate level of integration consistent with high levels of awareness but not active communication. In both cases, expected (or desired) depth of integration scores are somewhat higher than actual levels of integration indicating that service managers wish to raise the level of integration between services across the relevant regions but not dramatically so.

However, in both the Perth and Melbourne sites, both actual and desired levels of integration fall short of the two highest levels of integration, namely, cooperation and collaboration. Cooperation involves services across the region having an active program of communication and information sharing, while collaboration involves services working closely with each other to guide and modify their own service planning. The evidence suggests that services want to cooperate and collaborate with each other much more closely than they currently do in a given geographical area, but at the same time they are placing limits on the degree to which they integrate as well. There is no appetite apparently for generalised deep integration across all services in a region.

In addition to examining the depth of integration in the context of a given geographical region, we also examined the extent to which individual services experienced the highest level of integration of collaboration (a depth of integration score of 4 out of 4) with at least one service in the region of interest. The vast majority of services in both Perth and Melbourne do have collaborative relationships with one other service in the same geographical region. In the Perth sample, for example, three quarters of all services reported having a strong collaborative relationship with at least one other

service in another domain. In the Perth sample, 55 per cent of homelessness services had at least one collaborative relationship with another service included in the sample. However, 40 per cent had a collaborative relationship with at least one drug and alcohol service and none had collaborative relationships with mental health services. Strong integrated relationships with other services are more likely with services in own sector domains than with other services. The challenge posed by this evidence is to establish strong inter-sectoral integration among a network of services in different domains.

Services in both Perth and Melbourne who engaged in formal partnerships reported relatively high scores across the various domains of synergy, leadership, partnership efficiency, administration and management and resources. However, services generally reported relatively low scores across critical ingredients of integration thought to be important for success in sustaining and developing service integration arrangements. Across the domains of sharing and participation between services; client referrals; relationships between staff; and, inter-agency functioning, services were more likely to respond that they *never* engage in the practices outlined and least likely to respond that they *always* engage in these practices.

Client integration

This report provides findings from the *Integration Survey* on the views of clients on forms of service integration practice and their experience of integration in the service system using a set of measures of client integration. Client-level integration focuses on the experiences and perceptions of clients as to whether they face a seamless system of care and support in which needs are met, irrespective of who provides assistance to them. Client integration can be conceptualised in one of two ways: (1) how clients *perceive* the service system, and whether it works seamlessly in their eyes to meet their needs in a timely appropriate fashion; and (2) how clients *experience* the service system, and whether it works seamlessly in actual practice to meet their needs in a timely appropriate fashion.

In order to measure client integration, we assess the correlation between a given client integration indicator and the extent to which the service is integrated with other services using the service depth of integration score (Browne et al. 2004). The chapter also provides insights from interviews with case study and stakeholder participants on the impact of service integration on client outcomes.

The majority of client participants from the *Integration Survey* indicated that both information sharing and care coordination between services was very important. This was particularly the case for clients of specialist mental health services.

Clients from more integrated services (using the Browne depth of integration measure) were generally more likely to report positive outcomes across a range of client integration measures than were clients of less integrated services. For example, across all sector domains, clients of more integrated services were more likely to have a case manager than clients from less integrated services. Given the importance of case management for supporting clients with complex needs to access relevant services, this suggests that more integrated services can provide a more seamless approach to service delivery.

Clients from more integrated homelessness services reported that the relevant service was directly helping them with their mental health needs. In contrast, clients from drug and alcohol services with lower levels of integration were more likely to report that they had not told the service about their homelessness problems, or the service had not asked and therefore did not know. Clients from more integrated homelessness

services were also more likely to report that providers of different services have frequently worked together to coordinate their care over the past three months.

Clients listed the following key problems in accessing help for housing, mental health and/or drug and alcohol problems: long waiting lists, lack of knowledge of how to access a service, difficulty in negotiating the service system, limited access to transport, and lack of coordination of services.

Benefits and costs of integration

Do services overall see a net benefit from participating with other services in the delivery of support to clients? The broad answer is that, in the main, service participants perceived the benefits of participation exceeded the drawbacks and this was true for each of the separate service domains. The key benefits from greater participation, as perceived by service managers, was that services felt that they were able to have a greater impact than they could on their own, make a contribution to the community, meet the needs of clients better, develop valuable relationships, and acquire useful knowledge about services, programs, or people in the community. Nevertheless, services do report drawbacks from integration including less organisational flexibility, loss of organisational identity, time involved and they believe that clients prefer more specialist services.

Policy implications

Service integration has been a major plank of Australian policy discussions and settings in all jurisdictions in Australia. The White Paper: *The Road Home* and subsequent homelessness plans implemented by state and territory jurisdictions refer to the importance of service integration in achieving an end to homelessness for clients. A similar focus on service integration is evident in the mental health and drug and alcohol domains.

Based on the findings of this report, there are a number of issues that can be identified as relevant for consideration in future policy and by services themselves.

The most important conclusion to be drawn from the study from a policy perspective is that there is a desire on the part of both clients and service managers for greater levels of service integration and that service integration is associated with improved client integration. What this means is that there is significant support for the broad service integration agenda on the part of clients and services, the two 'actors' that matter the most.

However, beyond this there are significant implications of the findings as to the form that service integration should take and its extent and the role governments may play in supporting integration.

First, it is clear that some agencies have themselves expanded the range of services they provide so that integrated responses may come from within, rather than between, agencies. In other words, integrated care, provided by a single agency with multiple service functions, may prove particularly effective. Moreover, the majority of services have developed close collaborative relationships with at least one other service and so bottom-up attempts at service integration are flourishing. At the same time, there were some services who did not have a collaborative relationship and there was greater likelihood of collaboration within the same service domain than with services in other domains. The evidence from the *Integration Survey* is that these close collaborative relationships and formal partnerships are producing positive net benefits such as, for example, having a greater impact than they could have on their own and an enhanced ability to meet the needs of clients.

Second, while services wish to increase levels of integration across a broad set of services in a region they actually wish to do so while still clearly retaining their independence. Services report that they do not want to integrate to the point of extinguishing complete control over their own areas of service delivery. There are limits to desired integration and these limits should be recognised in government thinking and initiatives.

Third, service integration is highest between services in the same domain rather than between services in different domains. Governments and peak bodies may play a role in increasing connections between different service domains. The profile of clients in the three service domains examined indicates significant overlap in terms of need and hence there is a requirement for greater cross-sectoral dialogue.

Fourth, despite the fact that services perceive a net benefit from service integration services identified a number of issues around governance and resource support. The role of systems-level integration, the support of government and the funding of the additional resource costs of integration as well as the role of government health providers in integrated frameworks need to be considered. The resource implications and potential issues surrounding the leadership of the network and the autonomy of individual services and agencies also need to be considered as services consider more structured relationships.

Fifth, the evidence presented in terms of the functioning of integration suggests that integration practices remain relatively thin around the practices of sharing of information, relationships between staff in different services and so on and may need support to strengthen them before they are effective.

This study has only touched briefly on the question of the impact of integration on client outcomes and there remains a significant research agenda ahead before a more definitive assessment of client impact is possible. Both service providers and clients alike believe that it is important to strive for a collaborative and integrated model of service delivery. However, as many clients still report barriers to accessing services, including cost, long waiting lists and difficulties negotiating the service system, it is evident that further service delivery improvement and research in this area is needed. Organisational mechanisms need to be in place to support service providers in their pursuit of service integration, particularly in the area of providing direction around how to engage in client information sharing with other service providers.

Future research directions may include a deeper investigation of effective models of integration for homeless clients in other Australian regions, especially in relation to improved client outcomes. Identifying existing structural mechanisms within networks that assist with the sharing of protocols, policies and client-care plans in order to meet the needs of homeless clients and improve client outcomes would be of benefit to the continued growth in integration practices in the period ahead.

1 INTRODUCTION

The homelessness, drug and alcohol, and mental health systems are separate service systems in Australia. They have their own funding and governance arrangements and work in separate domains. Homelessness services operate within the community services sector, while alcohol and drug services and mental health services are funded and managed largely within the Australian health system. Nevertheless, despite these separate funding and management arrangements, all three sectors share many of the same clients and addresses and, in many cases, similar problems among their clients. It is this essential fact of an intersection in both clients and client needs across the three service domains that provides the underlying ground for greater collaboration between services across the homelessness, drug and alcohol, and mental health systems.

The significant co-occurrence of substance use disorders and (other) mental health disorders (co-morbidity) has been the subject of an extensive international research literature and of major Australian health initiatives (e.g., see Teesson & Proudfoot 2003; Kessler 2004; Compton et al. 2005; Conway et al. 2006).¹ However, it is the prevalence of substance use disorders, together with co-morbidity of substance use disorders and other mental health disorders among those who are homeless that is the key interest for us. The prevalence of co-morbidity in the homeless population is significantly higher than it is for the general population. This finding applies equally in Australia as in other countries and across different time periods and different homeless sub-populations (see, e.g., Koegel et al. 1988; Fischer & Breakey 1991; Jablensky et al. 1999; Teesson et al. 2000; Herrman et al. 2004; Teeson et al. 2004; Fazel et al. 2008; Flatau et al. 2010, 2012).

In an environment of co-morbidity of drug and alcohol and other mental health disorders and a link between homelessness and such co-morbidity, there is a strong, *a priori*, case for close collaboration between services in these three service systems. The aim of service integration—defined for the present as simply services working together to achieve common goals—is to provide a seamless system of support and flexible care for clients, with an ultimate objective of improving client outcomes relative to those that would prevail in an independent service delivery system—one in which services work independently of each other. An independent or autonomous service delivery system is unlikely to be able to address the needs of homeless people with multiple, high and long-standing needs (see Flatau et al. 2010 for further discussion).

The *a priori* argument in favour of service integration of homelessness, drug and alcohol and mental health services is a very strong one based as it is around the co-occurrence of substance use disorders and other mental health disorders among the homeless population. However, despite this, there is no guarantee that an integrated

¹ The National Co-morbidity Initiative, launched in 2000, responded to the growing evidence of co-morbidity of substance use disorders and other mental health disorders and was allocated \$17.9 million over seven years from 2003–04 to 2009–10 with the specific aim of improving service coordination and treatment outcomes for people with co-existing mental health and substance use disorders. The initiative focused on the following priority areas: (1) raising awareness of co-morbidity among clinicians/health workers and promoting examples of good practice resources/models; (2) providing support to general practitioners and other health workers to improve treatment outcomes for co-morbid clients; (3) facilitating resources and information for consumers; and (4) improving data systems and collection methods within the mental health and AOD sectors to manage co-morbidity more effectively. The rationale for the National Co-morbidity Initiative, that co-morbidity is the norm rather than the exception, is now well recognised. However, explicit attention to issues around housing and homelessness were not directly addressed in the initiative.

service system will produce better outcomes for clients than a largely autonomous system. The costs of integration may outweigh the benefits.

There are three aspects of the cost factor to take into account. First, integration involves higher transaction costs between services than would otherwise be the case brought about by the process of collaboration between separate organisations.² Second, services build up their own skill, knowledge and network specialisations. Integration may reduce the effectiveness of service delivery if it damages the accumulation of skill and knowledge among services and the benefits derived from skill specialisation.³ Third, potential governance issues arise with the integration of services: Who takes the lead in an integrated network? Are partnerships sustainable in the presence of possible free rider effects? Free-rider effects arise when members of an integrated team gain the benefits of integration without putting commensurate effort into developing and sustaining the partnership. Fourth, integration can result in a dilution of the autonomy and blur the uniqueness of individual services. This can have adverse impacts on service outcomes when staff in agencies have invested much in the development of the agency and have an attachment to it. Finally, service integration may create privacy issues for clients given the sharing of information and data that arises in an integrated service delivery framework.

Given the pros and cons of service integration, more research is needed to build the evidence base on how these countervailing forces play out in organisations and what the overall impact of service integration is on the effectiveness of services. However, there is a limited literature on the integration of services in the homelessness domain. For example, the only Australian study, which examines the issue of service integration in the homelessness domain using quantitative measures, is that of Keast et al. (2008), which examined integration among homelessness services in Queensland and mapped linkages between agencies based on shared resources, shared planning and programming, and shared referrals.⁴

The purpose of the present study is to increase our understanding of the extent and ways in which homelessness, drug and alcohol, and mental health services work together to provide services to homeless people. The study also considers the barriers, costs and benefits of service integration and the perceived effectiveness of various integrated service delivery responses. One of the important features of the present study is that it focuses at both the service level and at the level of the client and addresses client perceptions of the effectiveness of the services they are receiving, given their various needs.

The term integration is used in this study to cover all forms of working together, service linkage, cooperation, coordination, collaboration and partnership. We focus at the level of services in this study but do not lose sight of the critical importance of systems-level integration. *System-level integration* involves cross-sectoral and jurisdiction-level interventions, which bring together services from different support systems under purpose-built, centrally funded and managed, coordinated programs of support. *Service-level integration*, on the other hand, involves the coordinated delivery of individual services across different sectors irrespective of whether or not the

² Interestingly, such transaction costs can be reduced through the strongest form of integration, namely, direct merger of the separate organisations.

³ However, service integration may add to improved service effectiveness if knowledge is efficiently transferred between organisations.

⁴ The Keast et al. (2008) study differs from the present study in that it considers a narrower set of dimensions of integration using measures drawn from network analysis and focuses solely on the homelessness sector and not across the homelessness, drug and alcohol and mental health domains as in the present work.

coordination which occurs is part of a purpose-built, system-wide integrated service delivery program or reflects the actions of individual services working together at the local level.

Beyond the distinction between system and service level integration, it is also important to distinguish between vertical and horizontal integration. *Vertical integration* refers to the integration of services performing different functions within the same organisation or agency, while *horizontal integration* refers to the integration of services across agencies.

A critical point of focus in the present study is that we are concerned with how clients themselves see the service system. As such, we follow Mares et al. (2008) in focusing attention on *client-level integration*, a client-centred approach to integration.⁵ Client-level integration focuses on the experiences and perceptions of clients as to whether they face a seamless system of care and support in which needs are met, irrespective of who provides assistance to them. Client integration can be conceptualised in one of two ways: (1) how clients *perceive* the service system, and whether it works seamlessly *in their eyes* to meet their needs in a timely appropriate fashion; and (2) how clients *experience* the service system, and whether it works seamlessly *in actual practice* to meet their needs in a timely appropriate fashion.

The intended outcome of systems and service level integration is improved client-level integration, and the intended outcome of enhanced client-level integration is improved client outcomes. While an analysis of client outcomes is beyond the scope of the present study, we will investigate linkages between the depth of service integration and perceptions of clients in terms of the effectiveness of services provided to them given their needs.

Integration can be conceptualised in terms of its structure, functioning, and effectiveness (Browne et al. 2007). In Browne et al.'s (2007) framework, which we have found particularly helpful, the structure of integration reflects the number of sectors involved in the network (extent of integration), the number of service types or forms of assistance within the network ('scope'), and the degree of exchange among individual services ('depth'). The functioning of integration refers to the quality of networks and the critical ingredients for effective integration in the selected networks. The quality of a network is a function of synergy, leadership, efficiency, management and resource elements. The overall effectiveness of service integration is a function of the extent to which clients are receiving seamless support, given their needs, as well as the impact of an integrated service system on the operation of organisations themselves within the system. We discuss concepts of integration and the Browne et al. (2007) framework in detail in Chapter 2 of the report and use an adapted form of this framework in our empirical work.

Over the past few years, there has been an increased focus on the role of service integration in achieving improved outcomes in the homelessness service system, particularly with respect to the integration of specialist homelessness services with mental health and drug and alcohol services. The White Paper, *The road home*, specifically refers to the need for 'services to be more connected, integrated and responsive to achieve sustainable housing, improve social and economic participation and end homelessness for their clients' (see Australian Government 2008, 2009a). The *National Partnership Agreement on Homelessness* has, as one of its key

⁵ Our use of the term client integration is different from a variety of ways in which the term is used including in the health context as the integration of clients into the community after a period of residential care.

strategies, a better-connected service system (see Flatau et al. 2010 for a further discussion).

A similar focus on service integration is evident in the mental health domain. The *Fourth National Mental Health Plan* sets out an agenda for collaborative government action in mental health over the period 2009–14. The *National Mental Health Plan* takes a ‘whole of government’ approach by involving sectors other than health in achieving mental health objectives. More specifically, the *National Mental Health Plan* refers explicitly to the need for the development of ‘integrated programs between mental health support services and housing agencies to provide tailored assistance to people with mental illness and mental health problems living in the community’ (Australian Government 2009b, p.iv). It also calls directly for ‘integrated approaches between housing, justice, community and aged care sectors to facilitate access to mental health programs for people at risk of homelessness and other forms of disadvantage’ (Australian Government 2009b, p.iv).⁶

In the drug and alcohol space, the *National Drug Strategy* (NDS) and its forerunner, the *National Campaign Against Drug Abuse* (NCADA), have been operating since 1985 with a focus on partnerships across service sectors (Australian Government 2004, 2011). In the most recent version of the NDS (2010–15), explicit recognition is given of the need to connect alcohol and drug services with other services, including homelessness services, to meet those with complex needs. For example, the NDS states: ‘Strong partnerships and integrated service approaches with alcohol and other drug treatment, social welfare, income support and job services, housing and homelessness services, mental health care providers and correctional services are needed if people with multiple and complex needs are to be assisted to stabilise their lives, reintegrate with the community and recover from alcohol and other drug related problems’ (Australian Government 2011, p.7).

Despite the focus on systems and service integration in the present policy environment and among practitioners, there has been no study, as far as we are aware, of the integration of homelessness, mental health and drug and alcohol services in Australia. This study aims to fill this critical gap in the literature. The study addresses six research questions, as follows:

1. What do we mean by the term ‘service integration’? What models and typologies of ‘service integration’ have been advanced in the existing literature?
2. How do key policy and practice stakeholders in the homelessness, drug and alcohol and mental health sectors in Australia define ‘service integration’ and its role in the delivery of services to clients?
3. What is the current structure and functioning of service integration in selected networks within the homelessness, drug and alcohol and mental health sectors? How does the practice of service integration in Australia compare with the existing models?
4. What do clients and the practitioners who work with them, tell us about clients’ experiences of service integration and coordinated care within the homelessness, drug and alcohol and mental health sectors?
5. What are the views of homelessness, drug and alcohol and mental health services about the pros and cons of service integration and its overall effectiveness, particularly in relation to the delivery of services for homeless people?

⁶ However, the *National Mental Health Plan* includes little by way of practical detail concerning the implementation of such an approach.

6. In what ways can the findings of this study inform the development of policy with respect to service integration and the practice of integrated service delivery for homeless people?

We address the above research questions using a cross-sectional, mixed methods study design. Our research design comprises three key components:

1. Interviews at both the Commonwealth and state level with key stakeholders (policy-makers; senior industry representatives; departmental staff) within the homelessness, drug and alcohol and mental health sectors.
2. Case studies of specialist homelessness and health services in Sydney, Perth and Melbourne.
3. A multi-level survey (the *Integration Survey*) of senior agency managers, service managers and clients in selected networks within the homelessness, drug and alcohol and mental health sectors in Perth and Melbourne.

The report is structured as follows:

Chapter 2 addresses our first research question by reviewing key concepts in the integration literature, including existing models and typologies of integration. We present a conceptual framework that can be used to measure integration, which has been strongly influenced by the work of Browne et al. (2007).

Chapter 3 details the study's research design, outlining the approach taken to key stakeholder interviews, case studies, and the multi-level *Integration Survey*.

Chapter 4 addresses our second research question by examining the way in which the term 'integration' is used and applied in different settings by practitioners and policy-makers and its serviceableness for policy and practice.

Chapter 5 explores our third research question by assessing the structure and functioning of integration within selected networks. The structure of integration is considered using findings on the extent, scope and depth of integration. The functioning of these networks is then considered by examining the quality of partnerships and the critical ingredients for effective integration in the selected networks.

Chapter 6 addresses our fourth research question by examining clients' experiences and perceptions of service integration. In other words, the chapter focuses on the question of client integration. This chapter also discusses clients' views of the importance of integration, indicators of integrated service delivery at the client-level, access to services, and client outcomes. In addition to clients' own reports, the views of stakeholders are also discussed.

Chapter 7 addresses our fifth research question on the pros and cons of service integration, and considers its overall effectiveness, particularly in relation to the delivery of services for homeless people. In limiting our discussion of the effectiveness of service integration to views and perceptions of respondents to the *Integration Survey* and to qualitative interviews with stakeholders, we recognise that we are only just at the beginning of answering the question of how effective service integration is or could be in achieving improved outcomes for clients. That would require a detailed assessment of client outcomes arising from the application of different models of integration and the intensity of their application. This is beyond the scope of the present study.

Chapter 8 provides a summary of findings from the present research, and a discussion of the relevance of these findings. The implications of the present findings for policy and practice are then considered in line with our sixth and final research

question. Some key questions arising include: How is the decision to integrate made (when and how far)? Who should drive integration and how is the integration of services made sustainable? The limitations of the study are also discussed as well as future directions for research.

2 LITERATURE REVIEW

Research Question 1: What do we mean by the term 'service integration'? What models and typologies of 'service integration' have been advanced in the existing literature?

This chapter briefly reviews existing definitions and models of integration and examines the empirical literature on integration.⁷ We present a flexible framework of integration drawing on and, in some areas extending, the work of Browne et al. (2007) that provides a typology of integration as well as a measurement framework and the starting point for a normative account of integration. We use the Browne framework to help inform our empirical analysis presented in future chapters. This chapter also considers briefly key drivers of integration and the policy case for integration.

2.1 What is integration?

Integration is a term used in a number of different ways in the literature. However, common to all definitions is the notion that integration involves 'joint working' in one form or another (Care Services Improvement Network 2009, p.7). As Konrad (1996, p.6) suggests, integration is 'a process by which two or more entities establish linkages for the purpose of improving outcomes for needy people'. As these definitions suggest, the term integration is used to cover a range of models of working together, not simply the most comprehensive form of service interaction; namely, the case of 'a single system of needs assessment, service commissioning and/or service provision' (Care Services Improvement Network 2009, p.17).

Much of the work on service integration has been undertaken in the health care context. A commonly cited definition of integrated care in this context is that developed by the WHO European Office for Integrated Health Care Services:

Integrated care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency. (Gröne & Garcia-Barbero 2002, p.1)

Another prominent definition of integration is that used by the Canadian Council on Health Services Accreditation, which defines integration in the following terms:

Services, providers, and organizations from across the continuum working together so that services are complementary, coordinated, in a seamless unified system, with continuity for the client (cited in Suter et al. 2007, p.7).

Similarly, Leutz (1999, pp.77–78) defines integration in the health care context as:

The search to connect the health care system (acute, primary medical, and skilled) with other human service systems (e.g. long-term care, education, and vocational and housing services) in order to improve outcomes (clinical, satisfaction and efficiency).

What integration means depends on which stakeholders are of interest. Lloyd and Wait (2006) list these various stakeholders and their views of integration as:

- *Users*: a process of care that is seamless, smooth and easy to navigate.
- *Frontline providers*: working with professionals from different fields and coordinating tasks and services across traditional boundaries.

⁷ This chapter draws heavily on our earlier Positioning Paper on integration (see Flatau et al. 2010).

- *Managers*: merging or coordinating organisational targets and performance measures, and managing and directing an enlarged and professionally diverse staff.
- *Policy-makers*: design of integration-friendly policies, regulations and financing arrangements; evaluation of systems/programs on a holistic basis.

It is also important to distinguish between integration at the systems level involving jurisdiction-level interventions typically undertaken by government, which bring together services from different support systems under purpose-built, centrally-funded and managed, coordinated programs of support and integration at the service level. Service-level integration involves the coordinated delivery of individual services within and/or across different sectors, irrespective of whether or not the coordination that occurs is part of a purpose-built, system-wide integrated service delivery program or reflects the actions of individual services working together at the local level.

2.2 A typology of integration: construct

A number of typologies of integration exist in the literature. One typology of integration that has been influential and which we find particularly useful is that provided by Konrad (1996). Konrad's (1996) typology of integration is organised around two key main principles: the *intensity* of integration and the *dimensions* of integration. By the intensity of integration, Konrad (1996) means the extent or strength of integration. Konrad uses the term 'dimensions of integration' to cover a multitude of elements around structure and process including the parties who are involved in providing integrated care, the services that are subject to mechanisms of integration, who is financing the integrated services and so on.

Konrad's (1996) Integration Continuum begins with fragmented or independent service delivery undertaken by autonomous agencies. It then moves through various stages ending finally with 'integration'. The continuum is set out below:

- information sharing and communication
- cooperation and coordination
- collaboration
- consolidation
- integration.

The least intense type of informal integration involves information sharing and communication between independent services or agencies. A stronger form of informal integration involves inter-agency cooperation and coordination revolving around loose arrangements in relation to activities such as reciprocal client referral. The next level of intensity involves collaboration between agencies. Collaboration involves still-autonomous agencies working together to achieve a common goal or outcome and may involve activities such as partnerships with written agreements, cross-training and shared information systems.

A stronger form of integration in Konrad's typology involves an umbrella organisation delivering services on a consolidated basis with functions being centralised but with each organisation retaining its independent authority. The fully integrated system involves a single authority covering all relevant needs of clients and doing so in an individualised form with a blending of all activities and a common funding pool.

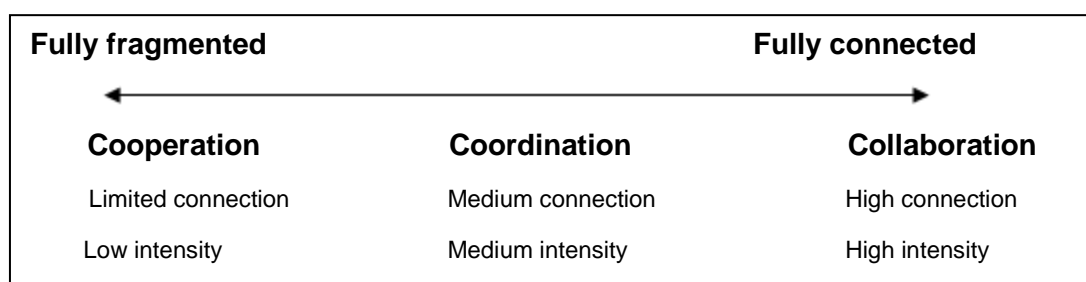
Glasby (2005) takes a similar approach to a typology of integration. He distinguishes between the *depth* of integration (similar to Konrad's intensity of integration) and the *breadth* of integration. The depth of integration is measured on a continuum from

sharing information and consulting each other, to coordinating activities, joint management, partnerships and mergers. The breadth of integration refers to the coverage of the integrated care response across different sectors or domains.

Keast et al. (2007) and Ahgren and Axelsson (2005) also use a continuum approach to conceptualise integration (see Figures 1 and 2 below). Keast et al. (2007) incorporate in the continuum the so-called three 'Cs' of cooperation, coordination and collaboration. The three Cs lie between a fully fragmented approach on the one hand and full integration on the other.⁸

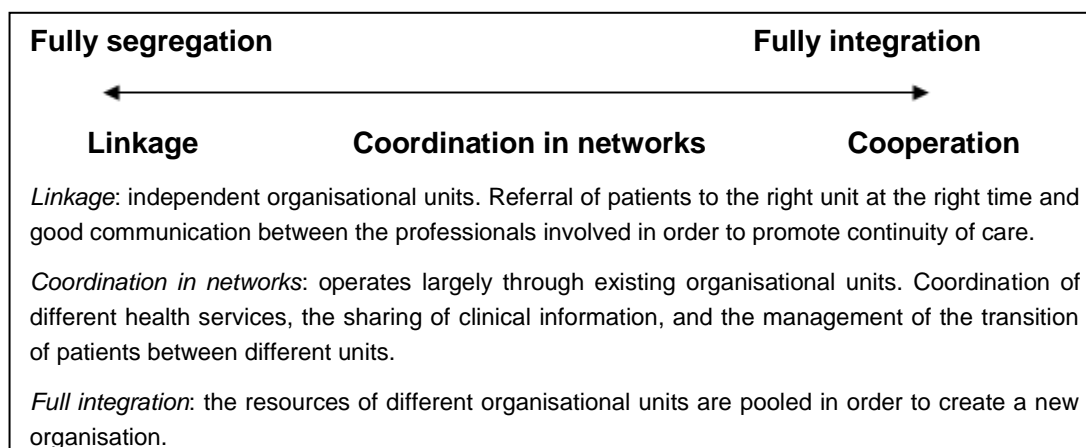
A number of conceptualisations of integration refer to the various levels at which integration can work or the strategies involved in integration. Kodner and Spreeuwenberg's (2002) structure, replicated in Table 1, differentiates between integrated care strategies at the funding, administrative, organisational, service delivery and clinical levels.

Figure 1: Keast et al.'s (2007) integration continuum



Source: Keast et al. (2007)

Figure 2: Ahgren and Axelsson's integration continuum



Source: Ahgren and Axelsson 2005

Leutz (1999, p.77) suggests that integration can occur at the policy, finance, management and clinical levels and may involve various means, including 'joint planning, training, decision- making, instrumentation, information systems, purchasing, screening and referral, care planning, benefit coverage, service delivery, monitoring, and feedback'. Ramsay et al. (2009, pp.3–4) suggest that effective integration requires that integration takes place across a number of domains, including:

⁸ A similar presentation, distinguishing between full segregation through to linkage, coordination and cooperation to full integration, is adopted by Ahgren and Axelsson (2005).

- *Organisational* (e.g. mergers, contracts between different parties).
- *Functional* (e.g. merging different functions such as non-clinical support and back office functions).
- *Service*—different services provided are integrated at an organisational level.
- *Clinical* (e.g. patient care being integrated within a single process).
- *Normative* (e.g. shared values in coordinating work and securing collaboration in delivering health care).
- *Systemic*—coherence of rules and policies at all organisational levels.

Lloyd and Wait (2006, p.10) extend the analysis of integrated care arrangements by developing a matrix of integration that involves the dimensions of *provider integration* and *user (or client) integration*. High levels of provider integration do not necessarily result in high levels of user integration or vice versa. User integration requires that clients experience a seamless system of care and that may not occur even with high levels of provider integration.

Table 1: Kodner and Spreeuwenberg (2002) Continuum of integrated care strategies

Funding
→ Pooling of funds (at various levels)
→ Prepaid capitation (at various levels)
Administrative
→ Consolidation/decentralisation of responsibilities/functions
→ Inter-sectoral planning
→ Needs assessment/allocation chain
→ Joint purchasing or commissioning
Organisational
→ Co-location of services
→ Discharge and transfer agreements
→ Inter-agency planning and/or budgeting
→ Service affiliation or contracting
→ Jointly managed programs or services
→ Strategic alliances or care networks
→ Consolidation, common ownership or merger
Service delivery
→ Joint training
→ Centralised information, referral and intake
→ Case/care management
→ Multidisciplinary/interdisciplinary teamwork
→ Around-the-clock (on-call) coverage
→ Integrated information systems
Clinical
→ Standard diagnostic criteria (e.g. DSM-IV)
→ Uniform, comprehensive assessment procedures
→ Joint care planning
→ Shared clinical record(s)
→ Continuous patient monitoring
→ Common decision support tools (i.e. practice guidelines and protocols)
→ Regular patient/family contact and ongoing support

Mirroring the distinction between provider and user integration is Gröne and Garcia-Barbero's (2002) distinction between the notions of *integrated care* and *continuity of care*. The former is a broader term referring to 'the technological, managerial and economic implications of service integration' (p.3), while continuity of care is a term referring to the experiences of clients/patients and workers in relation to the care or support that is provided or received. The continuity of care is defined in terms of longitudinal or provider continuity—continuity across service areas and continuity of information (through shared records).

A final element of a typology of integration is the distinction between vertical integration and horizontal integration. Varying definitions of vertical integration and horizontal integration exist. Gröne and Garcia-Barbero (2002) suggest that horizontal integration refers to strategies linking similar levels of care, while vertical integration relates to strategies linking different levels of care within a hierarchy (e.g. primary, secondary and tertiary care). Ramsay et al. (2009) use the term 'vertical integration' somewhat differently to describe a situation where different components of a supply chain are brought together in a single organisation. A closely related approach is that vertical integration refers to the one organisation providing support to clients across a number of different domains. A very different use of the terms 'vertical' and 'horizontal' integration is offered by Leutz (1999) who refers to a vertical authority-driven, formal, structural orientation to integration as opposed to a horizontal, relationship-based approach (see also Keast et al. 2008 who adopt this approach to vertical and horizontal integration as well).

2.3 Measuring integration

A focus on the measurement of integration is of relatively recent origin. As suggested by Provan and Milward (2006), the investigation of service delivery networks needs to move towards the empirical examination of studies on components of integrated networks and their interconnectedness, rather than simply looking at what they are and why they should be used. Dickinson (2006) and Granner and Sharpe (2004) have written of the growing consensus in the integration literature pointing to a need for a more comprehensive measurement approach that takes into account multiple service network dimensions, components and perspectives on integrated networks.

There are several frameworks that have been developed to measure integrated care (Ahgren & Axelsson 2005; Brazil et al. 2004; Gillies et al. 1993; Browne et al. 2007). Most of these have been used to measure health care service delivery, but research in the United States has also used measures for integration of client care in homelessness (Mares et al. 2008; Rosenheck et al. 1998) which we have used in our thinking around client integration.

In this study we have drawn on Browne et al.'s (2007) model of integration but adapted it and included a range of additional components. Her model brings together much of the existing work on integration and is flexible in its design. First, it provides a typology of integration and offers a comprehensive framework for investigating human service network integration built on theoretical constructs. In particular, it uses the network analysis and evaluation framework of Provan and Milward (Provan et al. 2004; Provan & Milward 2002, 2006). Second, it can be used to assist in modelling the workings of integration and its effectiveness and provides a starting point for a normative analysis of integration. Third, the Browne et al. (2007) model is fundamentally a measurement framework drawing together in a cohesive framework various instruments used to measure the various dimensions of integration.

The Browne et al. 2007 model includes the following key dimensions of integration:

- *Structural inputs*: the extent, scope, depth, congruence with and reciprocity between agencies (Browne et al.'s 2004 and Browne et al.'s 2007 *Integration of Human Services Measure* is used to measure the structural inputs of integration)⁹.
- *The functioning of the network*: broken down into the quality of the network (based on Weiss et al.'s 2002 *Partnership Self-assessment Tool*) and the ingredients that go into it¹⁰.
- *Network outputs (or effectiveness)*: measured by the network's capacity to achieve outcomes from the dual perspectives of the services as well as their clients.

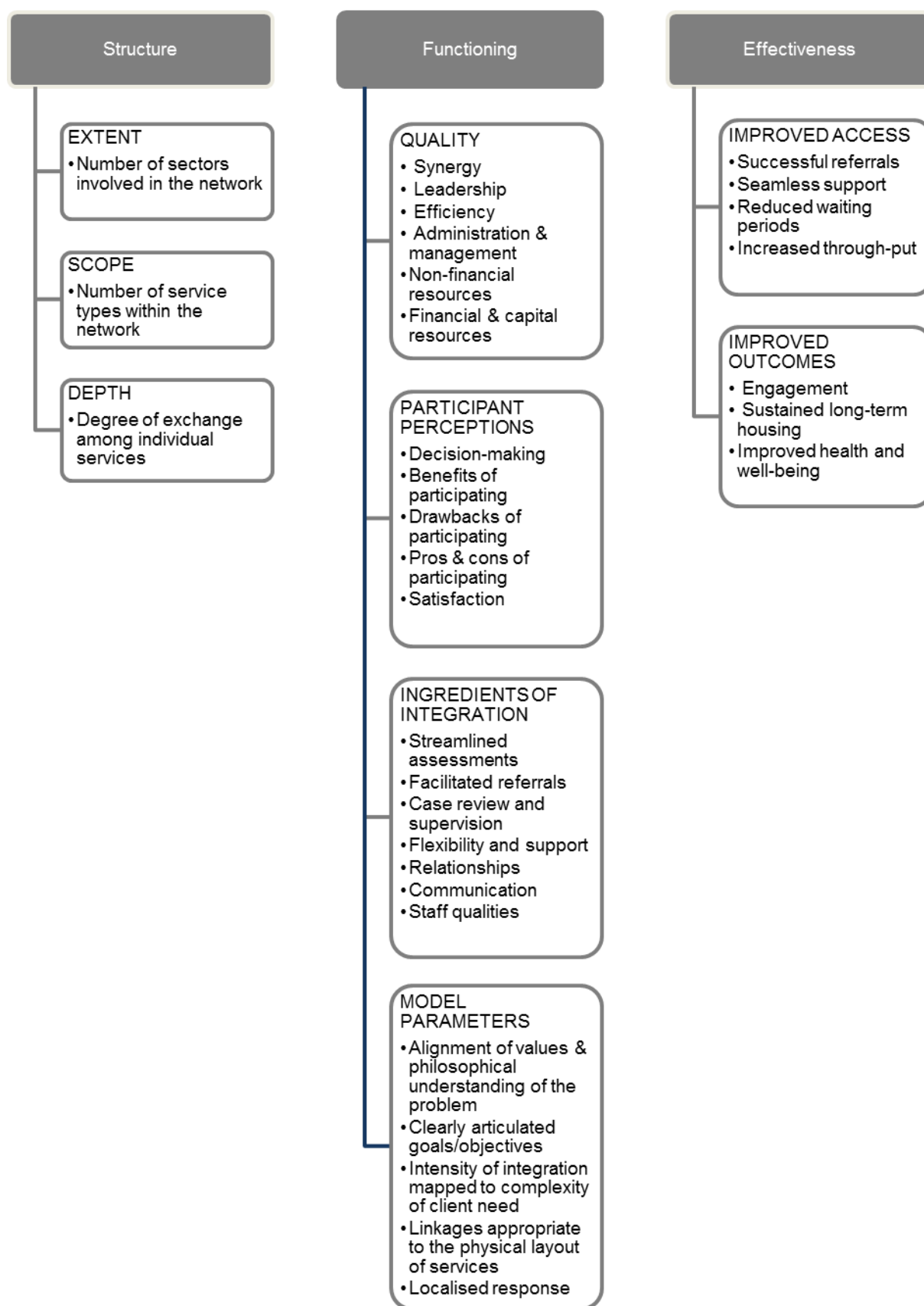
Our major additions to the Browne et al. (2007) framework are a focus on the clients of services and their perceptions of the effectiveness of services (integration from a client's perspective) given their needs and the views of services managers as to the benefits, costs and barriers of service integration and their views as to the effectiveness of integration practices. These are key missing links in the existing framework. We conceptualise these elements as being part of the network outputs of integration. The qualitative findings (see subsequent chapters of the study) also highlighted additional aspects of functioning that contributed to the effectiveness of integration.

Figure 3 depicts the adapted form of the Browne et al. (2007) model used in the present study. It includes additional elements around the effectiveness of service integration, links elements of the model to client needs, and seeks to gain perspectives on integration from a wide set of stakeholders.

⁹ See Thurston et al. (2010), Browne et al. (2012), and Ye et al. (2012) for recent uses of the Browne Integration of Human Services Measure. Browne et al. (2004) provides a discussion of the validity of the measure.

¹⁰ In Browne et al. 2004 (p.7), the Browne Integration of Human Services Measure correlated weakly with the Weiss measure of partnership synergy but more highly with satisfaction. They took this as evidence that the two questionnaires were measuring different components of integration.

Figure 3: Adaptation of Browne, Kingston, Gridisa and Markle-Reid's (2007) model of 'Dimensions of Human Service Network Integration'



Each of the dimensions (structure, functioning and effectiveness) represented in this framework of service network integration are unique aspects of integrated service networks. Thus, each dimension distinctly contributes to the description of an integrated human service network. For example, the quality of a network could be high as measured by strong partnership synergy. However, stakeholders may experience service integration as time intensive for their service. In this case, high levels of network functioning would not necessarily lead to better network outputs.

Browne et al.'s (2007) adapted model is a framework for measuring the different dimensions of integration using multiple levels of analysis, with information being potentially compiled from the CEO of an agency, a representative of the chief funding body of the agency, team leaders of individual services within an agency, and clients of the service. Results can therefore differ between levels of respondents and should be viewed as multiple perspectives of the network from the varying stakeholders. In the present study, perspectives were sought from agency executives, service managers and clients/consumers via the *Integration Survey*; front-line workers via case studies of homelessness and health services/programs; and policy and practice stakeholders from across the homelessness, mental health and drug and alcohol sectors via in-depth interviews.

The Browne et al. 2007 *Integration of Human Services Measure*, used to assess the structure of integration (extent, scope and depth of integration), has previously been applied to self-defined structured networks of services. Our approach in this study is somewhat different. We have selected geographical locations in Perth and Melbourne and defined the relevant 'network' as all homelessness, mental health and drug and alcohol services that lie in the chosen geographical area. We are aware that services in the chosen regions do work together, have protocols of engagement and exist in a policy and practice environment that seeks greater integration. However, only in the case of the Melbourne location does there exist a formal network entity (it was chosen for this reason to provide insights into the workings of such an approach). The Perth location represents in our view a standard non-formalised network structure common in respect of these three domain areas in Australia. We wish to understand the extent, scope and depth of integration in these chosen geographical regions.

2.4 Drivers and enablers of integration

When developing a model of integration we are interested in understanding the key drivers of integration among services and the critical enablers of integration. Williams and Sullivan (2009) suggest the major drivers influencing integration are agency and structural forces. Individuals and organisations are the creative drivers of integration but they create change within the structural parameters of their environment. Agency comes into play in various ways through motivation, goals, leadership and personal skills, experience and capabilities. In terms of structural forces, Williams and Sullivan (2009) focus on the role of economic and social drivers, the legislative and institutional framework, available resources, histories of collaboration, accountability structures and organisational cultures.

Ouwens et al. (2005) focus on a number of key enablers of successful integration. They include supportive service information systems; agreement between personnel involved on the nature of the integration; leaders with a clear vision of integrated care; resources for the implementation and maintenance of integrated care approaches (recognising the possible significant transaction costs involved in integration); management commitment and support; clients capable of, and motivated for, self-management; and a culture of quality improvement. At the other end of the spectrum, key barriers to successful integration include entrenched professional values and

approaches, which are often oriented toward specialisation and fragmentation (Gröne & Garcia-Barbero 2002; Goodwin 2008).

A number of authors point to the key aim of integrated care arrangements, namely, the implementation of a client-centred approach to care. As Lloyd and Wait (2006, p.7) suggest:

Integrated care seeks to close the traditional division between health and social care. It imposes the patient's perspective as the organising principle of service delivery and makes redundant old supply-driven models of care provision. Integrated care enables health and social care provision that is flexible, personalised, and seamless.

In much the same vein, Allen and Stevens (2007) and Goodwin (2008) suggest that the prime objective of integrated care is to shift the focus of attention from a service delivery to a client-centred approach. In a social housing context, Phillips et al. (2009) suggest that the key objectives and potential benefits of the integration of services are improved client outcomes, enhanced client access to services, greater equity and consistency, increased efficiency and enhanced accountability and control. We use this thinking in our definition of client-integration—the experience and perceptions of clients as to whether they face a seamless system of care and support in which needs are met irrespective of the actual services accessed by clients.

2.5 Summary

In this chapter, we have presented definitions and typologies of integration and a framework for measuring integration and its effectiveness to be used in subsequent analyses.

Integration involves 'joint working' in one form or another and this can range from loose collaborative arrangements around referral of clients and good communication between staff in different organisations to coordinated delivery of services and full integration where the resources of different organisational units are pooled in order to create a new organisation.

Integration can be developed on a system-wide basis and be centrally funded and managed (system-level integration) or be generated at a service level involving the coordinated delivery of individual services within and/or across different sectors (service-level integration). It may also occur within agencies (vertical integration) or between agencies (horizontal integration) and involve a broad range of stakeholders including users, frontline providers, managers and policy-makers. Ultimately, system-level integration and service integration is a means to the intermediate end of greater client integration (a seamless service system as perceived by clients of services) and the final end of improved client outcomes.

A typology of integration entails structural, functioning and output dimensions. In this study, we adapt the typology and associated measurement framework presented in Browne et al. (2007). We place particular focus on the clients of services and their perceptions of the effectiveness of services in meeting their needs in a timely and seamless fashion and the views of service managers as to the benefits, costs and barriers of service integration and the effectiveness of integration practices.

3 RESEARCH METHODOLOGY

This cross-sectional, mixed methods study comprises three components: interviews with key stakeholders; case studies of specialist homelessness and health services; and a multi-level survey of specialist homelessness, drug and alcohol, and mental health services, the agencies they operate from and the clients they assist (the *Integration Survey*).

The study was conducted in three stages. First, a round of key stakeholder and case study interviews were carried out in the homelessness sector. Along with a review of the extant literature on the measurement of integration (see Flatau et al. 2010), the findings that emerged from these interviews informed the development of the *Integration Survey*. The second stage of the study involved the dissemination of the *Integration Survey* among agencies, services and their clients and a second round of key stakeholder and case study interviews within the health sector. The third stage of the study involved the analysis of findings from interviews with key stakeholders; case studies of specialist homelessness and health services; and the multi-level *Integration Survey*.

3.1 Sites

The study was conducted across three capital cities: Perth, WA; Melbourne, VIC; and Sydney, NSW. These cities were chosen because of differences in the structure of the health systems across the three states. As outlined in the study's Positioning Paper, structural forces are an important driver of integration (Williams & Sullivan 2009).

Ethical approval was obtained for the conduct of the research in each state as follows:

- Murdoch University HREC (2009/210)
- University of Western Australia HREC (2009/210)
- University of New South Wales HREC (09269)
- University of Western Sydney HREC (H9437)
- Nepean Blue Mountains Local Health District HREC (11/42 – LNR/11/NEPEAN/69)
- Swinburne University of Technology HREC (2011/277).

It is useful to describe in more detail the operation of the three sectors in each of the jurisdictions of interest.

3.1.1 Victoria

Responsibility for the homelessness and housing sectors in Victoria rests with the Department of Human Services, Office of Housing. This government agency provides strategic oversight of the temporary accommodation system, social housing and tenancy support programs.

The Department of Health has oversight of both the mental health and drug and alcohol sectors. The mental health treatment system is divided into two parts. These are the clinical services provided directly by the Department of Health including hospital and community-based services (e.g., primary mental health teams, crisis assessment and treatment, consultation and liaison), and statewide specialist services (e.g., early psychosis services, dual diagnosis services); and Psychiatric Disability Rehabilitation and Support Services (PDRSS) provided through the NGO sector. PDRSS are funded to provide psychosocial support services including home-based

outreach support, day programs, care coordination, residential rehabilitation services, supported accommodation services and respite services.

In contrast, the drug and alcohol treatment system in Victoria is entirely comprised of NGOs funded to provide community-based treatment (e.g. counselling services, pharmacotherapy, withdrawal services, rehabilitation and post-withdrawal services), forensic treatment (e.g. diversion programs), needle and syringe programs and support services (e.g., telephone information service).

3.1.2 Western Australia

The lead agency for homelessness in Western Australia is the Department of Child Protection, which is responsible for the funding and delivery of homelessness crisis, transitional, outreach and other support services. The Department of Housing is responsible for capital infrastructure, tenancy management and tenancy support services to formerly homeless people as well as those who enter public and community housing with significant alcohol and other drug issues and mental health problems.

Unlike Victoria and New South Wales, the drug and alcohol and mental health sectors have separate governance structures (although they both report to the Minister for Mental Health)—the West Australian Alcohol and Drug Authority and the Mental Health Commission, respectively.

The alcohol and other drugs (AOD) treatment system is divided into two funding streams: government-delivered clinical services (Next Step); and counselling and support services provided through the NGO sector. The two service streams are co-located and operate as integrated Community Drug Services managed by the lead NGO partner.

In contrast, mental health services—both hospital and community-based services—are predominantly government services but also include some NGO community-based services. Recently, there has been a policy shift to provide individualised support packages for people with persistent and severe mental illness.

3.1.3 New South Wales

New South Wales Housing is the lead agency for homelessness in New South Wales. However, administrative responsibility for the temporary and crisis accommodation system rests with the Department of Community Services (DoCS). NSW Housing has operational responsibility for public housing and provides strategic support to the social housing sector, including funding of community housing providers. Homelessness services are provided by not-for-profit community service agencies that are funded by the NSW and Australian Governments. The same arrangement applies in each of the relevant jurisdictions.

In contrast to the homelessness sector, the NSW government is a direct provider of mental health and drug and alcohol services delivered through 15 Local Hospital Networks (LHNs; previously a smaller number of Area Health Services). The drug and alcohol treatment system comprises pharmacotherapy services, withdrawal management services, rehabilitation and counselling services, and consultation liaison services. This is augmented by an NGO sector that provides residential rehabilitation and education and prevention services.

The mental health treatment system comprises inpatient services (acute and non-acute), community mental health services, family and carer support programs, rehabilitation services, emergency services (hospital- and community-based acute

care teams), and supported accommodation services. Additional services are provided through the NGO sector (counselling and support services).

Policy direction, funding and governance of both treatment systems is provided by a single agency—the Mental Health and Drug and Alcohol Office (MHDAO), which was formed in 2006 from the merger of the Centre for Mental Health and the Centre for Drug and Alcohol. At an operational level however, the two treatment systems operate as distinct entities. Additionally, the two treatment systems are culturally distinct; for example, mental health has a stronger link to enforced service provision (e.g. community treatment orders) whereas drug and alcohol places more emphasis on client motivation for treatment.

3.2 Methods

A detailed description of the methodology for each component of the study is outlined in the following sections.

3.2.1 Key stakeholder interviews

Stakeholder interviews aimed to document:

- The policy environment (including governance structures and funding) at both the federal and state/territory levels regarding homelessness, mental health and drug and alcohol, and whole-of-government approaches.
- Stakeholder perceptions of integration—what it means, how it can be operationalised and implemented, and the benefits and costs of integration.

Key stakeholders were invited to participate in the study by way of an initial telephone or email contact and were provided with the study information sheet. If agreeable, a time and location for the interview was organised. The interview was approximately 30 to 45 minutes duration, conducted either face-to-face or via the telephone, audio recorded (with the consent of the participant) and later transcribed. A copy of the transcript was provided to participants upon request.

Participation in the study was voluntary. All participants provided verbal consent at the beginning of the interview; none declined to be audio recorded. No participant reimbursement was provided.

Interviews were semi-structured and included the following discussion prompts: meaning/definition of integration; objectives of integration; effective approaches to integration; key mechanisms of integration at the client level, service provider level, organisational level, strategic and policy levels; and the factors that facilitate and impede integration.

Key stakeholders were identified by a variety of means, including:

- An internet search for key commentators in the drug and alcohol, mental health and homelessness fields.
- Review of government department websites such as Premier and Cabinet, health, housing and community services/child protection.
- Perusal of membership on relevant national and state councils or boards.
- Recommendations made by key stakeholders already interviewed.

A total of 32 key stakeholders were approached to be interviewed. Four persons declined to be interviewed and three others did not respond to the invitation, resulting in a total sample size of 25 stakeholders.

3.2.2 Case studies

Case studies aimed to develop a comprehensive understanding of how integration is being implemented at the ground-level, including localised responses that agencies have developed to meet client need, the way in which agencies work within the current policy framework and governance system (especially funding arrangements), and their experience of when integration works well and when it does not.

An initial interview (either face-to-face or by telephone) was held with a senior staff member (usually the CEO or an Operational Manager) to ascertain the organisational structure of the agency and identify appropriate programs and services to be included in the case study. The senior staff member notified the staff about the project and contact details were provided to the research team. Individual staff were then approached and had the study explained to them, were provided with a copy of the study information sheet, and if agreeable, a time and place for the interview was arranged. Participation in the study was voluntary; staff had the option of declining to be interviewed despite their nomination by senior staff.

Interviews were approximately 30 to 45 minutes duration and predominantly conducted face-to-face, usually during a site visit to the organisation by a member of the research team. In a few cases, staff were unavailable during the site visit and their interviews were subsequently conducted by telephone at a later date.

Supporting documentation, either concerning the agency as a whole or for a particular service, was collected as part of the site visits and interviews. This included, but was not limited to, Annual Reports, service evaluations, MOU's or other agreements, and brochures for programs or services.

Interviews were semi-structured and included the following discussion prompts:

- Description of service/program and how it is linked into the broader organisational structure.
- Target client group and definition of client success.
- Integration mechanisms/strategies employed and the impact of these on successful client outcomes.
- Linkages and partnerships with external services/agencies; factors that facilitate and impede effective integration.
- Funding sources and reporting requirements.

3.2.3 The Integration Survey

The *Integration Survey* is a multi-level survey comprising three sub-questionnaires—an agency form, a service form, and a client form. The survey was designed to map the degree of integration that currently exists between agencies that provide homelessness, mental health and drug and alcohol services, to gather the views of service managers as to the effectiveness of partnership arrangements, the key ingredients of integration and its pros and cons, and to gather client-based data of relevance to the study.

The agency is the over-arching, auspicing or management organisation under which individual services operate. What constitutes the agency depends on the context involved. For example, compare a single site organisation (e.g. a women's refuge) to a national organisation that has a national head office, a state head office, several statewide operational divisions and numerous services or programs within each division, only one of which was located within the study catchment area. In the former, the agency is the same thing as the organisation. In the latter case, the agency would

be equated with the operational division that had corporate responsibility for services operating in the region of our study.

For the purpose of the study, a ‘service’ is a defined program of assistance provided by an agency typically but not always from a given geographic delivery site. Where there were a number of very similar services operating from a single site, but perhaps with different funding arrangements—such as a specialist drug and alcohol agency offering opioid pharmacotherapy, inpatient detoxification, general counselling and court diversion programs—we combined those services into a meta-service comprising multiple programs or teams for the purposes of the *Integration Survey*.

The client form was delivered to clients of services that completed the service form.

Survey development

The *Integration Survey* was developed on the basis of a review of the literature, preliminary findings from the homelessness key stakeholder and case study interviews, and previous service evaluations conducted by the research team.

All items were developed specifically for the present study with the exception of two critical measures, the *Partnership Self-Assessment Tool* (Weiss et al. 2002) and the *Integration of Human Services Measure* (Browne et al. 2004, 2007). The *Health Systems Integration Study System Integration Scales* (Gillies et al. 1993) guided the development of the integration with other services, question 15 of the Services Questionnaire.

The measures included in each form are summarised in Table 2.

Table 2: Measures included in the *Integration Survey*

Form	Measurement domains
Agency	<ul style="list-style-type: none"> → Jurisdiction, specialisation, services provided → Funding sources → Formal integration mechanisms—internal and external
Service	<ul style="list-style-type: none"> → Jurisdiction, specialisation, services provided → Funding sources → Target client population, presenting problems, referral sources → Staffing profile → Partnership Self-Assessment Tool (Weiss et al. 2002) → Integration of Human Services Measure (Browne et al. 2007) → Cross-sectoral service integration → Perceptions of integration—meaning, benefits, costs and desirability
Client	<ul style="list-style-type: none"> → Demographic details → Homelessness history (lifetime) → Psychosocial problems and support received (past three months) → Self-report mental disorder diagnosis (lifetime) → Service utilisation and access barriers (past three months) → Case management and experience of coordinated care → Perceptions of integration

Data collection

A comprehensive list of specialist homelessness, mental health and drug and alcohol services within each locality was generated using a number of strategies including a

web-based search and consultations with funding bodies, informal networks, inter-agency groups and coalitions. Consultation most often occurred by telephone but also involved attendance at inter-agency meetings and forums.

Confirmation of participation was sought from the appropriate management personnel at each agency and service. All potential participants were provided with a study information sheet. Survey packs—comprising a single agency form, one or more service forms (dependent on the number of homelessness, mental health and drug and alcohol services in the region), and five client forms for each participating service—were then generated for each agency. These were disseminated by post with a reply-paid envelope for their return.

All three forms, Agency, Service and Client, were designed to be self-completed. The time taken to complete each form was around 15 minutes, 30 minutes and 20 minutes for the Agency, Service and Client forms respectively.

Individual agencies were asked to identify five clients to participate in the survey. A staff member who was not directly involved in their clinical care and provided with a study information sheet and Client Form, approached clients. Participation was voluntary and clients simply returned the Client Form to the staff member if they declined to participate. Staff continued to approach clients until the maximum of five clients were recruited. The Client Form was anonymous and consent to participate was implied through completion of the survey. All client participants were provided with a \$10 gift card as reimbursement for participation.

There were significant delays in gaining the necessary ethical approvals for some of the larger agencies and their respective services. In particular, a restructure of the area health services in NSW (including a restructure of staff positions) meant it was difficult to identify the agency level and an appropriate local investigator in Sydney (necessary for ethical approval and site authorisation). Thus, the *Integration Survey* was administered in Perth and Melbourne only. Delays were also experienced in gaining ethical approval for the participation of government health services in Melbourne. However, this comprised only a small portion of the total Melbourne sample and thus the Melbourne sample was retained (but consists entirely of NGO services).

Localities for data collection

In Victoria, specialist homelessness, drug and alcohol, and mental health agencies from the outer eastern metropolitan region of Melbourne were invited to participate in the study. This was deemed a suitable site for the survey as it contains a diverse range of community organisations and cross-sector partnerships and is said to be an area of growing need. The outer east metropolitan region comprises of the following local government areas: Maroondah, Knox and Yarra Ranges. It also includes Whitehorse-East (Statistical Local Area). These regions form the outer east mental health service area (OEMHSA), as defined by the Government of Victoria.

A large multi-function agency network caters to residents in the outer east. This makes the outer east an interesting area to study in relation to service integration. Many of the services within this region, which historically functioned as independent agencies, are now part of a local consortium of health services. Health is broadly defined, and includes specialist homelessness services. For the most part, many of these services still function independently, but under the umbrella of the local consortium. The purpose of this consortium is to improve service coordination and cross-sector partnerships in the local area. While there are clients in the outer east requiring specialist homeless services, only a relatively small number of specialist

homelessness services are located in this region. A greater number of services for homeless clients are more centrally located in Melbourne's CBD.

In Western Australia, the survey was conducted in the Perth Central Business District (CBD) and surrounding suburbs and then down through the South Eastern Corridor which includes Victoria Park, Bentley and Cannington. These geographical areas were chosen as they include a range of government and non-government agencies, of various sizes, providing homelessness, drug and alcohol, and mental health services in an area of high need in Perth. The Perth CBD and South Eastern Corridor was a suitable area in which to conduct the survey. This was because of the concentration of homelessness, drug and alcohol and mental health issues, the varied government and non-government agencies that provide services and how these agencies not only service the local CBD area but also provide services to other northern and southern metropolitan areas. The Perth site was chosen as representing a typical area in which homelessness, drug and alcohol and mental health services work together, follow protocols of engagement that exist in relation to different service systems and exist in a policy and practice environment that seeks greater integration, but do not operate within a formal network entity.

The Melbourne and Perth sites were picked, in large part, to illustrate the extent and workings of integration in *different environments*. In particular, the Melbourne site has an advanced multi-function agency combining many different services in operation. It also has fewer homelessness services and relatively more mental health services than the Perth site. As such, we would expect findings on the extent and working of integration in the two sites to differ.

3.3 Participants

3.3.1 Key stakeholder interviews

Table 3 shows the jurisdiction, sector and level for each of the 25 stakeholders interviewed. The homelessness and drug and alcohol sectors are well represented; the mental health sector less so. The majority of key stakeholders held positions in the policy space, and were recruited to aid in documenting the policy framework and governance structures in the relevant regions.

3.3.2 Case studies

Three homelessness agencies (one from each capital city) and two health agencies (one from Melbourne, one from Sydney) were selected as case studies. Table 4 provides an overview of the agencies involved. Appendix 1 presents a summary structure of the operation of these agencies and their key homelessness, mental health and drug and alcohol programs.

3.3.3 The Integration Survey

Table 5 shows the number of agencies and services that participated in the *Integration Survey*. A total of 33 agencies and 66 services participated. Some agencies surveyed were single focus agencies, that is providing services for drug and alcohol treatment and support only, while others were multi-function in nature, providing clients with services covering more than one issue, for example, support services and treatment for homelessness and mental health issues.

The total number of agencies is less for Melbourne, as the majority of services identified within the Melbourne study site were part of a single, multi-function agency. The four Melbourne agencies were responsible for 19 services, the majority of which were specialist mental health services. The Perth sample included 29 agencies, approximately half of which were multi-function agencies, and 47 services, the

majority of which were specialist homelessness services. In Western Australia, mental health services are predominantly provided by several large government agencies (e.g. hospitals), whereas homelessness and drug and alcohol services are mostly provided by numerous smaller non-government agencies. It is for this reason that the number of agencies and services surveyed are lower for the mental health agencies in comparison to the homelessness and drug and alcohol services.

Agencies

All participating agencies identified as not-for-profit, non-government agencies. The agencies made use of a broad range of funding sources (see Table 6). For example, within the Melbourne sample, the single specialist homelessness agency received funding from all sources, as did the specialist mental health agency. Similarly, the Perth agencies also identified multiple funding sources although, in contrast, none of the agencies received any local council funding.

Services

Characteristics of the participating services are shown in Table 7. All of the specialist homelessness services provided temporary or crisis accommodation. In addition, approximately half also provided mental health support and half provided drug and alcohol support.

In addition to mental health support, approximately one-third of the specialist mental health services also provided temporary/crisis accommodation, one-half provided drug and alcohol support, but fewer provided long-term housing support. Many of the specialist drug and alcohol services also provided mental health support, as might be expected from recent investment in dual diagnosis training within the drug and alcohol sector.

Services were funded from a variety of sources but predominantly from government funding sources; the most common source of funding for all service domains was state/territory funding and this was followed closely by Commonwealth funding.

With regard to the target populations of services, most accepted both male and female clients. There was a fairly even distribution of homelessness and housing services that targeted individuals or families and those that accepted both client groups. In contrast, most mental health services targeted individuals only, whereas there were few drug and alcohol services that focused solely on this client group. Drug and alcohol services were more likely to either focus solely on families or cater for both individuals and families. Seventeen services provided assistance to youth predominantly drawn from specialist homelessness and drug and alcohol services. Indigenous Australian and CALD client populations were included across all service domains.

Most of the specialist homelessness, housing and mental health services were smaller services, servicing fewer than 300 clients in the last financial year. This is likely reflective of the low client turnover for these services. For example, the specialist homelessness services typically provided temporary or crisis accommodation and the average episode of care for these services ranged from one month to more than 12 months. For the specialist housing services, this ranged from three months to more than 12 months and the majority of the specialist mental health services supported their clients for one year or longer.

In contrast, specialist drug and alcohol services typically saw upwards of 100 clients per year, with over half of the services treating more than 500 clients in the past financial year. Approximately three-quarters of the services indicated an average

treatment episode of six months or less; few were longer than six months and only one drug and alcohol service typically saw clients for longer than 12 months.

Clients

Table 8 shows the sample characteristics for the client participants. A total of 269 clients completed the survey, with the largest proportion recruited from specialist homelessness services (39%), followed by mental health services (33%), drug and alcohol services (19%) and housing services (9%).

Approximately half of all client participants were male and this was true for all service domains except specialist housing services where three-quarters of participants were male. The mean age of participants was similar across all service domains (range: 35–42 years), with the youngest participants found in drug and alcohol services (35 years) and the oldest in mental health services (42 years). The majority of client participants were born in Australia (range: 73–86% across the service domains) but a significant minority spoke a language other than English in their family homes. The proportion that spoke another language at home was highest for the homelessness service domain (32% and 20%, respectively) whereas it was much lower for the mental health and drug and alcohol service domains (12% and 9%, respectively).

The drug and alcohol service domain had the highest proportion of Indigenous Australian participants (22%), followed by the homelessness service domain (18%). Only 8 per cent of housing participants and 5 per cent of mental health client participants identified as Indigenous Australians.

The majority of client participants across all service domains had fewer than 11 years of schooling; this was highest for the specialist housing service (72%), followed by mental health (68%), drug and alcohol (65%) and homelessness (57%). Just under one-half of the specialist homelessness client participants had achieved a minimum of 12 years schooling; this reduced to approximately one-third for the other service domains (range: 28–35%). There were also substantial proportions of clients with post-school education, ranging from 12 per cent among the specialist housing clients to 32 per cent among the specialist homelessness clients.

Most clients were in receipt of government benefits (range: 89–96% across the different service domains). Four per cent of clients from the specialist drug and alcohol services had no source of income. The proportion of clients in paid employment was found to be very low across all domains (1–5%), with the lowest rate for specialist mental health services (1%).

Lifetime exposure to homelessness was high across all service domains: 94 per cent among drug and alcohol services; 91 per cent among specialist homelessness services; 90 per cent among housing; and 79 per cent among mental health services. Unexpectedly, drug and alcohol clients had the highest rates of rough sleeping at some point over their lifetime (82%) compared to 51 per cent for homelessness clients, 51 per cent for mental health clients and 68 per cent for housing clients.

A similar pattern was found for couch surfing: the highest rate of couch surfing was for drug and alcohol clients (82%), followed by housing (76%) then homelessness (64%) and mental health (57%). Client participants from specialist housing services had the highest lifetime exposure to crisis accommodation (76%) while the lowest prevalence for this form of homelessness was found among clients of mental health services (52%).

Staying in a boarding house was most common for housing client participants (68%) and least common for homelessness client participants (37%); client participants from mental health and drug and alcohol services reported similar exposure rates (40%

and 45%, respectively). The highest rate of exposure for hotel/motel stays (as a last housing resort) was found for the housing (52%) and drug and alcohol service domains (51%), whereas the rates were much lower for the mental health and homelessness client participants (34% and 32%, respectively).

The most common form of homelessness among client participants from the specialist homelessness and housing services was couch surfing and staying in crisis/temporary accommodation. In contrast, the most common forms of homelessness for the mental health and drug and alcohol client participants was sleeping rough and couch surfing.

What this profile of agency, service and client participants in the *Integration Survey* reveals is a close underlying connection in client background between the homelessness and drug and alcohol services in particular but also with mental health services. Using the incidence of lifetime homelessness as an indicator, there is, for example, little difference between drug and alcohol services and homelessness services in terms of the prevalence of exposure to homelessness among clients of these service domains.

These findings lend support to the contention presented earlier that all three sectors share many of the same clients and addresses and, in many cases, similar problems among their clients. It is the intersection in clients and client needs across the three service domains that provides the underlying ground for greater collaboration between services across the homelessness, drug and alcohol, and mental health systems.

3.4 Summary

Our study of service integration is the first major empirical analysis of integration in Australia across three service systems—homelessness, drug and alcohol services and mental health services. It combines a multi-level quantitative survey, the *Integration Survey*, with an extensive qualitative program of qualitative research involving interviews with key stakeholders (policy-makers; senior industry representatives; departmental staff) and case studies of specialist homelessness and health services in Sydney, Perth and Melbourne. The multi-level *Integration Survey* obtains data at the agency, service and client level and therefore provides critical insight into the extent and workings of integration within and across agencies and services and its impact on clients' perception of the service system.

Table 3: Stakeholder profile, key stakeholder interviews

ID #	Jurisdiction	Sector			Level			
		Homelessness	Mental health	Drug & alcohol	Policy	Research/Advocacy	Operations	Clinical
KS01	Federal	✓			✓			
KS02	Federal			✓	✓			
KS03	NSW	✓			✓			
KS04	NSW		✓	✓		✓		
KS05	NSW	✓		✓		✓		✓
KS06	NSW		✓			✓		
KS07	NSW		✓	✓		✓		
KS08	NSW	✓			✓			
KS09	NSW			✓	✓			
KS10	NSW	✓			✓			
KS11	VIC	✓			✓			
KS12	VIC		✓			✓		
KS13	VIC	✓		✓		✓		
KS14	VIC	✓	✓	✓	✓			
KS15	VIC	✓			✓			
KS16	VIC	✓			✓			
KS17	VIC	✓					✓	
KS18	WA	✓			✓			
KS19	WA	✓					✓	
KS20	WA			✓	✓			
KS21	WA			✓			✓	
KS22	WA	✓			✓			
KS23	WA		✓	✓	✓			
KS24	WA	✓	✓	✓	✓			
KS25	WA			✓			✓	

Table 4: Agency profile, case studies

	Sector	Jurisdiction	Sites	Services/Programs	Participants
The Haymarket Foundation	Homelessness	NSW	2	7	17
St Vincent's Homeless Health Service	Health	NSW	1	5	13
Homeground Services	Homelessness	VIC	2	5	11
Moreland Hall	Health	VIC	2	5	6
Ruah Services	Homelessness	WA	8	5	4

Table 5: Number of participating agencies and services in the *Integration Survey*

Study site	Locality description	Number of agency participants					Number of service participants			
		Total	Homeless	Drug & alcohol	Mental health	Multi-function	Total	Homeless	Drug & alcohol	Mental health
Melbourne, VIC	Outer-East Mental Health Service area: Maroondah, Knox, Yarra Ranges and Whitehorse-Nunawading East	4	1	0	1	2	19	3	2	14
Perth, WA	Perth City area (including several surrounding suburbs e.g. Northbridge, Highgate) and the South East Corridor, through to, though not including Armadale	29	6	7	5	11	47	26	12	9
Total sample		33	7	7	6	13	66	29	14	23

Table 6: Agencies in the *Integration Survey*, by sources of funding and area of specialisation

Jurisdiction	Funding source	Agency specialisation			
		Homelessness	Mental health	Drug & alcohol	Multiple
Melbourne	Commonwealth Government	1	1	0	2
	State/territory government	1	1	0	2
	Local government	1	1	0	2
	Donations	1	1	0	2
	User pay fees	1	1	0	1
	Other	0	1	0	1
Perth	Commonwealth Government	3	2	7	11
	State/territory government	5	5	7	11
	Local government	0	0	1	4
	Donations	4	1	3	9
	User pay fees	3	0	2	7
	Other	1	1	1	3
Total	Commonwealth Government	4	3	7	13
	State/territory government	6	6	7	13
	Local government	1	1	1	6
	Donations	5	2	3	11
	User pay fees	4	0	2	8
	Other	1	2	1	4

Note: The category 'other' includes grants, trusts and foundations, social enterprises, rental income, and corporate sponsorship.

Table 7: Services in the *Integration Survey*, by area of specialisation by assistance provided, funding sources, target population, service size and mean episode of care

	Crisis/Transitional Accommodation	Long-term Housing	Mental Health	Drug and Alcohol
Assistance provided				
Crisis/transitional accommodation support	21	3	8	1
Long-term housing	3	3	6	0
Mental health support	9	1	23	9
Drug and alcohol support	8	1	9	14
Funding sources				
Commonwealth Government	12	3	6	11
State/territory government	23	4	20	13
Local government	1	0	0	2
Donations	8	0	7	5
User pay fees	7	0	5	4
Other	4	0	1	1
Target population				
Males only	4	0	0	0
Females only	3	0	2	1
Both males and females	17	5	21	13
Individuals only	9	1	11	4
Families only	6	1	3	7
Both individuals and families	10	3	9	3
Young people only (aged 24 years or less)	7	1	4	5
Indigenous Australians	17	4	18	14
Culturally and linguistically diverse people	17	4	18	13

	Crisis/Transitional Accommodation	Long-term Housing	Mental Health	Drug and Alcohol
Service size				
Less than 50	4	0	3	0
50 to 100	10	4	13	0
101 to 300	5	1	5	3
301 to 500	3	0	0	3
More than 500	2	0	2	8
Mean episode of care				
Less than 1 month	0	0	0	2
1 to 3 months	7	0	0	6
3 to 6 months	4	2	2	3
6 to 12 months	8	2	3	2
More than 12 months	4	1	17	1

Table 8: Characteristics of client participants, stratified by service domain

	Crisis/transitional accommodation (n=104)	Long-term housing (n=25)	Mental health (n=89)	Drug and alcohol (n=51)
Demographics				
Male (%)	47	76	47	51
Mean age (yrs)	37	39	42	35
Australian born (%)	74	76	79	86
Non-English language spoken at home (%)	32	20	10	8
Aboriginal or Torres Strait Islander (%)	19	8	5	22
Highest level of education				
Primary school (%)	6	4	1	4
Some secondary school (%)	16	36	23	18
Completed secondary school to Year 10 or 11 (%)	36	32	44	43
Completed secondary school to Year 12 (%)	11	16	12	8
Trade certificate, apprenticeship (%)	3	0	3	10
TAFE qualification (%)	21	8	14	10
University bachelor degree or higher (%)	8	4	3	8
Main source of income				
No income (%)	0	0	0	4
Registered and awaiting benefit (%)	2	0	0	0
Government benefit (%)	93	96	96	89
Spouse/partner's income (%)	0	0	1	0
Maintenance/Child Support (non-government) (%)	0	0	1	0
Weekly allowance from family/friends (%)	0	0	1	0
Paid employment (%)	5	4	1	4
Workers compensation (%)	0	0	0	0
Other (%)	0	0	0	2

	Crisis/transitional accommodation (n=104)	Long-term housing (n=25)	Mental health (n=89)	Drug and alcohol (n=51)
Lifetime homelessness				
Slept rough or in makeshift dwelling (%)	51	68	51	82
Stayed with family/friends (couch surfing) (%)	64	76	57	82
Stayed in an accommodation service (%)	66	76	52	59
Stayed in a boarding/rooming house (%)	37	68	40	45
Stayed in a hotel/motel (%)	32	52	34	51

4 UNDERSTANDINGS OF INTEGRATION

Research Question 2: How do key policy and practice stakeholders in the homelessness, drug and alcohol and mental health sectors in Australia define the concept 'service integration' and its role in the delivery of services to clients?

A primary aim of this study is to deconstruct the term 'integration' and explore the extent to which different stakeholders understand the concept of integration so as to complement the review of uses of the term 'integration' in the literature (see Chapter 2).

This chapter will discuss the ideas raised by key stakeholders and case study participants on how integration can be defined (in a way relevant to the sectors involved in the present study). It also examines the serviceableness of the concept of integration for practice and policy.

4.1 System and service integration

Integration means that we've divided up officially things in the past which shouldn't have been divided.

Four broad themes emerged from the interviews: coordination of networks, connectedness, client-centred service delivery, and extension of professional boundaries. Overall, the consensus was that integration can be defined as a coordinated network of connected and 'joined up' services that takes a multidisciplinary approach to supporting clients' needs.

4.1.1 Coordinated networks

A number of participants described integration as involving a network of coordinated services. For example, a homelessness case study participant commented:

It's a matter of a coordinated network of services being involved.

This was expanded upon by a drug and alcohol research/advocacy key stakeholder:

I think about the core requirements for a person to be sustained in the community and then having one service identified as the key linking service or responsible service that then needs to bring in and work with other services to ensure that the person is cared for. And so, in reverse order, that I guess would then be my definition of integrated service provision. So yeah, for me it's really about the how-to and achieving efficient and effective use of resources in as coordinated and timely manner, so that is the sequencing issues and timeliness issues. To try and discover what is the most effective and efficient way for a person to be supported in the community and to work towards that being sustainable.

A health case study participant saw a well-coordinated network as akin to a community of smaller service teams:

It's about services working together for common goals. And, I guess with that, there's an understanding that services are going to have different goals as well, and that's okay. But a strong and clear communication and shared goals and aims, I guess. And an understanding of how each service or each individual is working, because you're looking for integration between individuals and a team to create the team, and then integration between teams to create a service. But then it's more about all those different services linking in. So it's kind of a community.

There was some discussion regarding formal versus informal development of networks and the degree to which government should be responsible for creating and enforcing system-level integration. For example, a policy key stakeholder held the view that:

Integration for me is more about trying to make sure that all agencies are aligned to being able to respond to the problem—not just at an individual level, at a systemic level. The other models I think appear to be created for the individual. Integration to me is about the system being integrated, so that it responds in a systemic way so that you know that for 100 cases it's going to deliver the sorts of responses that will meet the client's housing requirements, their health requirements, their immediate crisis requirements, their drug and alcohol issues. There might be employment or there might be child issues; other risk factors that need to be dealt with. For 100 clients the system is going to be able to systemically respond rather than have to be created. I think with some of the other models where they talk about integration, it's a forced integration. And what I'm talking about is clearly a lot harder to achieve.

On the other hand, networks that developed informally were seen to have an advantage of being flexible and responding to local needs. This is indicated in the following comment from a mental health research/advocacy key stakeholder:

You know, people don't want to be running from pillar to post to access services needed. But I think what those one-stop shops might look like will vary community to community. It will be about what local infrastructure exists, what skill deficits exist and I think the process of communities coming together to agree on what their services might look like is as important as setting these things up. Like, right now, the government seems to be saying, 'Here, cop these medical care locals, they are going to be your one-stop shops'. And, in some communities there are informal one-stop shops. You see organisations cluster together, their relationships are really strong and the smaller the town, the stronger their relationships become.

A common observation was that services tend to align themselves with other services that hold similar values to their own, as this is where integration is most harmonious and synergistic. Thus, the development of grass-roots networks may occur more easily within a sector and less easily across sectors, given the different philosophies and ideologies and historical ways of working that define the different service spaces of homelessness, mental health and drug and alcohol.

In this regard, there is likely to be a need for some governance or direction across the network to ensure that key services are represented. This is, however, a difficult and fraught process, as indicated by a mental health advocacy key stakeholder:

What you see from a planning perspective is that—and this is coming from our state but is actually starting to push out into a national framework—they are trying to come up with models where they can work out all of the needs inside and outside of the [mental health] sector and start coming up with a methodology of how to resource that. But, you know, there are always these idealised models; they are based on very generic figures and the reality is we have done our mapping of the sector, we know that homeless are doing the same thing right now ... What we see on the ground is it's like there's some sort of static in the transmission: they have got maybe only one of that sort of service, and then six of this service for some reason, and then zero of three other types of services that they really need, and the place just down the road has the reverse.

4.1.2 Connectedness

Connectedness and a 'joined-up' service delivery was the most common definition of integration given by participants. It was commonly expressed with respect to redressing the siloed service system that dominates the human services system:

I think of different things, like a cog, fitting into each other. Things just sitting in nicely, working together and it keeps working, it's all—that analogy of a cog.

Participants referred to connections between services within a multi-function agency (vertical integration), to connections between services from different agencies, and connections across levels of need or specialty areas such as drug and alcohol and mental health (horizontal integration). Moreover, it was the act of connecting rather than the *method* by which services connected that appeared to be most relevant. Participants offered many different examples of how services could be connected or 'joined-up' as indicated in the following comment by a mental health research/advocacy stakeholder:

I mean, basically, service integration is about services working together but how you do that can look radically different, you know, it can be a collaboration, it can be about cooperation, it can be about networking.

Case study participants did not necessarily focus on a particular strategy by which connectedness could be achieved. Key stakeholders, on the other hand, were more likely to emphasise a particular model over another. This may relate to different aims of integration between the practice and policy levels. For example, client engagement and client-identified needs were deemed to be critical aspects of integration for front-line workers and this typically involved patience and restraint on the part of the worker and necessitated the use of multiple strategies to achieve the desired outcomes.

Health case study participants typically talked about connectedness as 'coordinated care'. Inherent in this definition is the role of effective communication between the different health specialities providing care for an individual. This concept was also strongly linked to the notion of multi-disciplinary teams, as explained by the following participant:

So our integrated care is us as a team working as a whole. We're not separate even though we have our own specialties within a specialty. We work together ... they have different skills as well and they might focus on one specialty whereas we might have other things we can help with: we can't do housing, but we can do the health side. So it's about me going, 'okay, what have you got, what do you need, what can work together?'

Moreover, some participants expressed the belief that integration could continue in the background among health and other professionals even where the client was not fully engaged. This was explained by a health case study participant as follows:

It just depends upon the client whether what they need [as defined by the health professional] is what they might need at that time—that doesn't mean that all of us can't work together in all specialties ... There might be just physical health [needs] at the moment because they can't cope with the other issues, but those people are still on standby in the background and offering advice anyway. So I think it's just as many or as few as the client needs to look after them.

Integration is commonly examined from a systems and service perspective and there is surprisingly scant mention of client integration in the research or policy space. Client integration refers to clients' perceptions that their treatment is delivered as a

'one-stop shop', single location on a single day or they are receiving coordinated care rather than having to repeat historical information and receive separate care programs; how the client measures the integration of the services they receive (Brindis et al. 2005; Mares et al. 2008). The findings from the interviews conducted in this study suggest, however, that front-line workers and operational managers are acutely aware of the need to respond respectfully to clients' needs and not to impose their own framework of helping onto the client. The tension between the provision of care and respect for client choice was highlighted by a number of key stakeholders and case study participants, as indicated by the following quote:

What that means to me is services working better together in more joined-up ways, but that doesn't negate the person and their rights and choices being central to that process. I guess, philosophically the view would be that the person needing and wanting and choosing the services is their own case manager and it's about the services respecting that.

Client respect and human rights also underpinned the idea of integration being a seamless service delivery response from the perspective of the client. We now turn to this issue below.

4.1.3 *Client centred*

Integration as a 'client centred' process was the least tangible and most 'idealistic' definition proffered by participants. It encompasses assessment and referral processes, but also the experience of a seamless service response, such that a client's movement through the system is almost imperceptible. Ultimately, of course, it is a *client's own perception* of a seamless service system that matters and which lies at the heart of the notion of client integration (a subject we return to in Chapter 7).

One drug and alcohol research/advocacy key stakeholder explained the notion of integration as 'client centred' in the following terms:

I think it is quite a complicated idea about how you give opportunity, capacity and resources to a lot of services, to potentially recognise a core coordinating role and then ability and authority to bring in other services as needed while you actually follow the person, wherever they're at, in the community. So in an ideal world we would all be able to go to whatever service we were currently either nearest to or felt like going to, and say, 'these are the things that are troubling me at the moment', or get someone to discern that through some sort of assessment or screening process. But we've tended historically to assume that when people walk through a service, that let's say has got 'drug treatment service' on the door, that what they're after is drug treatment and they're ready to express that desire and to receive whatever it is that we are offering. We don't assume that this is someone who's looking for something, let's find out what it is.

Central to the idea of a client-centred approach as defined by the key stakeholder and case study participants were the following characteristics:

- *No wrong door*—the idea that a client can gain access into the entire human services system regardless of the service type at which they first present.
- *Comprehensive needs assessment*—the idea that clients are treated as a 'whole' and that professionals consider the multiple needs of clients rather than 'picking off' only those that sit within their area of expertise.

- *Self-directed care*—the idea that clients have a right to decide on the number and timing of needs to be addressed and the services that are to be involved in their care.
- *Facilitated referral*—the idea that a ‘client doesn’t have to individually negotiate all the different services’ that are required; that much of the bartering for services happens behind the scenes by the human services professional.
- *Wrap-around care*—the idea that services are brought to the client, whether that be through co-location of services or via facilitated referral pathways or other mechanisms.

4.1.4 *Extension of professional boundaries*

The final means by which integration was understood by key stakeholders and case study participants was in terms of the professional backgrounds and disciplines of the human services workforce. At the lowest level, this was expressed as the need for multi-disciplinary approaches to the care of an individual. Although this could include multi-disciplinary teams within a single service, it was also talked about in terms of peer consultation with others outside of one’s own discipline or profession and the learning of new knowledge through this shared experience. This is encapsulated in the following comment from a homelessness service case study participant:

I think there’s definitely that element of working in partnership, yeah, and division of labour. It can be that multi-disciplinary approach which is what I see in the hospital so we’re kind of working together. As a social worker within allied health, I’m working with the nursing staff as well as the medical team, but I’m working as a social worker. In the community setting it’s a bit more different in terms of integration ‘cause it’s more inter-disciplinary so, yeah, I’m looking a bit more outside my sphere so I’m looking at other kinds of medical issues around substance abuse and other health concerns but working with the services that specialise in this area as well. So seeking advice from the experts, so to speak, but monitoring the client for my own work.

This broader way of working requires an additional skill set, something that may not always be addressed in professional development pathways, but which invariably tends to happen through experience and can, at times, be quite haphazard. As one key stakeholder in the mental health space commented:

So you can sort of conceptualise behaviours in that space as occurring at the services and systems level on the one hand, but also at the individual worker service provider/practitioner level at the other end. And most of the spotlight in the literature, interestingly enough, was on the services and systems level, not on the worker level. It was almost like workers were expected to learn it through osmosis.

Integration requires an extension of skills and knowledge beyond professional boundaries and specifically funded activities to ensure that the gaps in the system are overcome. The extension of boundaries can be viewed at multiple levels—individual worker, service and system—as articulated in the previous quote and in the following quote from a policy key stakeholder:

I think good integration means that there’s a degree of swap over between services and policy areas and the degree of crossover in principles and practice and intent.

This will require commitment from all stakeholders in the system, as it is, on a set of core attributes that all human services professionals should have, regardless of their professional background:

So it is everybody's task. It is not some specialist group's task. It is not some specialist group's task to hive off a person's feelings about themselves. At some point, yes, but for the most part every person that you see at the frontline has feelings about themselves, of being unwell in some way, of being dispirited or concerned or whatever it might be. But that's not something you shove off. So I think we've got to get people to have much more ownership.

4.2 The serviceableness of integration

Well, we know what dis-integration is

Compared with case study participants, key stakeholders, particularly those with clinical and policy/advocacy experience, were more likely to admit to finding it difficult to define and operationalise integration and to acknowledge the shortcomings of the term. For example, a homelessness policy key stakeholder commented:

I don't think it's a useful term. I think integration in itself is a very worthy thing to strive towards. I think that it's just been used so much and so broadly that really we don't often pause to consider whether its uses actually are entirely appropriate and whether we will be better off using words like coordination or collaboration which are also, I think, probably, incredibly over-used words. To me, service integration means that a whole range of services are working together to create a whole unit. And more frequently when the word integration is used, I think it's probably more relevant to collaboration. You know, services working together, but I don't know if you could say that their efforts are really creating a single combined whole.

This same stakeholder went on to describe the ubiquitous labelling of research studies, demonstration projects and policy objectives as 'integration' without due consideration of the implications of doing so:

... if you just look at something like the housing sector, particularly where an initiative or a particular model is supported by government, people are really very quick to adopt the lingo and the rhetoric and to bastardise certain ideas without really understanding what it is that any one of those things does. So that becomes a complicating factor.

Part of the difficulty in understanding integration is related to the fact that the underlying architecture of integration may not exist, leaving the concept to work in a vacuum. This was expressed by a clinical drug and alcohol stakeholder as follows:

Oh, I don't think it is a very good word because it's unclear as to what it means. At one level it could mean integration of services, which is a very difficult thing to achieve unless you've got organisational, administrative and structural strategies to do that. For example, I imagine that the GP super clinics may achieve this, but in most other environments it's really not achieved at all. It's certainly not achieved through the conventional drug and alcohol services and certainly not achieved through current mental health services ... So, that goes back to my point that you need people engaging with the individuals who have these problems who have a range of competencies and a comprehensive approach. Unfortunately, medical care/healthcare/service provision has retreated from that idea and so we have lots of different groups with specific interests picking off elements of it, and in fact, complicating things for the patient.

It was also acknowledged that 'integration' might not hold the same significance for clients as for front-line workers and policy-makers. Language has the potential to exclude people from the decision-making process and to pathologise individual experiences. This is suggested in the following quote by a drug and alcohol policy stakeholder:

It's an interesting term because it can be a very valuable term but it can also be loaded. So in terms of, for instance, mental health consumer politics, if I can put it that way. People want to be citizens and participate in society, but they don't necessarily want to be integrated.

Some participants felt the problem was in defining integration as a structural determinant rather than as a process by which positive client outcomes were more likely to be possible. The latter conceptualisation of integration was considered to be more useful by this drug and alcohol stakeholder:

I think I have a bit of a problem with some of the ideas that you can just have an integrated service. For me, an integrated service isn't a service that can provide everything like a one-stop shop. Because just as you co-locate, say, a drug and alcohol service, a mental health service and an acquired brain injury service, then what you discover is that the person is actually incredibly physically ill and so you are going to need primary health care services. Or you discover the person's eyesight is pretty poor and they need glasses. Or they are going through a long-term grieving process and they have a post-traumatic stress disorder and that needs very specialised intervention and you can't actually deliver it, even though you are there with all of these wonderful grouped services. So that's why I think of integration as a process, not a place or a product or a service. And I think, to be done well, it needs to be individualised.

4.3 Summary

The preceding sections demonstrate a shared understanding of integration among professional groups across the homelessness, mental health and drug and alcohol sectors although there were some differences with respect to the terminology used across these service sectors. For example, health participants were more likely to use the term 'coordinated care' to refer to the assessment process and subsequent development of an individualised care plan. Both homelessness and health participants however understood integration to involve connections between services and an emphasis on client need.

There were also some differences between policy and practice stakeholders in how they perceived integration. For example, policy stakeholders placed a greater emphasis on particular models of integration. In contrast, practice stakeholders had a greater sensibility about integration as a means to an end—that is, using whatever strategies enabled them to achieve connectedness with other services and to meet the needs of their clients.

5 THE STRUCTURE AND FUNCTIONING OF INTEGRATION

Research Question 3: What is the current structure and functioning of service integration in selected networks within the homelessness, drug and alcohol and mental health sectors? How does the practice of service integration in Australia compare with existing models?

In this chapter, we describe the structure and functioning of integration within the chosen networks, drawing upon data from the *Integration Survey* and interviews with stakeholders and case study participants. This chapter is organised according to the adapted model of integration of Browne et al. (2007) presented in Chapter 2. The structure of integration is described in terms of the extent, scope and depth of integration. The functioning of integration is examined in terms of the quality of networks and the critical ingredients for effective integration.

5.1 Structure of integration

5.1.1 Extent of integration

Browne et al. (2007) define the extent of integration as the number of sectors involved in a network. There are two separate components to this construction—the concept of a sector and that of a network.

The term ‘sector’ denotes commonality/clustering in terms of human service functions, discipline backgrounds, funding arrangements, sets of practices and rules, and group allegiances. The term ‘network’ refers to a connected set of entities. This could be at the macro level involving human service sectors or at the micro level involving organisations or services.

In the Australian environment, the homelessness, mental health, and drug and alcohol domains all operate as separate human service sectors. A narrower reading of the term sector could increase the number of sectors involved in the present case from three to more than three. In the case of homelessness, for example, it is certainly useful to distinguish between the specialist homelessness sector and the long-term housing sector, which provides long-term housing and tenancy support to those who were formerly homeless and those at risk of homelessness. Within the homelessness sector itself, it is possible to distinguish between different sub-sectors such as the domestic violence sector, the single homelessness sector, the family homelessness sector, and the youth sector.

Within the health domain, there exists a clear division between clinical or hospital-based services and community-based services, particularly in the mental health area.

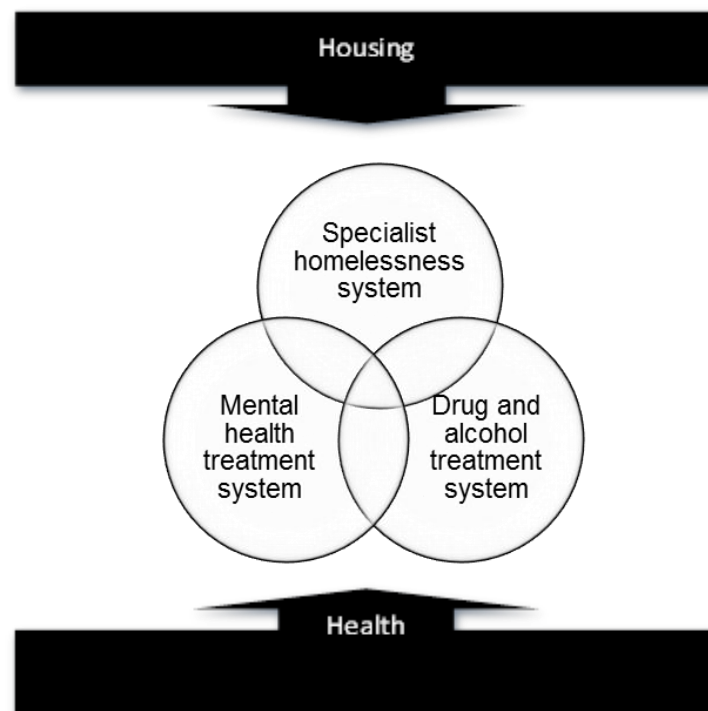
Browne et al. (2007) apply their measure of the extent, scope and depth of integration in cases where an explicit network exists. In the present case, we would argue that the notion of a network at a systems-level between the homelessness, mental health and drug and alcohol sectors is something of a work in progress. Indeed, at the service level it is something that we are indeed seeking to test.

In the case of the Perth location, we would argue that there exists, at the system-level, a well-developed set of connections and partnerships between the mental health and drug and alcohol sectors. These partnerships also operate with the homelessness sector but not as decisively. There has always existed protocols and linkages between the homelessness sector and each of the other two sectors, but, it is only now, with the increasing emphasis on integration among all three sectors, that the partnership between the three sectors is beginning to reach anything like maturity (see Figure 4).

Additional support sectors—namely child protection, disability and ageing—also connect on to the nascent network that exists. In the case of Melbourne, there exists a structured network arrangement in the outer east, which incorporates mental health and drug and alcohol services and homelessness sectors.

In summary, we are taking forward into our empirical work the notion of an emerging nascent network that comprises homelessness, mental health and drug and alcohol sectors and a range of possible sub-sectors within these broader sectors.

Figure 4: Extent of integration considered in the present study



Findings from interviews regarding the structure of the three sectors

Across the three jurisdictions, only Victoria situated the homelessness and housing sectors within a single agency. For NSW and WA, responsibility for the delivery of homelessness services was separate from the management of the housing sector.

There are benefits to both structures. One key stakeholder suggested the child protection portfolio was better placed for crisis responding and hence better placed to manage the homelessness system. Other key stakeholders talked about the specialisation of skills and the distinction between social support services on the one hand and capital infrastructure and tenancy management on the other. Regardless of where homelessness was placed in relation to housing, both key stakeholders and case study participants frequently stressed the need for homelessness policy to be strongly linked to the housing sector given that pathways into and out of homelessness are ultimately highly dependent on access to sustainable housing options.

In terms of the health sector, many participants believed the current structure poses significant challenges for service and client integration. A number of key stakeholders suggested the health system should be re-structured to reflect a primary health care network and a second tier of specialist services. It was thought that this type of structure would better reflect a holistic conceptualisation of health and make better use of the range of workforce skills.

Across all jurisdictions, key stakeholders and case study participants commented on the increasingly narrow focus of mental health services on crisis-driven presentations (e.g. psychosis and self-harm) and pharmacotherapy. For example, a stakeholder made the following comment regarding mental health services in Victoria:

Well in Victoria, I think, these days it is really hard for someone to get case-managed, integrated care in a mental health service if they haven't got a condition for which there is a medication. And so if you've got anxiety or depression or just not feeling good, or post-traumatic stress, or social anxiety or personality disorder or Asperger's syndrome, mental health services don't want to see you.

This was explained in terms of a threshold for disorder severity by a NSW key stakeholder:

... public mental health services don't necessarily pick up lots of care from people that may have a range of issues but don't have a mental illness. There are many, many people in public housing who may need some low-level support from somebody that can help them through various issues in their lives. Your average community mental health team doesn't provide that kind of service. They're mostly dealing with people that have serious mental illness.

5.1.2 Scope of integration

Browne et al. (2007) define the scope of integration as the number of 'service types' offered within a network. In what follows we take it as given that the network consists of the homelessness, mental health and drug and alcohol sectors. Operationally, the network is taken to be the agencies and services in these three sectors that participated in the *Integration Survey*.

The number of instances of forms of support provided by the participating agencies across the homelessness, drug and alcohol, and mental health functional areas is shown in Figures 5 to 7, respectively. It is important to note that the data represented in Figures 5 to 7 is frequency data and therefore dependent on sample size. The Perth sample consisted of 29 agencies, whereas the Melbourne sample consisted of only four agencies. Hence, the number of instances of service provision of various kinds will appear much lower in Melbourne than in Perth.

Types of homelessness services provided by agencies include crisis/transitional accommodation; domestic violence refuges; day support programs; early intervention programs; outreach; street-to-home programs; and tenancy support programs (see Figure 5). Of these, crisis and transitional accommodation was the assistance type most often offered in the inner Perth and South East Corridor area. Nineteen participating agencies from the inner Perth and South East Corridor of Perth region reported that they provide crisis and transitional accommodation services. There were four such agencies in the Melbourne region, resulting in 23 agencies across the two jurisdictions. Outreach support was the second most commonly provided form of homelessness-based assistance, with 19 agencies providing this type of service in the two regions (including 16 in Perth and three in Melbourne). The type of assistance provided least often by agencies in the sample was day support, with nine agencies providing this service.

The various drug and alcohol programs of support provided by participating agencies is shown in Figure 6. For both Melbourne and Perth, the most commonly provided drug and alcohol service was information and education (25 agencies), followed by support and case management (23 agencies) and harm reduction (21 agencies). The

least commonly provided type of service was needle and syringe programs (5 agencies).

Figure 7 shows the various mental health programs provided by participating agencies. The most commonly reported type of mental health service offered was short and long-term support (21 agencies), followed by case management (16 agencies) and psychoeducation (16 agencies). Mental health inpatient clinics were rare among the participating agencies (2 agencies).

Figure 5: Types of homelessness support provided by participating agencies, stratified by jurisdiction

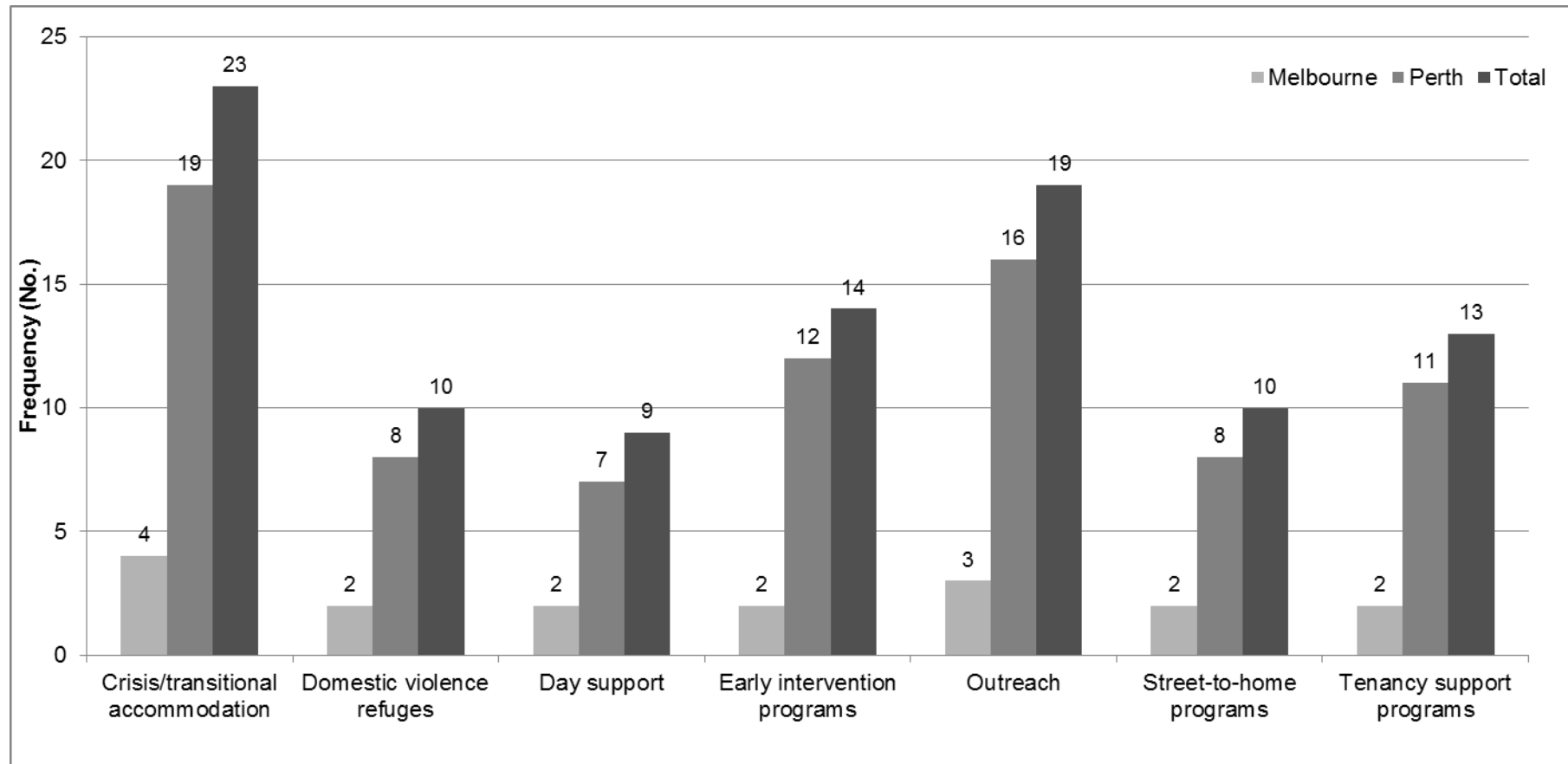


Figure 6: Types of drug and alcohol support provided by participating agencies, stratified by jurisdiction

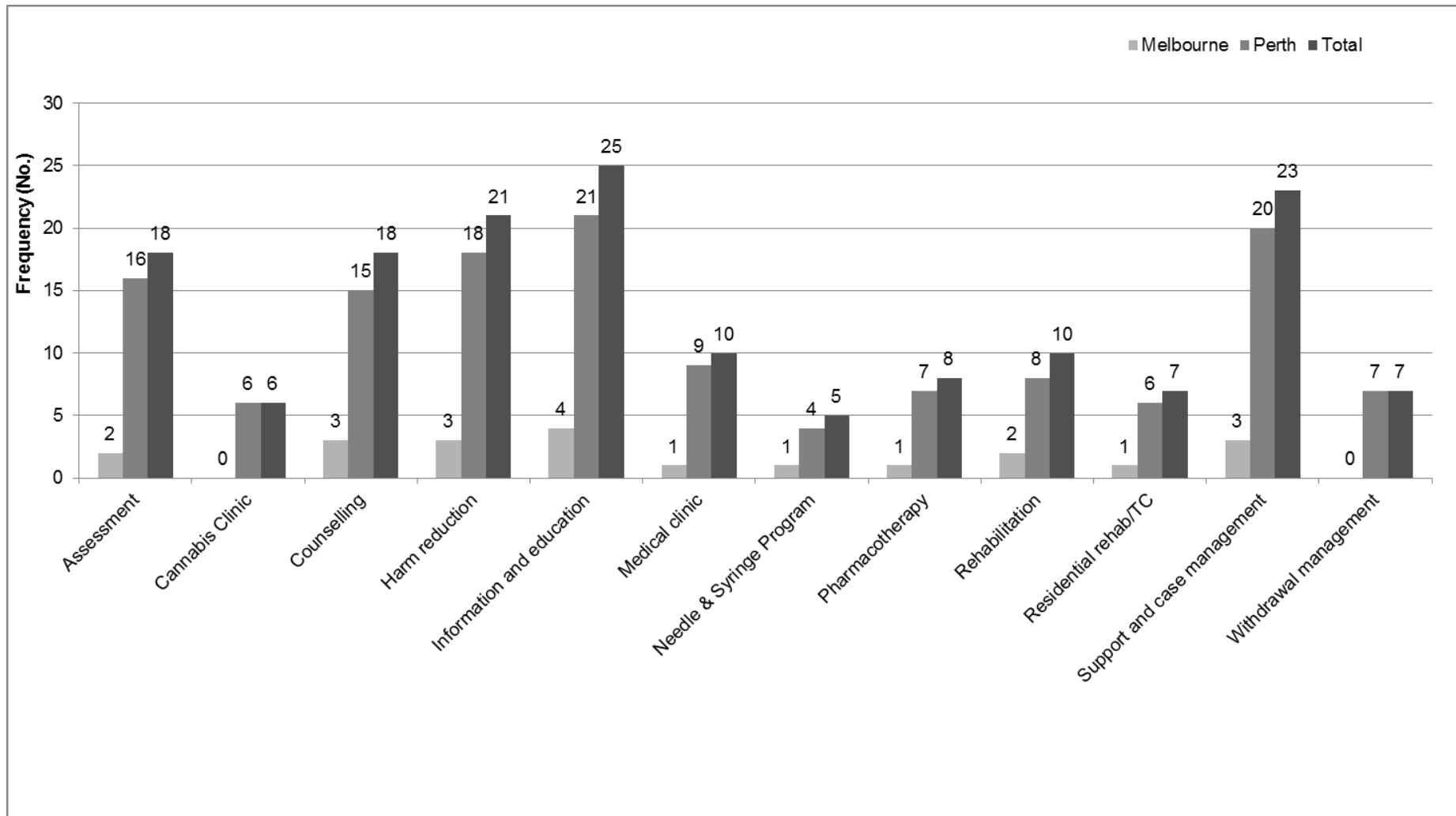
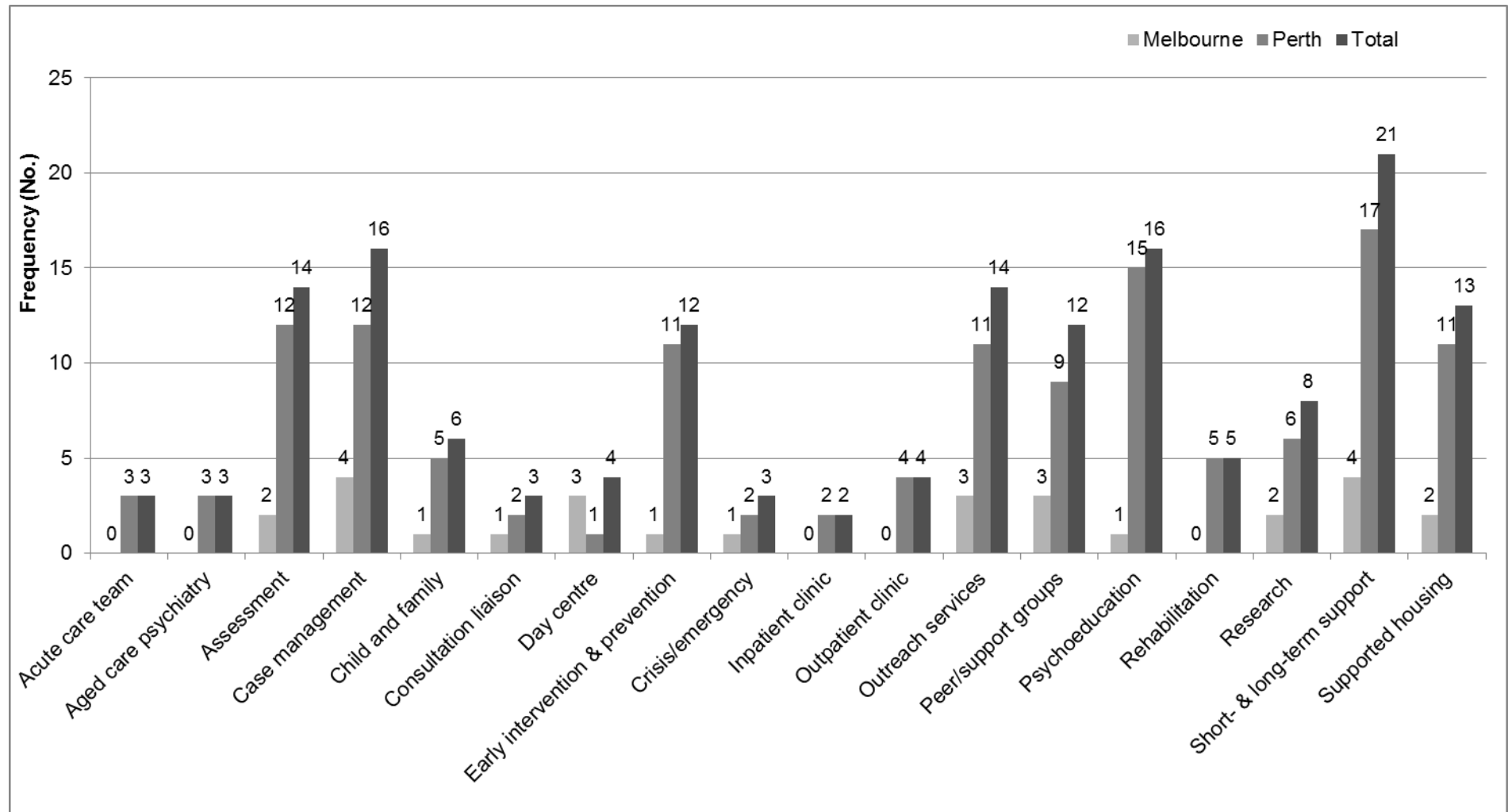


Figure 7: Types of mental health support provided by participating agencies, stratified by jurisdiction



In order to further establish the scope of integration within the network, we have examined the extent to which specialist homelessness, housing, drug and alcohol and mental health services are providing programs of support in domains *other than* their area of specialisation. Evidence of such support suggests a degree of internal integration within the relevant agency, what we have termed 'vertical integration'.

Fifteen per cent of specialist homelessness services in the sample also provide long-term housing, 40 per cent provide mental health services and 35 per cent also provide drug and alcohol support. In addition to mental health support, specialist mental health services also provide crisis and transitional accommodation and support, 28 per cent also provide long-term housing and 28 per cent also provide drug and alcohol support. Finally, in addition to drug and alcohol support, specialist drug and alcohol services also provide significant levels of mental health support with 62 per cent of services providing such support. This finding points to a high level of vertical integration of drug and alcohol and mental health support among participating agencies and reflects the emphasis on meeting co-morbidity issues in the drug and alcohol and mental health area (and in the homelessness sector).

5.1.3 Depth of integration

The *Integration of Human Services Network Measure* (Browne et al. 2007) was used to measure the depth of integration across the three service domains (specialist homelessness, mental health and drug and alcohol services) within the two defined regions of Melbourne and Perth. The observed and expected depths of integration scores were calculated for the total group and for each service domain to establish the degree of exchange within and across the sectors in the geographical areas of interest.

Service managers from specialist homelessness, mental health and drug and alcohol services were asked to rate, on a five point scale, from 0 = no awareness to 4 = collaboration, the extent to which they *are* involved with all other services in the geographical region, as well as the extent to which they *should be* involved with other services. Scores were also calculated to generate a 'clinical' indicator scale ranging from very little integration (0–49) to perfect or complete integration (3.5–4). See Tables 9 and 10 for a description of each clinical indicator and level of scoring, respectively.

Data for Perth and Melbourne services were analysed separately to determine the extent of service integration in their respective networks. Responses from 17 services in the outer eastern geographic region of Melbourne were analysed. This consisted of three specialist homelessness services, 12 mental health services, and two drug and alcohol services. For the City and South East Corridor of Perth, data from 47 services were analysed. This consisted of 26 specialist homelessness services; eight specialist mental health services; and 13 drug and alcohol services.

In line with the recommendations of Browne et al. (2007), observed and expected depth of integration scores were calculated. Observed depth of integration can be described as the degree to which service managers self-report that they interact, jointly plan and communicate with other services in their local network. The observed depth of integration is a positive measure of integration. The expected depth of integration is the degree to which service managers self-report that they *should* interact, jointly plan and communicate with other services in a network.¹¹ It is a normative measure of integration as perceived by service managers.

¹¹ The study also measured the degree of congruence and reciprocity reported by each individual service within the network. Congruence is the difference between each individual service's observed and

Table 9: Extent of integration scores for both observed and expected integration

Range of scores	Level of involvement	Description of observed integration	Description of expected integration
0	No awareness	Your service is <i>not</i> aware of the other service	Your service <i>should not</i> be aware of the other service
1	Awareness	You <i>have</i> knowledge of the other service although no effort is taken to organise activities according to any principles except those that conform to individual service missions.	You <i>should</i> have knowledge of the other service although no effort is taken to organise activities according to any principles except those that conform to individual service missions.
2	Communication	You and the other service <i>have</i> an active program of communication and information sharing.	You and the other service <i>should</i> have an active program of communication and information sharing.
3	Cooperation	You and the other service <i>each use</i> your knowledge of the other's service to guide and modify your own service planning in order to obtain a better set of links between services.	You and the other service <i>should</i> each use your knowledge of the other's service to guide and modify your own service planning in order to obtain a better set of links between services.
4	Collaboration	You and the other service <i>jointly</i> plan the offering of policies and/or services and actively modify service activity based on advice and input from mutual discussions.	You and the other service <i>should</i> jointly plan the offering of policies and/or services and actively modify agency activity based on advice and input from mutual discussions.

Source: Browne et al. 2004, Integration of Human Services Measure

Table 10: Indicators for level of service integration scores

Score range	Clinical indicator
0.0 – 0.49	Very little integration
0.5 – 0.99	Little integration
1.0 – 1.49	Mild integration
1.5 – 1.99	Moderate integration
2.0 – 2.49	Good integration
2.5 – 2.99	Very good integration
3.0 – 3.49	Excellent integration
3.5 – 4.00	Perfect integration

Source: Browne et al. 2004

expected depth of integration scores within a network, while reciprocity is a measure of the difference between an individual service's self-reported depth of integration score and the group reported depth of integration score for that service. These results are presented graphically in Appendix 2.

In interpreting the results, it is important to be mindful of two things. First, that the geographical boundaries are wide and, in the case of Perth, combine potentially two sub-regions into one region. Second, that especially in the case of Perth, there are a large number of services operating. The practical implication of this is that services may have a highly integrated network of services that they work in across the three main domains but may have relatively little interaction with the broad set of services in the area of interest. We consider this question further below.

Total integration score for each network: Perth and Melbourne

In relation to the total observed depth of integration, service managers in the outer eastern region of Melbourne (N = 17) reported a score of 2.19 out of 4 (or 55%), indicating that overall, service managers reported a good level of interaction, joint planning and communication between services in the specified geographical region. The total expected depth of integration score for Melbourne was slightly higher (2.81 out of 4, or 70%), indicating that service managers expected that depth of integration should be higher in their local network.

For the Perth network of services (N = 47), the total observed depth of integration score was 1.52 out of 4 (or 38%) indicating that overall, service managers reported only a moderate level of interaction, joint planning and communication between services in their network. The total expected depth of integration score for Perth was 1.94 out of 4 (or 48%), indicating that service managers expected that the depth of integration in their local network should be slightly higher.

As indicated previously, the Perth site was chosen as indicative of what might be expected in terms of service integration in an area, which has been a focus of homelessness and drug and alcohol and mental health services (inner city to immediate outlying suburbs of high need) without a defined general partnership model in place. The Melbourne site would be more indicative of narrowly defined geographical sites outside the traditional focus of homelessness services where a strong formal partnership model is in place for a number of services in the region. Hence, we would expect the observed level of integration to be lower for the Perth site than for the Melbourne site. However, interestingly, the expected level of integration was also lower in Perth than in Melbourne suggesting that observed levels of integration may anchor expectations of the desired level of integration.

Domain-specific integration scores for the Melbourne network

Table 11 shows the total observed depth of integration scores for each of the service domains for Melbourne; the extent to which each of these domains report that they should be involved with other services in their network; and the extent to which services in a network report that they should be involved with each of the other service domains. The results should be read in light of the fact that there are a relatively small number of services in each domain in Melbourne.

On average, service managers in all three domains reported good levels of interaction, joint planning and communication between their domain and other service domains within their local network in Melbourne. However, service managers from both the specialist homelessness and mental health services domains reported that there should be a higher level of integration between their service and others in the network. Mental health service managers reported the greatest difference between observed and expected levels of integration and indicated that they should be at the level of cooperation with other services rather than being at the level of where they are now, which is at the communication level within the network (see Table 10 for a description of scores).

While mental health service managers report this higher expectation, on average other service managers from other domains within their network expect a slightly lower level of involvement and integration with them. Furthermore, homelessness and drug and alcohol service domains both had higher network-reported expected depth of integration scores than their own expected levels of involvement with these other groups. For example, while service managers from mental health and specialist homelessness services expected excellent integration and a more cooperative involvement with drug and alcohol services, drug and alcohol service managers themselves in the network only expected good integration at the communication level of involvement with these other services.

Domain-specific integration scores for the Perth network

Domain-specific integration scores for the Perth network are set out in Table 12. Table 12 shows the total observed depth of integration scores for each of the service domains (specialist homelessness service, mental health and drug and alcohol) for Perth. It also shows the extent to which each of these domains report that they should be involved with other services in their network, and the extent to which services in a network report that they should be involved with each of the other service domains.

On average, service managers in both the specialist homelessness and mental health domains in Perth reported relatively low levels of interaction, joint planning and communication between their service domains and other domains in the network. Drug and alcohol service managers reported a slightly higher level of depth of integration.

All service managers within each domain of the Perth region reported that there should be a higher level of integration between their service domain and the services within their local network. In particular, mental health and drug and alcohol service managers indicated that they need to move beyond simply having an awareness of other services, to establish an active program of communication and information sharing. There was no discrepancy between domain-reported expected depth of integration with other services' scores and network-reported expected depth of integration scores. This indicates that all service domains expect that the same level of involvement should occur within the local network. This expected level of involvement is reported to be at the very good to excellent level of service integration.

Localised depth of integration

The integration measure used by Browne et al. (2007) is appropriate for assessing the depth and scope of integration within a singular cohesive network. Our sample consists of large geographical regions across Melbourne and Perth, within which there are likely to be multiple network clusters. Thus, the aggregation of scores within each of these geographical regions to calculate the total depth of integration may not reflect the intricacies of network connectivity within these regions. Specifically, this aggregate measure may under-represent the degree of networking present within each cluster.

Further examination of the integration data reveals important patterns in terms of strength of relationships within specific clusters of each region. The proportion of services reporting collaborative relationships with other services is outlined below.

Collaborative relationships are indicated by a depth of integration score of 4 out of 4, and are representative of joint planning of policies and/or services and active modification of service activity based on advice and input from mutual discussions (Browne et al. 2007).

Collaborative relationships for the Melbourne network

Of the services recruited in Melbourne, 94 per cent indicated that they held a strong collaborative relationship with at least one other service in the sample.

All homelessness services from the Melbourne sample indicated that they hold at least one strong collaborative relationship with another service in the sample. Two of the three reported having a strong collaborative relationship with at least one mental health service and one of the three reported a strong collaborative relationship with at least one drug and alcohol service. In contrast to the pattern seen in the Perth sample, there were no collaborative relationships between services within the homelessness domain in the Melbourne sample.

Table 11: Total observed and expected levels of depth of integration by specialist homelessness, mental health and drug and alcohol services within the outer eastern metropolitan region of Melbourne

	Total observed depth of integration scores for each <i>domain</i> <i>To what extent do services from each of the three domains report that they are involved with other services within the network?</i>		Domain-reported expected depth of integration with other services <i>To what extent do service managers in each domain report that they should be involved with other services in their network?</i>		Network-reported expected depth of integration with each domain <i>To what extent do other services in the network report that they should be involved with the services in each domain?</i>	
Melbourne network domain	Total observed depth of integration score for each domain	Clinical indicator and observed level of involvement for each domain	Total expected depth of integration score for each domain	Clinical indicator and expected level of involvement as reported by domain	Total expected depth of integration score reported by the network about each domain	Clinical indicator and expected level of involvement as reported by network
Specialist homelessness services N=3	2.15 or 54%.	Good integration Communicating	1.85 or 46%.	Should have moderate integration Should be aware and communicating	2.70 or 68%.	Should have very good Integration Should be communicating and cooperating
Mental health services N=12	2.02 or 50%.	Good integration Communicating	3.12 or 78%.	Should have excellent integration Should be cooperating	2.69 or 67%.	Should have very good integration Should be communicating and cooperating
Drug and alcohol services N=2	2.39 or 60%.	Good integration Communicating and cooperating	2.35 or 59%.	Should have good integration Should be communicating	3.07 or 77%.	Should have excellent integration Should be cooperating

Table 12: Total observed and expected levels of depth of integration by specialist homelessness, mental health and drug and alcohol services within the City and South East Corridor region of Perth

	Total observed depth of integration scores for each domain <i>To what extent do services from each of the three domains report that they are involved with other services within the network?</i>		Domain-reported expected depth of integration with other services <i>To what extent do service managers in each domain report that they should be involved with other services in their network?</i>		Network-reported expected depth of integration with each domain <i>To what extent do other services in the network report that they should be involved with the services in each domain?</i>	
Perth network domain	Total observed depth of integration score for each domain	Clinical indicator and observed level of involvement for each domain	Total expected depth of integration score for each domain	Clinical indicator and expected level of involvement as reported by domain	Total expected depth of integration score reported by the network about each domain	Clinical indicator and expected level of involvement as reported by network
Specialist homelessness services N=26	1.41 or 35%.	Mild integration	1.58 or 39%.	Should have moderate integration	1.84 or 46%.	Should have moderate integration
		Aware		Should be aware and communicating		Should be aware and communicating
Mental health services N=8	1.30 or 33%.	Mild integration	2.39 or 60%.	Should have good integration	1.99 or 50%.	Should have moderate integration
		Aware		Should be communicating		Should be aware and communicating
Drug and alcohol services N=13	1.75 or 44%.	Moderate integration	2.26 or 57%.	Should have good integration	2.26 or 57%.	Should have good integration
		Aware and communicating		Should be communicating		Should be communicating

The vast majority (92%) of mental health services recruited from Melbourne reported having at least one strong collaborative relationship with another service. Collaborative relationships with other mental health services were most likely (92%), followed by homelessness services (54%), and then drug and alcohol services (46%).

All the drug and alcohol services within the Melbourne sample reported at least one strong collaborative relationship with a service. However, this collaboration was limited to the drug and alcohol sector; neither of the drug and alcohol services included in the sample reported collaborative relationships with services in the mental health or homelessness domains.

Collaborative relationships for the Perth network

In the Perth sample, 71 per cent of services reported having a strong collaborative relationship with at least one other service in another domain. Fifty-five per cent of homelessness services recruited from Perth reported having at least one collaborative relationship with another service included in the sample. In terms of specific domains, none of the homelessness services had collaborative relationships with mental health services, 40 per cent have a collaborative relationship with at least one drug and alcohol service, and 55 per cent reported having a collaborative relationship with at least one other homelessness service.

Seventy-five per cent of mental health services surveyed indicated that they have at least one strong collaborative relationship with another service from the Perth sample. The same proportion had a strong collaborative relationship with at least one drug and alcohol service, and one homelessness service and 100 per cent have a strong collaborative relationship with at least one other mental health service.

Among drug and alcohol services in the Perth sample, 91 per cent reported having at least one strong collaborative relationship with another service in any domain. Strong collaborative relationships with other drug and alcohol services were most likely (82%), followed by homelessness services (64%), and then mental health services (27%).

5.2 Functioning of integration

The second main dimension of integration we consider is concerned with the functioning of the network. Network functioning is reflected in the quality, participant perceptions and ingredients of the network. The following section presents the findings from the *Integration Survey* that measured each of these domains complemented by a discussion of the themes that emerged from the case studies.

5.2.1 Quality of the network

One of the aims of this study was to explore the current level and nature of service and system integration within selected networks in Perth and Melbourne, as it relates to the provision of support services to homeless people with poor mental health and problematic substance use. Furthermore, a typology of integration in the homelessness context was sought, coupled with an account of how and over what dimensions homelessness services in these regions coordinate and partner with mental health and drug health services (and vice versa).

The Weiss et al. (2002) *Partnership Synergy Self-Assessment Tool* was included within the *Integration Survey* to explore how services work with other services to meet the needs of client/consumers. Table 13 gives a brief description of each of the scale's dimensions.

Service managers who indicated that their service works together with other services in the areas of housing/homelessness, mental health, and/or alcohol and drug issues

in a formal partnership were invited to complete the measure. Managers completed the measure by considering the most important partnership that exists between their service and another. The results presented below are conditional in the sense that only those services who indicated they had a partnership completed the relevant questions.

Service managers were asked to rate on a scale from 1–5 (with 1 indicating worst and 5 indicating best) the degree to which their formal partnership operationalised or engaged in the given dimensions.

Table 13: Dimensions of the Weiss Partnership Synergy Self-Assessment Tool¹²

Dimension	Description
Synergy	The extent to which the combined perspectives, knowledge, and skills of the partners strengthen the thinking and actions of the group and the partnership's relationship to the broader community.
Leadership	Leadership in partnerships may be informal or formal and may include (but is not limited to): taking responsibility for the partnership; inspiring and motivating partners; fostering respect, trust inclusiveness, and openness in the partnership.
Partnership efficiency	The extent to which services make good use of partner's financial resources, in-kind resources and time.
Administration and management	Administration and management activities that may be especially important in supporting the partners and achieving high levels of synergy.
Non-financial resources	The extent to which partnerships have what they need to work effectively to achieve their goals in relation to skills and expertise; data and information; connection to target populations, connection to political decision-makers, etc.
Financial and other capital resources	The extent to which a partnership has the financial and other capital resources needed in order to work effectively and achieve its goals.

Network quality: Melbourne

Table 14 shows the average partnership synergy dimension scores for the total Melbourne sample, and for specialist homelessness, mental health and drug and alcohol services in Melbourne. Note that the scale ranges from 1–5, from worst to best, with 3 being the midpoint.

The responses from Melbourne service managers reveals that for the total Melbourne sample all dimensions of partnership synergy are generally being experienced or applied by services. Overall, on average, services in the Melbourne sample are:

- Able to achieve various goals somewhat well by working together (synergy).
- Have fair to good effectiveness across multiple areas of leadership (leadership).
- Have partnerships that make good use of time and resources (partnership efficiency).
- Have partnerships with good levels of effectiveness in carrying out administrative and managerial activities (administration and management).
- Have some of the non-financial resources they need to work effectively (non-financial resources).

¹² See Weiss et al. (2002) for a more detailed description of each of the Partnership Synergy dimensions.

Table 14: Average partnership synergy dimension scores for Melbourne

Dimension	Total	Homelessness	Mental health	AOD
Synergy	3.33	3.33	3.36	3.56
Leadership	2.71	3.05	2.66	2.27
Partnership efficiency	2.94	2.55	3.10	3.00
Administration and management	2.78	2.39	2.70	3.00
Non-financial resources	3.09	2.67	3.08	4.00
Financial and other capital resources	3.00	3.22	2.71	4.00

Although there does appear to be some differences between the experience or application of partnership dimensions between service domains, particularly in the domains of non-financial resources and financial and other capital resources, a one-way between groups ANOVA revealed that these differences were not significant.

Network quality: Perth

The responses from Perth service managers reveals that for the total Perth sample all dimensions of partnership synergy are generally being experienced or applied by services at an effective level. Overall, services in the total Perth sample are:

- Able to achieve various goals somewhat to very well by working together (synergy).
- Have good effectiveness across multiple areas of leadership (leadership).
- Make good use of time and resources (partnership efficiency).
- Are involved in partnerships with good levels of effectiveness in carrying out administrative and managerial activities (administration and management).
- Report that their partnerships have some to most of the resources they need to work effectively (non-financial resources; financial and other capital resources).

A one-way between groups ANOVA revealed no significant differences between any of the reported partnership synergy dimensions of specialist homelessness, mental health and drug and alcohol services.

Table 15 shows the average partnership synergy dimension scores for the total Perth sample, and for specialist homelessness, mental health and drug and alcohol services in Perth.

Table 15: Average partnership synergy dimension scores for Perth: total group and total service domains

Dimension	Total	Homelessness	Mental health	AOD
Synergy	3.61	3.56	3.87	3.46
Leadership	3.45	3.37	3.70	3.43
Partnership efficiency	3.41	3.40	3.89	3.08
Administration and management	3.15	3.16	3.09	3.15
Non-financial resources	3.67	3.63	3.77	3.67
Financial and other capital resources	3.60	3.62	3.50	3.62

5.2.2 Participant perceptions

Satisfaction with participation

Service managers' satisfaction with participation in partnerships was explored using Weiss et al.'s (2002) *Partnership Synergy Self-Assessment Tool*. Satisfaction was measured using the item 'How satisfied are you with the way the people and organisations in the partnership work together?' Respondents were asked to rate from 1–5 the degree to which they are satisfied or not (1 = not at all satisfied and 5 = completely satisfied).

Table 16 shows the average score reported for the total sample and for each of the service domains. There were no significant differences in satisfaction with participation between each of the service domains and, on average, participants reported that they were somewhat to mostly satisfied with the various elements of participation measured.

Table 16: Average satisfaction with participation scores for service participants, stratified by service domain

Dimension	Total	Homelessness	Mental Health	AOD
Satisfaction with participation	3.54	3.65	3.30	3.66

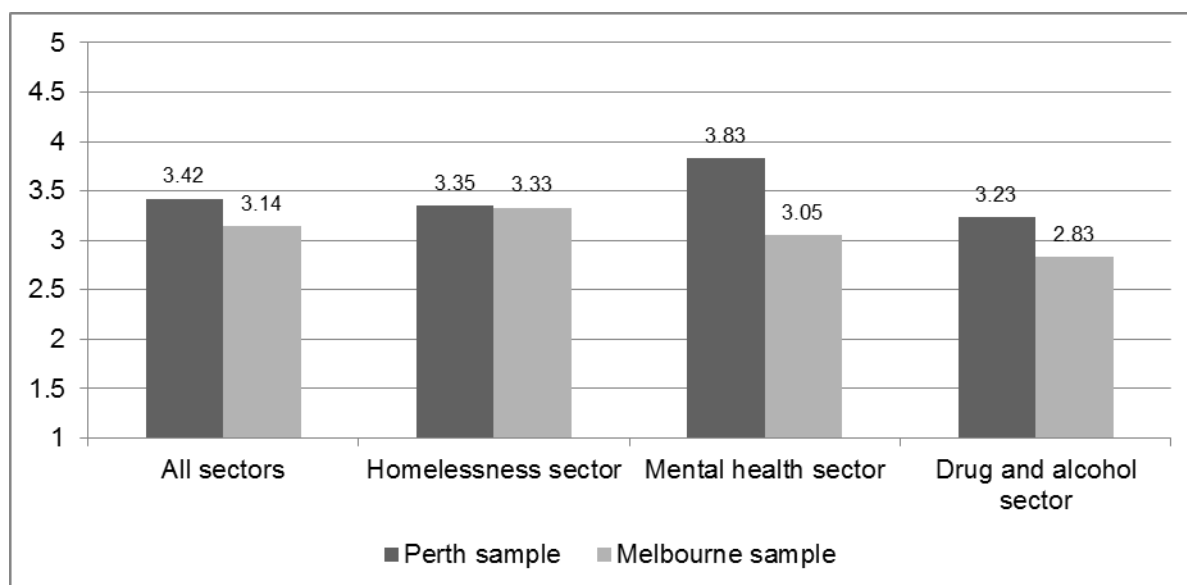
Decision-making

Browne et al. (2004) define decision-making in the context of integration as the way decisions are made in the partnership. For example, whether stakeholders feel supported or alternatively excluded in the decision-making process, whether the network gives due consideration to all stakeholders in the decision-making process, and whether individual stakeholders feel pressured to conform with group decisions.

Results from the *Integration Survey* suggest that, on average, respondents are somewhat comfortable with the way decisions are made in their formal partnerships. A one-way between groups ANOVA revealed no differences between the sectors in their experience of decision-making within their networks.

Figure 8 shows the average decision-making dimension scores for the total sample and for specialist homelessness, mental health and drug and alcohol services across the two study sites and for the entire sample. As with the dimensions presented in the previous section, the scale ranges from 1–5, from worst to best, with three being the midpoint.

Figure 8: Decision-making dimension scores stratified by study site



Interviews with case study participants revealed two important factors that contribute to effective decision-making in partnerships—respect among partners for each other’s areas of expertise and feeling comfortable to raise concerns outside of one’s own area of expertise. In this sense, decision-making was linked to the experience of the *relationship* between partners. A homelessness case study participant in Sydney gave an example of how collaborative decision-making can be effective:

One client was suffering chest pains that he thought was angina, and so by agreement with the case manager from the [health] community team, we sent him down to our doctor at the clinic. The case manager in the [health] community team followed up with the doctor after that particular visit, and in that particular case they felt he needed to have a number of tests done. So between them they actually worked out a strategy as to how he might be able to get into [hospital] and get those tests done.

5.2.3 Critical ingredients for integration

Results from the *Integration Survey*

According to the Browne et al. model (2007), the overall functioning of the network is dependent on both the quality of partnership functioning and the ingredients of integration within the network’s working arrangements. The *Integration Survey* included a series of questions to ascertain the extent to which the necessary ingredients for integration are present in the working arrangements of services in the sample. Services indicated the degree to which these critical ingredients are present in their relationships with other services from each of the four domains: homelessness, housing, mental health, and drug and alcohol.

The critical ingredients can be conceptualised as belonging to four key categories:

- Sharing and participation between services.
- Client referrals.
- Relationships between staff.
- Inter-agency functioning.

The sharing/participation component refers to whether services share protocols, procedures, goals, funding, client plans of care and client data. Services were asked to indicate how frequently ('never', 'rarely', 'sometimes', 'often' or 'always') they share these components with other services in each of the four domains.

For the nine items within the sharing/participation category, the most common response was that services *never* share these resources. There was some variation depending on the resource shared. However, of all the components listed, assessment protocols (policies, procedures) were the most likely to be shared between services (20% of services 'always' share these protocols), and planning and budgeting goals were the least likely to be shared between services (4% of services 'always' share goals). In terms of the different domains, sharing was most likely with mental health services and least likely with homelessness and housing services.

The client referrals component pertains to whether services refer clients on to other services, receive referred clients from other services, and whether reciprocal referral arrangements exist between services. Overall, services stated that client referrals occur 'sometimes' between their own service and those in the homelessness/housing sector, and 'often' between their own service and those in the mental health/drug and alcohol sector. The most common practice was services referring clients onto other services (this was most frequently noted to occur 'often' across all domains). Having reciprocal client referral arrangements in place with other services was less likely; across all domains, only 9 per cent of services 'always' use such agreements, and 33 per cent 'never' use such agreements.

Critical ingredients of integration relating to staff include sharing of staff, cross-training of staff, awareness of staff members in other services, inter-agency MOUs and the involvement of staff from other services during and after a client's discharge. On average, these integrative processes for staff are most commonly used 'sometimes' (36%) with other services in the mental health and drug and alcohol domain, and 'never' (32%) with other services in the homelessness/housing domain. The sharing of staff between services was found to be a very uncommon practice (71% responded that their staff are never shared with other services). The most common practice in this category was the referral of discharged clients to other services (92% of the services surveyed 'sometimes', 'often', or 'always' refer clients on to other services once they have been discharged).

The inter-agency component involves the frequency of inter-agency case review meetings with other services, communication between services and sharing of a physical locality. Overall, services were most likely to report that they 'sometimes' conduct inter-agency case review meetings with other services (this response was given by 40% of services). Regular (monthly) inter-service communication appears to be more likely than formal meetings; services were most likely to report that this type of regular communication occurs 'often' (36%). Sharing a physical location with other services was uncommon (58% 'never', 14% 'always').

In conclusion, these results suggest that services in this sample are lacking many of the necessary ingredients of integration. Across all categories and relationships with each of the service domains (see Figure 9), services were most likely to respond that they 'never' engage in the practices outlined (28%), and least likely to respond that they 'always' engage in these practices (10%).

Figure 9: Frequency with which critical ingredients of integration are present across all service domains

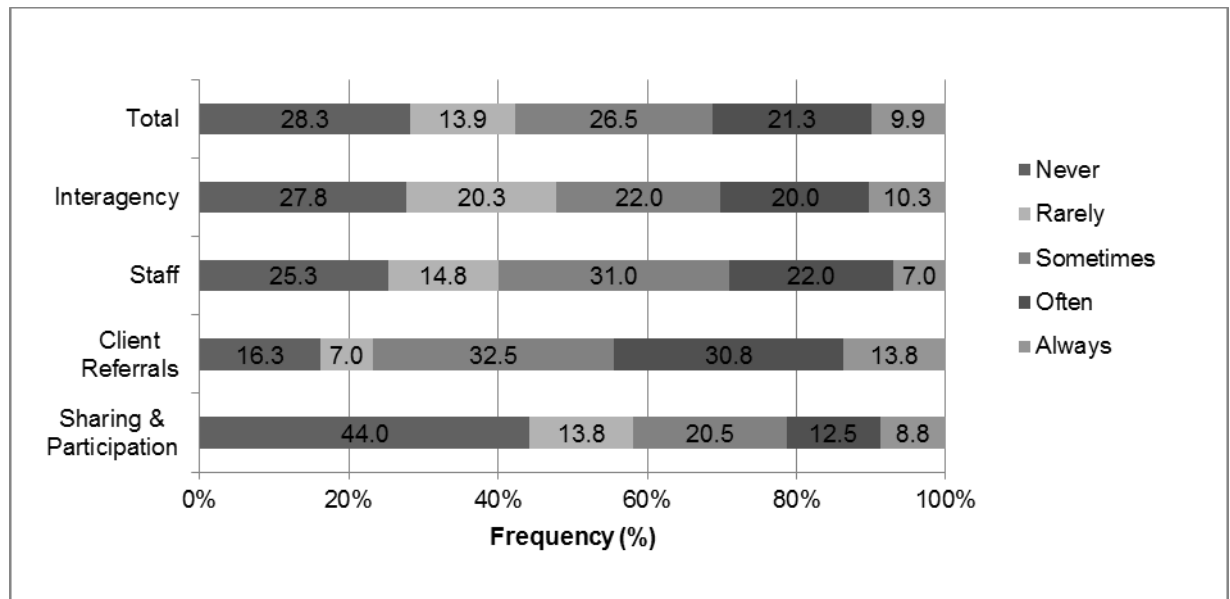


Figure 10: Frequency with which critical ingredients of integration are present in partnerships with homelessness services

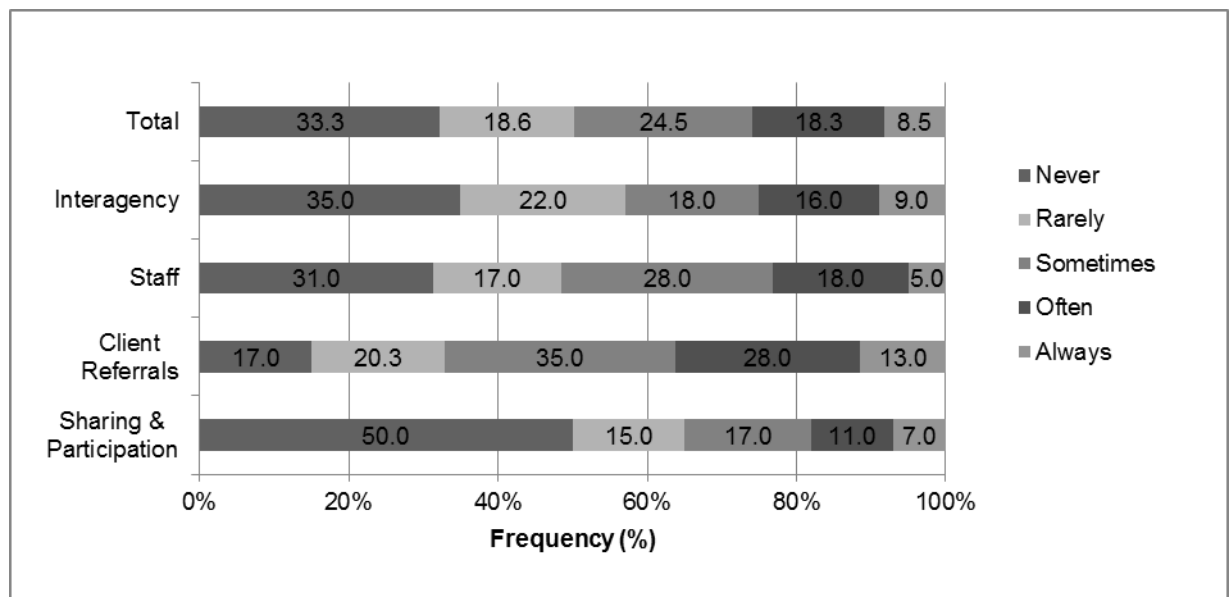


Figure 11: Frequency with which critical ingredients of integration are present in partnerships with housing services

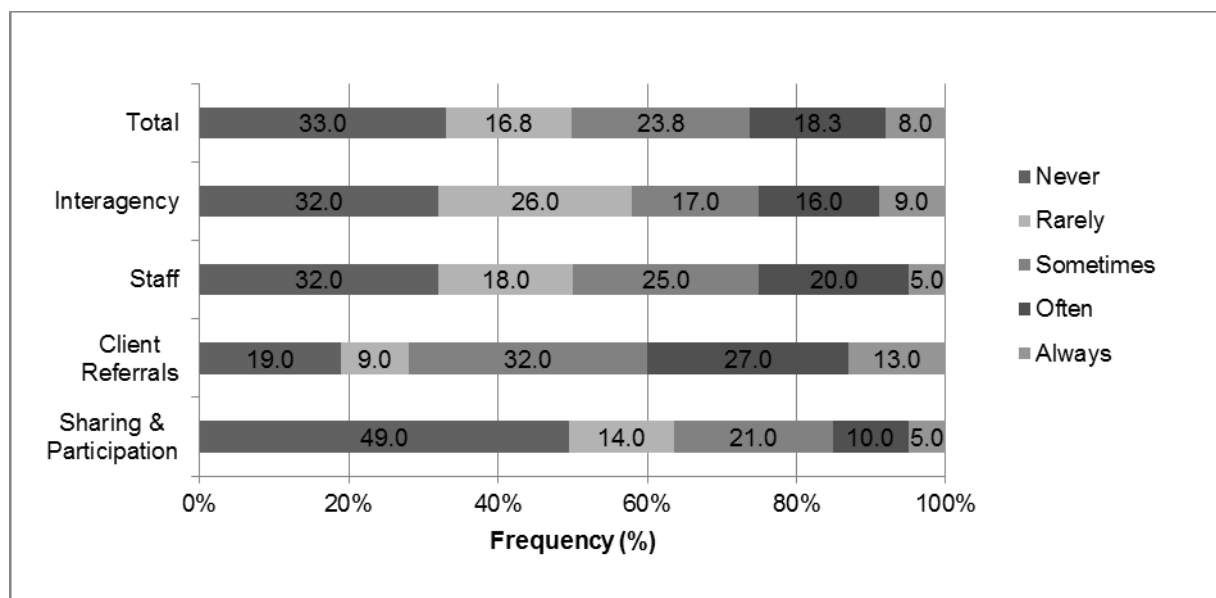


Figure 12: Frequency with which critical ingredients of integration are present in partnerships with mental health services

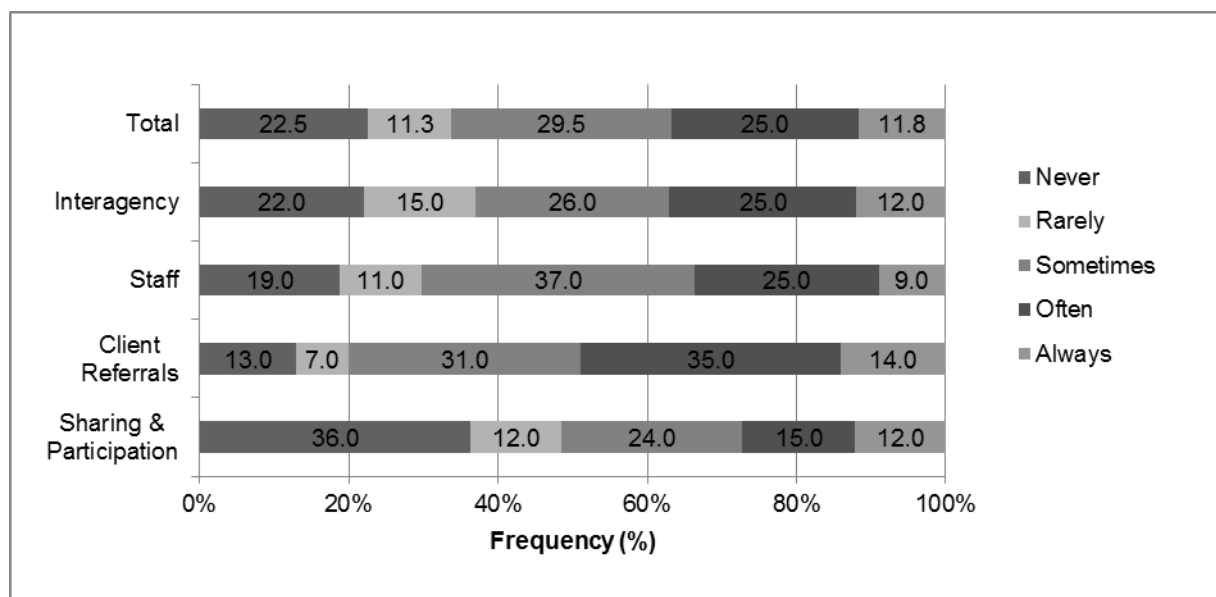
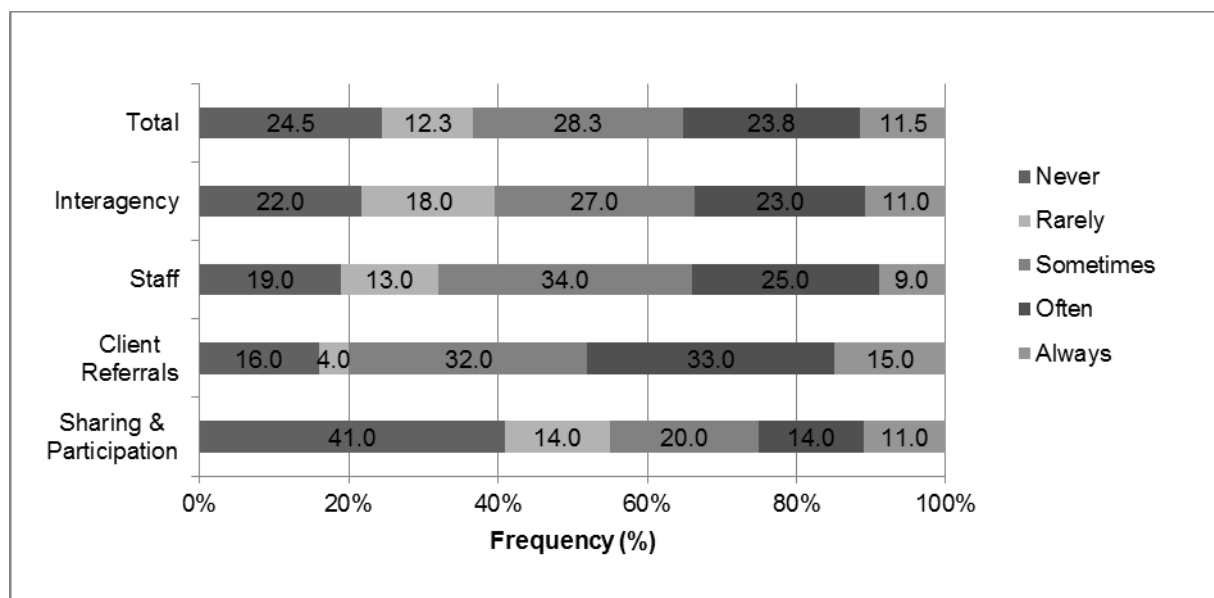


Figure 13: Frequency with which critical ingredients of integration are present in partnerships with drug and alcohol services



Partnerships with services in the homelessness and housing sectors were found to have the fewest critical ingredients overall, with 33 per cent saying these practices and policies ‘never’ occur or exist, compared to 22 per cent for partnerships with mental health and 24 per cent for partnerships with drug and alcohol services (see Figures 10–13).

Results from interviews with stakeholders and case study participants

Key stakeholders and case study participants were asked to comment on the ingredients they considered critical to achieving effective integration.

There was overwhelming consensus for the first six categories shown in Table 17—streamlined assessment, facilitated referrals, case review and supervision, flexible and supportive governance, relationships and communication and staffing. The final category in Table 17—model integrity—was less frequently cited by participants. However, general observations of the partnerships examined in the case studies suggested the inevitable challenges of new partnerships could be minimised somewhat if due process was given to establishing model parameters first.

The factors identified by the present study are consistent with factors reported by other researchers. For example, Ouwens et al. (2005) identified shared agreement on the nature of integration and commitment and support from management as key enablers of successful integration. In the present study, commitment was considered an important attribute of front-line workers in addition to managerial staff; this was often explained with regard to the development of relationships among workers with direct responsibility for addressing client need.

Case study participants considered integration to be more harmonious and less difficult if partners shared similar values and common ways of working with clients. Consistent with this finding, Gröne and Garcia-Barbero (2002) acknowledged that entrenched professional values and approaches could impede integration. The findings of the present study suggest that this barrier can be overcome with the establishment of good relationships. In particular, case study participants talked enthusiastically about the gaining of new understandings and insights of how to work with clients when involved in multi-agency and cross-sectoral partnerships.

Table 17: Critical ingredients for integration

Streamlined assessments
<ul style="list-style-type: none">→ Single entry point; else multiple entry points linked to efficient referral system→ Assessments that follow a client through the system→ Multi-disciplinary assessments, for example psychologist and psychiatrist assessing a client together→ Formal arrangements (e.g. MOUs) for the acceptance of assessments from referring agencies, for example suicide risk
Facilitated referrals
<ul style="list-style-type: none">→ On-the-spot referrals in the presence of the client→ Transporting clients to referrals (predominantly between agencies but also walking a client from one service to another within an agency)→ Attending initial appointments with clients (particularly within mainstream health settings)→ Preparing the client about the referral (e.g. assessment processes of service being referred to, reason for referral) and following up with the client afterwards regarding the outcome of the referral→ Negotiating the referral on behalf of the client; minimally this involves researching referral options and establishing the eligibility criteria and assessment processes with services before referring a client→ Assertive referral of clients back to the referring agency at the end of an episode of care (e.g. post-treatment care plans, discharge summaries)
Case review and supervision
<ul style="list-style-type: none">→ Secondary consultation to staff from outside own area of expertise→ Regular case/clinical review meetings involving multi-disciplinary or multi-sectoral staff (e.g. mental health clinician attending the weekly case review meeting of homelessness support workers)→ Seeking advice from others, including consulting with expert partners within a partnership or consulting with staff from co-located teams or services→ Shared knowledge of how to work with a client (e.g. impact of mental health disorder on capacity to engage)
Flexible and supportive governance
<ul style="list-style-type: none">→ Ability to revise model parameters or approaches based on ongoing assessment of the program/service in meeting the needs of the target population→ Management support staff to undertake their role in such a way that enables them to meet client needs (e.g. flexible work hours to accommodate after-hours support for clients)
Relationships and communication
<ul style="list-style-type: none">→ Developing knowledge within the team including the exchange of knowledge from one sector to another→ Developing awareness and understanding of client need and service/program objectives across sectors or specialty areas→ Two-way accountability of relationships→ Collaborative approach to working with others (involves trust and respect among partners)→ Division of roles within a partnership to avoid ethical conflicts (e.g. housing support versus tenancy management)→ Multiple mechanisms for communication including formal meetings, electronic information exchange and informal 'as needed' conversations→ Established protocols for the protection of client privacy and shared understanding of confidentiality

Staffing

- Recruitment of the 'right kind' of people—committed, passionate, genuine
- Low staff turn-over
- Adequate staffing for the workload
- Expertise and experience built up over time, including established relationships and knowledge of the broader service landscape

Model integrity

- Alignment of values and philosophies among partner agencies
 - Intensity of integration mapped to complexity of client need
 - Clearly articulated goals for the partnership
 - Governance structure including mechanisms for resolving conflicts
 - Shared approach to working with clients (e.g. adoption of a particular case management model or therapeutic approach)
 - Linkages appropriate for the physical location of services, e.g. on-site clinics, satellite sites, co-location of services
-

In addition to identifying the key dimensions of effective integration, Table 17 demonstrates the particular strategies most commonly practiced by case study participants when engaging in integration practice. The breadth of strategies employed underscores the importance of developing localised responses even within a policy framework that establishes governance for an entire region. For example, the ConnectED program commenced as a pilot between a single homelessness agency and a single hospital emergency department to reduce the number of repeat presentations among homeless clients. It was subsequently extended to include additional hospital-support agency partnerships and although all participating partnerships adhere to a single governance structure, each partnership has its own protocol that specifies the relationship between the hospital and support agency. Achieving a balance between top-down and bottom-up processes is an important dynamic of integration.

There was clear evidence from the case studies that integration worked well where there was strong leadership and commitment from stakeholders with clear authority (e.g. government departments, agency management) and localised responses driven by stakeholders with ground-level knowledge and expertise (e.g. front-line workers, local networks). In this sense, integration appears to be driven by both top-down and bottom-up processes and the tension between the two processes can create different experiences of service and client integration.

5.3 Summary

This chapter used findings from the *Integration Survey* in relation to Perth and Melbourne to paint a picture of the structure and functioning of integration of homelessness, mental health and drug and alcohol services in selected regions of Perth and Melbourne.

Our first important finding is that specialist homelessness, housing, drug and alcohol and mental health services are providing programs of support in domains other than their direct area of specialisation. Evidence of such support suggests a degree of internal integration within the relevant agency, what we have termed 'vertical integration'. For example, 40 per cent of specialist homelessness services provide mental health services and 35 per cent also provide drug and alcohol support.

We measured the depth of integration in the specified geographical areas using Browne's *Integration of Human Services Network Measure* (Browne et al. 2007). On a scale from no integration through to excellent integration, Melbourne service managers reported a good level of interaction, joint planning and communication between services across the defined geographical area consistent with an active program of communication and information sharing. In Perth, services reported a lower moderate level of integration consistent with high levels of awareness but not active communication. In both cases, expected (or desired) depth of integration scores are somewhat higher than actual levels of integration indicating that service managers wish to ratchet up the level of integration between services across the relevant regions but only by a notch.

However, in both the Perth and Melbourne sites, both actual and desired levels of integration fall short of the two highest levels of integration—namely, cooperation and collaboration. Cooperation involves services across the region having an active program of communication and information sharing, while collaboration involves services working closely with each other to guide and modify their own service planning. The evidence suggests that services want to work more closely than they do in a given geographical area, but there are strict upper limits to integration across a broad set of services in a given geographical region.

In addition to examining the depth of integration in the context of a given geographical region, we also examined the extent to which individual services experienced the highest level of integration of collaboration (a depth of integration score of 4 out of 4) with at least one service in the region of interest. The vast majority of services in both Perth and Melbourne do have collaborative relationships with one other service in the same geographical region. In the Perth sample, for example, three-quarters of all services reported having a strong collaborative relationship with at least one other service in another domain. In the Perth sample, 55 per cent of homelessness services had at least one collaborative relationship with another service included in the sample. However, 40 per cent had a collaborative relationship with at least one drug and alcohol service and none had collaborative relationships with mental health services. Strong integrated relationships with other services are more likely with services in own sector domains than with other services.

Services in both Perth and Melbourne who engaged in formal partnerships reported relatively high scores across the various domains of synergy, leadership, partnership efficiency, administration and management and resources. However, services generally reported relatively low scores across critical ingredients of integration thought to be important for success in sustaining and developing service integration arrangements. Across the domains of sharing and participation between services; client referrals; relationships between staff; and inter-agency functioning, services were more likely to respond that they 'never' engage in the practices outlined and least likely to respond that they 'always' engage in these practices.

6 CLIENT EXPERIENCES OF SERVICE INTEGRATION

Research Question 4: What can clients and the practitioners who work with them tell us about clients' experiences of service integration and coordinated care within the homelessness, drug and alcohol and mental health sectors?

Drawing upon the results from the *Integration Survey* and interviews with case study participants and stakeholders, this chapter explores the issue of clients' views on the importance of service integration, their experiences of integration, difficulties with accessing services, and outcomes of service provision. In short, this chapter is concerned with the issue of client integration.

Client integration can be conceptualised in one of two ways: (1) how clients *perceive* the service system and whether it works seamlessly *in their eyes* to meet their needs in a timely, appropriate fashion; and, (2) how clients *experience* the service system and whether it works seamlessly *in actual practice* to meet their needs in a timely appropriate fashion. This chapter provides evidence on the former, 'subjective' reading of client integration, from the *Integration Survey* and the latter, 'objective' interpretation, indirectly, from expert opinion. It is for another study to provide direct evidence, using service usage and outcomes data against need, on whether clients actually do receive timely, appropriate, seamless service and how important service integration is to that outcome.

Nevertheless, we examine, in some depth in the present chapter, the relationship between perceptions of the quality of service delivery, including care coordination, and client outcomes on the part of clients on the one hand, and the depth of service integration exhibited by a service on the other.

6.1 Clients' views on the importance of integration

The *Integration Survey* included several structured and open-ended questions that sought to elicit accounts from clients on their understanding of the importance of service integration. We draw on their responses in what follows.

Clients described an optimal service as one that delivered a 'holistic package' where staff had an awareness of client needs and were proactive in following up with clients. Other clients described the importance of services working together to deliver a streamlined service and this was often linked to a need for better communication between services.

The consequences of poor integration cited by clients were two-fold:

- Continual re-telling of stories that clients found distressful and inhumane.
- Confusion, partly related to the sheer number of different professionals involved, but also to poor delineation of roles among staff from different services.

Some clients felt a lack of integration was best overcome through the provision of on-site care through a single service delivery model. Under this model, relevant professionals would attend the client's primary service rather than the client attending a range of relevant services. Other clients felt a greater emphasis on information sharing and care coordination would be of benefit, although they also recognised the costs involved, as articulated by a drug and alcohol service client:

Every single service has helped but [you] have to repeat your set of circumstances to each one, which can be hard, and I worry about who can access this information.

Clients from each of the three service domains expressed similar views. A number of them cautioned that care coordination and information sharing needed to be transparent, confidential and consensual.

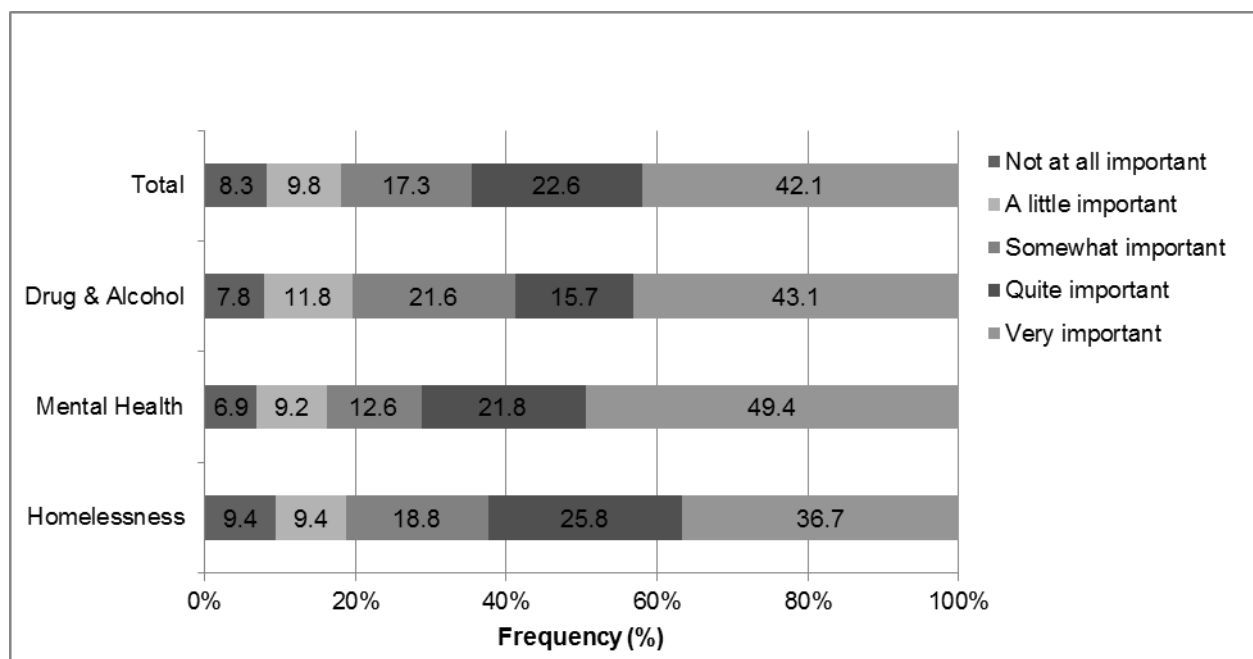
Many clients emphasised the qualities of workers as being critical to the service they received. These qualities included a genuine regard for the client, expressed as concern for the client's wellbeing and a willingness to help that went beyond the mere undertaking of a job; and a respectful attitude that made clients feel 'like a person needing a home rather than rubbish thrown on the streets'. The qualities of workers had the potential of overcoming some of the deficits of a poorly coordinated system, as noted by this housing service client:

I feel fortunate to have come into contact with some very good staff. Their genuine caring nature has made all the difference despite any difficulties or lack of with regard to services being coordinated. The quality and caring nature of the staff has been the most effective factor in helping me to start helping and caring for myself.

Indeed, there was recognition by some clients of the resource limitations of the service system that restricted the ability of workers to address client's needs. Resources mentioned by clients included knowledge and awareness of other services to facilitate referrals, adequate staffing to enable individualised assistance, and additional accommodation places to improve access.

Client participants were asked to rate how important it was that different services share information with each other about their needs. The majority of client participants (65%) indicated that information sharing was quite or very important (see Figure 14); 28 per cent felt it was somewhat or a little important and only 9 per cent of clients thought it was not important at all. Information sharing appears to be perceived as most important for clients of specialist mental health services. Almost half of the mental health clients rated it as 'very important' compared to 37 per cent of homelessness clients and 43 per cent of drug and alcohol clients.

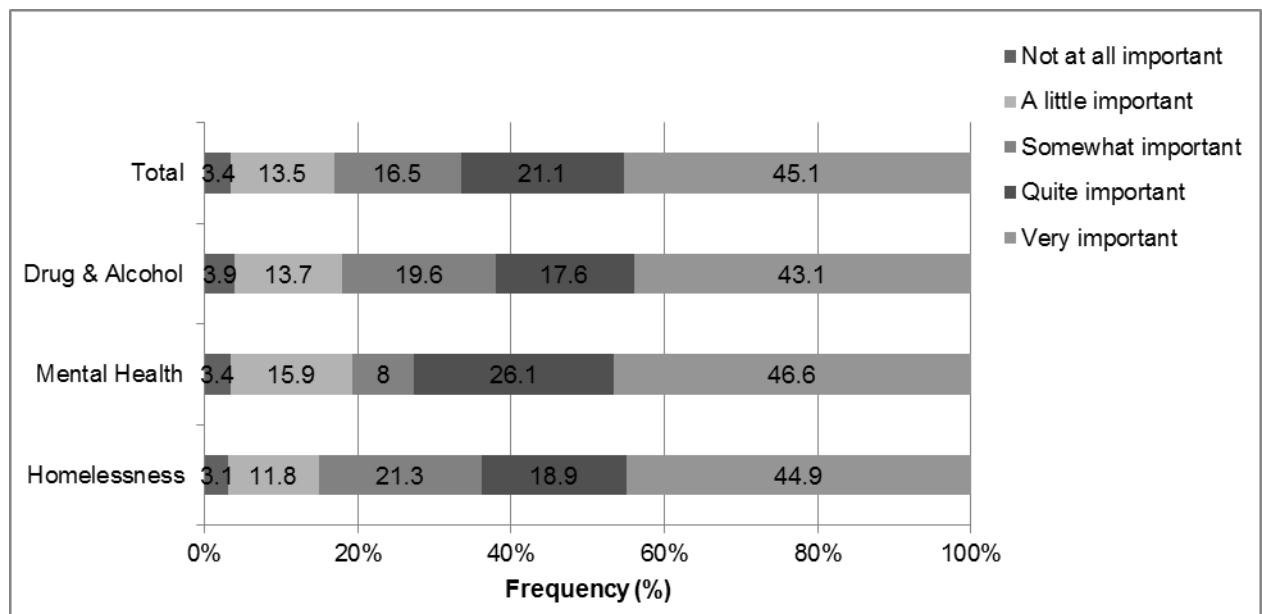
Figure 14: Degree of importance placed on information sharing by client participants of the *Integration Survey*



Client participants were also asked to rate how important it was that they had someone to help coordinate their access to different services. These results are shown in Figure 15.

Similar to the findings for the importance of information sharing, the majority (66%) of the total sample felt care coordination was highly important. Again, this was more commonly endorsed by the mental health client participants (73%) and slightly less often by the homelessness (64%) and the drug and alcohol (60%) clients. Of note, the proportion of client participants who felt care coordination to be 'very important' was similar across the three service domains; the difference in overall importance appears to be driven by a greater proportion of mental health clients (26%) endorsing 'quite important' compared to homelessness (19%) and drug and alcohol (18%) clients.

Figure 15: Degree of importance placed on care coordination by client participants of the *Integration Survey*



In summary, both care coordination and information sharing appear to be important to clients. Across all three service domains, fewer client participants felt care coordination was not at all important compared to the proportion who endorsed this category for information sharing.

6.2 Client-level indicators of integration

Evidence regarding clients' experiences of integration was gathered via the *Integration Survey*. Client participants were asked a series of questions regarding their experience of integration over the previous three months.

Table 18 outlines the indicators of integration that were measured. Correlations between each client integration indicator and the service depth of integration score (Browne et al. 2004) were tested.

6.2.1 Case management

Depth of service integration was significantly related to the presence of a case manager, such that clients from more integrated services were more likely to have a case manager. Significant correlations were present in all three sectors: homelessness ($r = .22$, $p < .05$), mental health ($r = .27$, $p < .05$) and drug and alcohol ($r = .29$, $p < .05$). Given the importance of case management for helping clients with

complex needs to access relevant services, this finding suggests that more integrated services can provide a more seamless approach to service delivery.

6.2.2 Awareness of need

Mental health problems

Within the homelessness client group, greater service integration was associated with the provision of direct assistance for mental health issues ($r = .34, p < .001$). That is, clients from more integrated homelessness services tended to report that the service was directly helping them with their mental health needs. Findings from interviews with case study participants (which will be outlined in the following section) further expands on this finding, highlighting the importance of providing health services within the homelessness setting (whether through outreach teams or co-location of services) to overcome some of the barriers homeless clients face in accessing mainstream health services. For drug and alcohol clients, when asked about the service's awareness of their mental health issues, clients from less integrated services tended to respond 'No, I don't tell them or they don't ask' ($r = -.29, p < .05$). This suggests that less integrated drug and alcohol services may not be actively seeking to identify other issues that clients may have in other areas.

Table 18: Indicators of client integration measured in the *Integration Survey*

Indicator	Item	Response categories
Case management	Do you have a case manager?	Dichotomous: Yes/No
Awareness of need	Do workers know about your:	a) I don't have a problem
	→ Homelessness problems?	b) No, I don't tell and they don't ask
	→ Mental health problems?	c) No, I receive support from another service
	→ Drug and alcohol problems?	d) Yes, but no-one is helping me e) Yes, and they have referred me elsewhere f) Yes, and they are helping me directly with this g) Yes, but I am receiving support from another service
Coordinated care	How often have providers of different services worked together to coordinate your care?	Range: 'never' to 'always'
Duplicate information	How often have you had to give different services the same information about yourself and your current situation?	Range: 'never' to 'always'

Homelessness problems

In terms of direct assistance with homelessness, clients from mental health services with lower levels of integration were more likely to report that they were receiving support for their homelessness problems from another service ($r = -.27, p < .05$) and that the service had referred them elsewhere for help with their homelessness problems ($r = -.22, p < .05$). Clients from drug and alcohol services with lower levels of

integration were more likely to report that they have not told the service about their homelessness problems, or the service has not asked ($r = .29, p < .05$). Again, this may be indicative of a 'don't ask, don't tell' approach adopted by drug and alcohol services that are not well integrated with other services in the network.

6.2.3 Care coordination

For homeless clients, a significant positive correlation was found between depth of integration and care coordination ($r = .57, p < .05$). Clients from more integrated homelessness services tended to report that providers of different services have frequently worked together to coordinate their care over the past three months, whereas clients from less integrated homelessness services reported less frequent care coordination. No significant relationships were found between service integration and care coordination for mental health or drug and alcohol clients.

6.2.4 Duplicate information

No significant relationship was found between service integration and the client integration measure of duplicate information. This is surprising given client comments regarding the continual re-telling of stories and confusion associated with different workers and their roles (see Section 7.1). It is possible that the measure of duplicate information used in the present study was not a particularly good indicator of client integration or that it was not easily interpreted by clients and thus undermined the study's ability to detect a significant relationship. It is also highly likely that the association between service integration and client integration is more complex than the correlation of two indicators. For example, although many clients placed importance on information sharing, they wanted this to be a transparent and consensual process (see Section 7.1). This may moderate the association between service integration and the client integration indicator of duplicate information.

6.3 Client access to services

6.3.1 Findings from the Integration Survey

Service participants in the *Integration Survey* were invited to consider the impact of integrated care for their clients. Most responses suggested that integrated care improved access to services and did so by providing clear directions to clients and through the co-location of related services.

Results from the *Integration Survey* revealed that many clients had experienced difficulties accessing services. Table 19 shows the percentage of clients reporting access difficulties for the total sample, and for specialist homelessness, mental health and drug and alcohol services. Clients responded to the question: 'In the past three months, have you experienced any of the following difficulties in accessing help for housing, mental health and/or drug and alcohol problems?'

Table 19: Difficulties with access for total group and total service domains

Item	Total Yes/No	Homelessness Yes/No	Mental health Yes/No	AOD Yes/No
Not willing to go to more than one service	12% / 88%	13% / 87%	11% / 89%	10% /90%
Services are not coordinated	26% / 74%	19% / 81%	28% / 72%	38% / 62%
Excluded because of drug and alcohol use	10% / 90%	2% / 98%	7% / 93%	34% / 66%
Excluded because of mental health problem	10% / 90%	5% / 95%	13% / 87%	18% / 82%
Excluded because of legal or criminal problems	5% / 95%	2% / 98%	6% / 94%	12% / 88%
No relevant service in local area	15% / 85%	13% / 87%	12% / 88%	28% / 72%
Limited access to transport	27% / 73%	22% / 78%	24% / 76%	44% / 56%
Waiting lists	49% / 51%	48% / 52%	47% / 53%	58% / 42%
Cost of service	23% / 77%	21% / 79%	21% / 79%	32% / 68%
Don't know how to access service	29% / 71%	27% / 73%	26% / 74%	40% / 60%
Difficult to negotiate service system	29% / 71%	24% / 76%	25% / 75%	47% / 53%

For the total sample, the most notable difficulties experienced were those of waiting lists, lack of knowledge of how to access a service, difficulty in negotiating the service system, limited access to transport, and lack of coordination of services. Nearly half of the clients surveyed had difficulties with waiting lists. Additionally, the AOD clients experienced the highest frequency of difficulties compared to the other two client groups (homelessness and mental health), demonstrating that access difficulties are particularly prevalent in the drug and alcohol sector.

To test whether greater integration was associated with better access for clients, correlational analyses were conducted between the depth of integration score (Browne et al. 2004) as measured in the Service survey and the index of access difficulty as measured in the Client survey. Only the significant correlations are presented here. Results are presented for the total sample of client participants and for the specific client groups of homelessness, mental health and drug and alcohol.

In the total sample, the degree of service integration was correlated with two forms of difficulty. Clients from services with lower depth of integration scores (i.e., less integrated services within the local network) were more likely to report greater difficulties accessing help due to services not being coordinated ($r = -.14$; $p < .05$) and due to a lack of understanding of how to access services ($r = -.15$, $p < .05$).

There were differences in the relationship between service integration and client access across the three client groups. The significant relationship between service integration and access difficulties due to poor coordination was seen for both mental health clients ($r = -.23$; $p < .05$) and drug and alcohol clients ($r = -.46$; $p < .01$) but not homeless clients. For both mental health and drug and alcohol clients, there was a significant association between service integration and access difficulties due to clients not knowing how to access relevant services ($r = -.27$, $p < .01$, and $r = -.28$, $p < .01$, respectively). Additionally, for drug and alcohol clients, low service integration

was significantly associated with difficulties negotiating the service system ($r = -.33$; $p < .05$). Furthermore, for mental health clients, low service integration was correlated with access difficulties due to there being no perceived relevant service in their local area ($r = .29$, $p < .01$).

Access difficulties: Perth

Results from the *Integration Survey* for the Perth sample of clients are presented in Table 20. In accordance with the findings for the total sample, the most prominent difficulties experienced were waiting lists, lack of knowledge of how to access a service, difficulty in negotiating the service system, limited access to transport, and lack of coordination of services.

Table 20: Difficulties with access for total group and service domains within Perth sample

Item	Total Yes/No	Homelessness Yes/No	Mental health Yes/No	AOD Yes/No
Not willing to go to more than one service	12% / 88%	14% / 86%	11% / 89%	11% / 89%
Services are not coordinated	28% / 72%	19% / 81%	37% / 63%	40% / 60%
Excluded because of drug and alcohol use	11% / 89%	2% / 98%	9% / 91%	34% / 66%
Excluded because of mental health problem	10% / 90%	4% / 96%	20% / 80%	19% / 81%
Excluded because of legal or criminal problems	6% / 94%	3% / 97%	9% / 91%	10% / 90%
No relevant service in local area	17% / 83%	12% / 88%	20% / 80%	25% / 75%
Limited access to transport	28% / 72%	21% / 79%	29% / 71%	45% / 55%
Waiting lists	51% / 49%	46% / 54%	57% / 43%	60% / 40%
Cost of service	23% / 77%	17% / 84%	31% / 69%	32% / 68%
Don't know how to access service	32% / 68%	26% / 74%	40% / 60%	40% / 60%
Difficult to negotiate service system	30% / 70%	22% / 78%	31% / 69%	48% / 52%

To test whether service integration was related to improved access for clients in the Perth sample, correlational analyses were again conducted between the depth of integration score (Browne et al. 2004) and indices of access difficulty. Although there were no significant results for the total client group in Perth, relationships between service integration and access difficulties did emerge for the mental health and drug and alcohol client groups.

Mental health clients from less integrated services were more likely to report being excluded from services in the past three months due to drug and alcohol use ($r = -.40$, $p < .05$) and that there was no relevant service in their local area ($r = -.40$, $p < .05$). Drug and alcohol clients from less integrated services have encountered greater access difficulties due to services not being coordinated, ($r = -.36$, $p < .05$), a lack of knowledge as to how to access relevant services ($r = .34$, $p < .05$), and problems negotiating the service system ($r = .37$, $p < .01$).

Access difficulties: Melbourne

Results from the *Integration Survey* for the Melbourne sample of clients are presented in Table 21. For clients in this sample, the most prevalent access difficulties were waiting lists, lack of knowledge of how to access a service, difficulty in negotiating the service system, limited access to transport, cost of the service, and lack of coordination of services.

Table 21: Difficulties with access for total group and service domains within Melbourne sample

Item	Total Yes/No	Homelessness Yes/No	Mental health Yes/No	AOD Yes/No
Not willing to go to more than one service	11% / 89%	12% / 88%	11% / 89%	0% / 100%
Services are not coordinated	20% / 80%	19% / 81%	22% / 78%	0% / 100%
Excluded because of drug and alcohol use	7% / 93%	6% / 94%	6% / 94%	33% / 67%
Excluded because of mental health problem	10% / 90%	12% / 88%	8% / 82%	0% / 100%
Excluded because of legal or criminal problems	8% / 92%	0% / 100%	4% / 96%	33% / 67%
No relevant service in local area	11% / 89%	18% / 88%	6% / 94%	66% / 33%
Limited access to transport	23% / 77%	29% / 71%	21% / 79%	33% / 67%
Waiting lists	44% / 56%	59% / 41%	40% / 60%	33% / 67%
Cost of service	22% / 78%	47% / 53%	13% / 87%	33% / 67%
Don't know how to access service	22% / 78%	35% / 65%	17% / 83%	33% / 67%
Difficult to negotiate service system	25% / 75%	35% / 65%	21% / 79%	33% / 67%

There are several differences in the results for the Perth and Melbourne client samples. Chi-square tests revealed that homeless clients in Melbourne were significantly more likely to cite the cost of the service as representing an access difficulty than homeless clients in Perth ($p<.01$). In contrast, mental health clients in Perth were significantly more likely to report access difficulties due to service costs than were mental health clients in Melbourne ($p<.05$). This issue was not explored further in the client questionnaire. However, It may possibly reflect different funding and governance structures between the two regions. Compared with those in Melbourne, mental health clients in Perth were also significantly more likely to report difficulties accessing help due to a lack of knowledge of how to access relevant services ($p<.05$).

In contrast to the combined Perth and Melbourne and Perth alone samples, for the Melbourne sample, there were no significant correlations between service integration (using the depth of integration measure) and indicators of access difficulty. This may be a result of insufficient statistical power due to the smaller sample size in Melbourne (74 clients) compared to Perth (195 clients) and the total sample (269 clients).

6.3.2 Findings from interviews with case study participants

Interviews with case study participants (i.e., practitioners who work with clients of homelessness, mental health and drug and alcohol services) described a number of issues that clients encounter in terms of accessing services, and outlined how an integrated service delivery approach can help to improve ease of access.

Improved access to services was described as being driven by engagement and relationships, both with the client and between workers. From the client perspective,

this was primarily about building trust as explained by a health case study participant involved in health outreach:

Often they're unlikely to access mainstream health services due to a number of reasons. I think they may have had negative experiences with the health care system. So I think it's my role just to be out there continually, regularly be a face that these guys learn to trust, and then I can try and discuss some of their health care needs, and try and link them where appropriate or try and help them then and there.

The lack of trust was explained by a homelessness case study participant as a result of previously stressful interactions with the health system. Homelessness case study participants commonly raised the provision of both physical and mental health care via on-site clinics as an effective means of overcoming the distrust and uncomfortableness often felt by their clients when attending mainstream health services.

You've got the issues of paranoia as well, as: 'Last time I saw a doctor they threw me into hospital and I couldn't get out!'... It's one of the reasons why it's really important that we have medical and psychiatric services here because the guys can access them in a situation that's familiar to them, they don't feel like they're going to get dragged off to hospital straight away, particularly in the case of mental health issues.

Many homelessness case study participants considered that access into the mental health system was particularly difficult. This was the focus of a number of integration initiatives examined as part of the case studies for the present study. Integration strategies that demonstrated benefit in this regard included co-location of mental health services with homelessness services, either through the direct employment of a mental health professional (e.g., a psychologist) or through establishing links with local mental health teams to deliver weekly clinics on-site. Although there were additional benefits to an agency in employing their own mental health professional, both strategies resulted in improved access into the health system as well as a temporary accommodation system. For example, a health case study participant involved in mental health outreach commented:

If a client wants to access crisis accommodation, say [the service] has noted that they've got a history of mental illness and they haven't seen the psychiatrist in a long time and aren't on any medication. What we'd be able to do is provide that assessment and find out some of the background and provide a report which they [the client] can take to the right refuge which will enable them to get into the service. We're also able to go out and know where someone is and able to arrange to assist them to come into their appointments. So, to help them navigate the services, in a way. I think one of the big problems is the NGOs have had issues getting crisis intervention for some of their customers because of the inclusion criteria of the acute mental health services, where we've been able to assist the NGOs into framing their requests into a way that is understandable for acute care.

In the above quote, the outreach health professional operates as a link between the two systems to create more effective referral pathways from one sector to another. This link works on multiple levels—restoring a client's trust in the system; increasing tolerance in the health system for chaotic presentations; extending the reach of mainstream health professionals into the homelessness sector; negotiating eligibility criteria so that appropriate referrals are not excluded unnecessarily; and acting as a

translator so that real communication between health and homelessness workers can occur.

Importantly, integration had an impact on *appropriate* access (as opposed to *any* access). One aspect of the service utilisation by homeless people with complex needs is the use of multiple services. Improved communication between services reduces duplicate service provision and this benefits clients because it improves appropriate access, as explained by a health case study participant:

I think that benefits the client, that they know what the particular services are able to deliver so that they get the appropriate care delivery from the appropriate service. They become more aware where they get appropriate service and also it helps open the doors for them to the services. ... Our team, for myself, by getting that assessment and getting a report done enables them to access services which they wouldn't previously possibly have not been able to access.

Sometimes, facilitating access to health care (rather than improved health outcomes per se) was a key objective of integrated practice, as can be seen in the following quote from a health case study participant:

To provide specialist health care to people who aren't otherwise accessing it. And, in the provision of that health care, obviously you're improving people's quality of life, but also preparing people to access mainstream health. So, it's not necessarily that we're here to resolve all health issues; it's that we're a vehicle to help people to access mainstream health.

In this sense, coordination plays a significant role in identifying individual needs and mapping those needs to the relevant part of the system in order that the system can be most effective in doing what it is meant to do (i.e. address need). This is not only true for services that interact across different systems (e.g. a hospital and a housing support service), but also for individual agencies with multiple services. Coordinated assessment and referral processes were seen as critical to effective service delivery. Strategies included single entry points for triage and the separation of the assessment process from service delivery. This enabled the development of a comprehensive treatment plan with all referrals (both internal and external) being organised at the point of assessment and coordinated or structured in such a way that the client moved seamlessly through the required services according to need.

The waiting list was considered an important indicator of integration for some services and made an organisational priority through the formation of committees designed to review wait times on a regular basis and develop strategies to achieve immediate access for clients. Improved access was also achieved through the facilitation of referrals, described by a health service as 'assertive' referrals. This view was typically associated with the assertive case management model and targeted at clients with multiple and complex needs. Within the health sector, facilitation of referrals was often necessary between treatment stages because of the high degree of specialisation within the health sector. This can be seen in the following quote from a health case study participant:

Well, we're not linked to any other agency. But we certainly try and work with other agencies if we know there's a plan for that client. So, for example, we will get clients coming through here who are hoping to go to rehab and they've got a tentative bed date at rehab where it's not confirmed until they do a withdrawal. So, we'll do a lot of liaison that way with the rehabs to try and marry up that bed date with the rehab so they move straight through. It can be

quite difficult, again, 'cause of waiting lists of other agencies. So it often isn't a seamless service. That can be quite frustrating.

6.4 Client outcomes

While it is beyond the scope of the present study to undertake a robust assessment of the overall effectiveness or impact of service integration on client outcomes, there are some interesting findings in this direction both from the *Integration Survey* and from the qualitative analysis in terms of the perceptions of clients of outcomes.

6.4.1 Findings from the Integration Survey

To test whether greater integration was associated with better outcomes, client participants were asked to indicate how helpful their current service had been in addressing their needs. Response categories ranged from 'not at all helpful' to 'extremely helpful'. This score was then correlated with the depth of integration score (Browne et al. 2004) for the service from which the client was recruited. There was no evidence of a significant relationship between level of service integration and client ratings of met need for the total sample. When examined by service domain, the only significant association was found for specialist homelessness services: a higher depth of integration score was associated with client reports that the service had been more helpful in addressing the client's needs ($r = .21, p < .05$).

Client outcomes were also considered from the service managers' perspective, via open-ended questions in the *Integration Survey*. Responses from service participants were limited to general endorsement of integrated practices in improving client outcomes. Few responses mentioned specific outcomes that were likely to improve because of integration. One service participant suggested clients experienced improved feelings of support. Greater mention was made of the mechanisms by which integration achieved better client outcomes and this included an enhanced ability to identify and manage client needs.

6.4.2 Findings from interviews with case study participants

There were two major themes identified from the case study interview data. The first is concerned with the specification of client outcomes and this was reflected at the level of policy and practice. The second theme relates to the specific outcomes commonly targeted by integrated interventions and programs for homelessness. Participants commonly discussed four outcomes—engagement, housing, health and wellbeing. Each of these themes are discussed in turn in the sections following.

Identifying outcomes

Case study participants found it difficult to define client outcomes primarily because they were often highly individualised, as indicated in the following quote from a homelessness case study participant:

All those little steps that get the person so they can keep their housing and they are paying rent and they are not fighting with neighbours and not going back into custody, all that kind of stuff. Same with recidivism as well, all those bits and pieces come together to make the person more stable so that they aren't going to go back to re-offend and aren't going to be put back into custody. So it is a hard one to define because it is so different with every client and there is no prescriptive way that is going to work with everyone.

Although program outcomes necessarily focus on population-level indicators such as treatment completion, client outcomes were typically broken down into smaller units and addressed one at a time and at a pace determined by the client (as mentioned in

the preceding section on improved access). Moreover, the identification of client outcomes was commonly negotiated between a client and their worker and in this sense was sometimes antagonistic with service integration goals—for example, the benefits ascribed to comprehensive, single point assessments. This tension was described by a health case study participant as follows:

So, but I think that that's the hardest part is that every service has their own little way of dealing with certain things and that when you get all together, the outcome needs can also be different; sometimes it might be the government that's actually ruling it because they want funding in a particular way.

One other thing of note regarding the evidence for client outcomes is the fact that service providers are not always privy to outcomes. For example, a homelessness case study participant involved in a formal partnership with the local hospital commented on the transient lifestyle and multiple service use of many homeless clients with complex needs and the possibility they will re-present at a different hospital. This can only be addressed with longitudinal research methods or a shared information system that would allow for the tracking of individual clients across services. Additionally, service providers are more likely to learn of the not-so-good outcomes of clients:

We very rarely hear of the stories of the clients who have got on with their lives, are going on to paid employment, got married. We don't hear their stories. What we do see is the clients who relapse, who come back through, we see them, but we never see our clients who do really well. And that's quite a shame really.

In some circumstances, however, repeat presentations could be considered as positive outcomes as explained by one homelessness case study participant:

But in some ways they are touching base with us because they had that trusting relationship, we were able to support them, and now something is going on and they think maybe [program name] can help me.

Finally, sometimes staff had to accept the absence of outcome as described in the following quote from a homelessness case study participant:

The important thing is that a lot of homeless people don't want to engage, they actually don't want any help, they want to sleep out in the streets. And a lot of the time the accommodations aren't appropriate and they are not safe enough too. So they prefer to sleep in the streets. And we understand that, but it is at least trying to get to the core of what is actually happening, to engage with the service, to actually just take some time to sit down and talk to someone and see what we can actually do with the issues. A lot of the times it's non-responsive and that's fine. This person actually does have a few crisis admissions and sometimes we have to accept that. But a lot of the time it actually does work. They then know they have got [support worker] to talk to in relation to their homelessness and trying to seek alternative accommodation.

Engagement

Many case study participants considered that engagement was a key goal of integrated programs for clients with multiple and complex needs. This could occur at multiple levels, including engagement with a particular service or program, engagement within their local community, or engagement with the mainstream service system. For example,

[The goal is to] develop relationships so they've got the confidence in you, and they want to change, and facilitating that.

Staff qualities were critical in this regard; specifically, patience, tolerance and understanding were key drivers of successful engagement with clients, as noted by a mental health case study participant working with clients experiencing homelessness:

We're quite flexible about times, locations, how we deliver the services. Patience as well, I think we take time to build a relationship with the client. The other part of what we deliver is knowledge about homelessness and experience in the homeless sector; that we understand their issues and we understand what the pressures may be and how to tailor a response to that.

Significant investment in inter-agency liaison in addition to an assertive outreach approach was often required to build engagement with highly transient and complex needs clients:

It was also bringing in all the other agencies that might be involved. So we are talking about it being assertive, but it was also the inter-agency (the client may be known to quite a few agencies). And so a care plan could be developed prior to building that relationship with the client. These other agencies knew what the goal was and would be involved in trying to draw that client back into the project. And it did work quite successfully.

Housing

Although the aim of many integrated programs was an exit out of homelessness, this was not always possible and the pragmatic aim was for the least-worst homelessness state. For example, a homelessness case study participant involved in a formal partnership with the local hospital commented:

The aim of the program is for people not to be discharged into homelessness. We're having to refer to boarding houses which is tertiary homelessness, but not everyone is referred into the most appropriate housing because that's not available. Success would be that we were able to place them in accommodation where they felt safe and secure, that was affordable, and they were linked to appropriate services of their choosing.

One health case study participant explained that they'd given up on housing as it just wasn't a realistic outcome:

I guess I don't always see it in terms of housing success now; I measure success in terms of relative success, from where they were from the point at which they first accessed the service to where they are now and what their level of engagement is ...

The key impediment to achieving positive housing outcomes was capital resources. Programs that were able to resource appropriate housing options demonstrated significant success:

We have 50 transitional properties where we are able to place clients ... our clients do exceptionally well in the transitional properties. We've had clients who have stayed for 15 months and that stability has ensured that they have got back into uni or back into employment, and none of those clients have come back into the criminal justice system.

Aside from sufficient resources, programs with strong partner relationships also demonstrated highly successful outcomes as noted by a health case study participant involved in a partnership with a homelessness support service:

But, of course, as an [integrated] service, we're also housing people. So supporting people into accommodation, and then making sure they don't fall out the other side. So, providing really a secure kind of wrap-around service to people that as they go into housing and have huge life changes that are often positive but can be quite stressful. So, we're—we're there to provide that throughout.

Health

Many health-homelessness partnerships demonstrated improvements in treatment adherence and treatment retention. For example, outreach health clinics offered alternative means of addressing breached Community Treatment Orders (CTOs) and avoided the more invasive process of having the client forcibly brought into the mental health service for their scheduled medication. This was possible because the outreach health professional had opportunistic access to clients. In the case of a homelessness-specific health service, this outreach model was enhanced through remote access to the hospital client information system, enabling the outreach health professional to make the most of opportunistic contact with clients:

But I can check what's happened, the latest notes in terms of the mental health service, where they're up to with things, and to contact the necessary person, ascertain exactly what's going on.

With regard to treatment retention, one health case study participant revealed that the proportion of clients completing treatment improved following the implementation of a single agency-wide assessment process. The new process involved a comprehensive needs assessment and the generation of a coherent treatment plan specifying the timing of referrals to the relevant programs and services within the agency. The participant explains:

We've changed our assessment process, we've changed all our processes over at [site name] and as a result of that, by the time the clients get here they're a lot more prepared and they stay the seven days. Whereas in the old system, they weren't prepared and they didn't stay.

Another health participant described the improvement realised with a more client-centred approach that involved taking the time to inform clients about the way in which the health system worked and where they could best get their needs met:

But if they're given information and can make a good informed decision, things work. That's when their health can actually improve.

Health-homelessness partnerships also had a direct impact on client health outcomes by way of secondary consultations with other professionals involved in the client's care. This was explained by a mental health case study participant:

And often patients are pretty chaotic and can't adhere to what they're told to do ... So we work with that. And it's also allaying the anxieties of the treating teams as well, [especially] if you've got a non-complying patient. We're not providing cotton wool for them, we're not providing a place to stay, because often we can't, because they don't want to go there. But at least we're trying our best to be a familiar face for patients, and they're less anxious when seeing the medical team.

A specific example of the success of this approach was described by a health case study participant attempting to engage with a homeless client who required surgery but had repeatedly failed to return phone calls or attend appointments. Because they were able to liaise directly with admissions staff, the client's referral remained active,

well after the usual referral mechanisms had been exhausted. Additionally, they took the time to introduce the client to the nursing staff on the ward and in this way alleviated much of the anxiety that was driving the client's non-responsiveness. As a result, surgery was successfully undertaken and the client's ongoing pain issues were resolved.

6.5 Summary

This chapter provides findings from the *Integration Survey* on the views of clients on forms of service integration practice and their experience of integration in the service system using a set of measures of client integration. We assess the correlation between a given client integration indicator and the extent to which the service is integrated with other services using the service depth of integration score (Browne et al. 2004). The chapter also provides insights from interviews with case study and stakeholder participants on the impact of service integration on client outcomes.

The majority of client participants from the *Integration Survey* indicated that both information sharing and care coordination between services was very important. This was particularly the case for clients of specialist mental health services.

Clients from more integrated services (using the Browne depth of integration measure) were generally more likely to report positive outcomes across a range of client integration measures than were clients of less integrated services. For example, across all sector domains, clients of more integrated services were more likely to have a case manager than clients from less integrated services. Given the importance of case management for supporting clients with complex needs to access relevant services, this suggests that more integrated services can provide a more seamless approach to service delivery. Clients from more integrated homelessness services reported that the service was directly helping them with their mental health needs. In contrast, clients from drug and alcohol services with lower levels of integration were more likely to report that they had not told the service about their homelessness problems, or the service had not asked. Clients from more integrated homelessness services were more likely to report that providers of different services have frequently worked together to coordinate their care over the past three months.

Clients listed the following key problems in accessing help for housing, mental health and/or drug and alcohol problems—long waiting lists, lack of knowledge of how to access a service, difficulty in negotiating the service system, limited access to transport, and lack of coordination of services.

7 EVALUATING THE INTEGRATED SERVICE DELIVERY APPROACH

Research Question 5: What are the views of homelessness, drug and alcohol and mental health services about the pros and cons of service integration and its overall effectiveness, particularly in relation to the delivery of services for homeless people?

This chapter presents and examines the views of service managers, policy-makers, and senior industry representatives in relation to the benefits and drawbacks of service integration. The findings from interviews and the *Integration Survey* provides indirect and non-conclusive data about what this means in terms of the effectiveness of an integrated service delivery approach.

Service providers' perceptions of the benefits and drawbacks of integration were measured using the Weiss et al. (2002) *Partnership Synergy Self-Assessment Tool*, as part of the *Integration Survey*. Lasker, Weiss and Miller's (2001) review of the relevant literature suggests that one of the factors influencing whether or not agencies integrate with others in a network is their perception of the benefits and drawbacks of such activities. The Weiss et al. (2002) 1-item *Comparing Benefits and Drawbacks of Participation* scale, 11-item *Benefits of Participation* scale and 6-item *Drawbacks of Participation* scale were used to measure service managers' perceptions of the pros and cons of integrating within the Perth and Melbourne networks.

In regard to comparing benefits and drawbacks, respondents were asked to rate on a 5-point scale how the benefits of participating in their chosen partnership compared to the drawbacks (with 1 representing 'drawbacks greatly exceeds the benefits' and 5 representing 'benefits greatly exceeds the drawbacks').

Table 22 shows that, on average, for the total sample, service participants perceived the benefits of participation exceeding the drawbacks (M= 3.91). This was also true for each of the separate service domains. A one-way ANOVA showed that there were no significant differences between the service domains on this measure.

Table 22: Comparison scores for benefits and drawbacks of participation among service participants

Dimension	Total	Homelessness	Mental health	Drug & alcohol
Comparing benefits and drawbacks	3.91	3.87	3.80	4.14

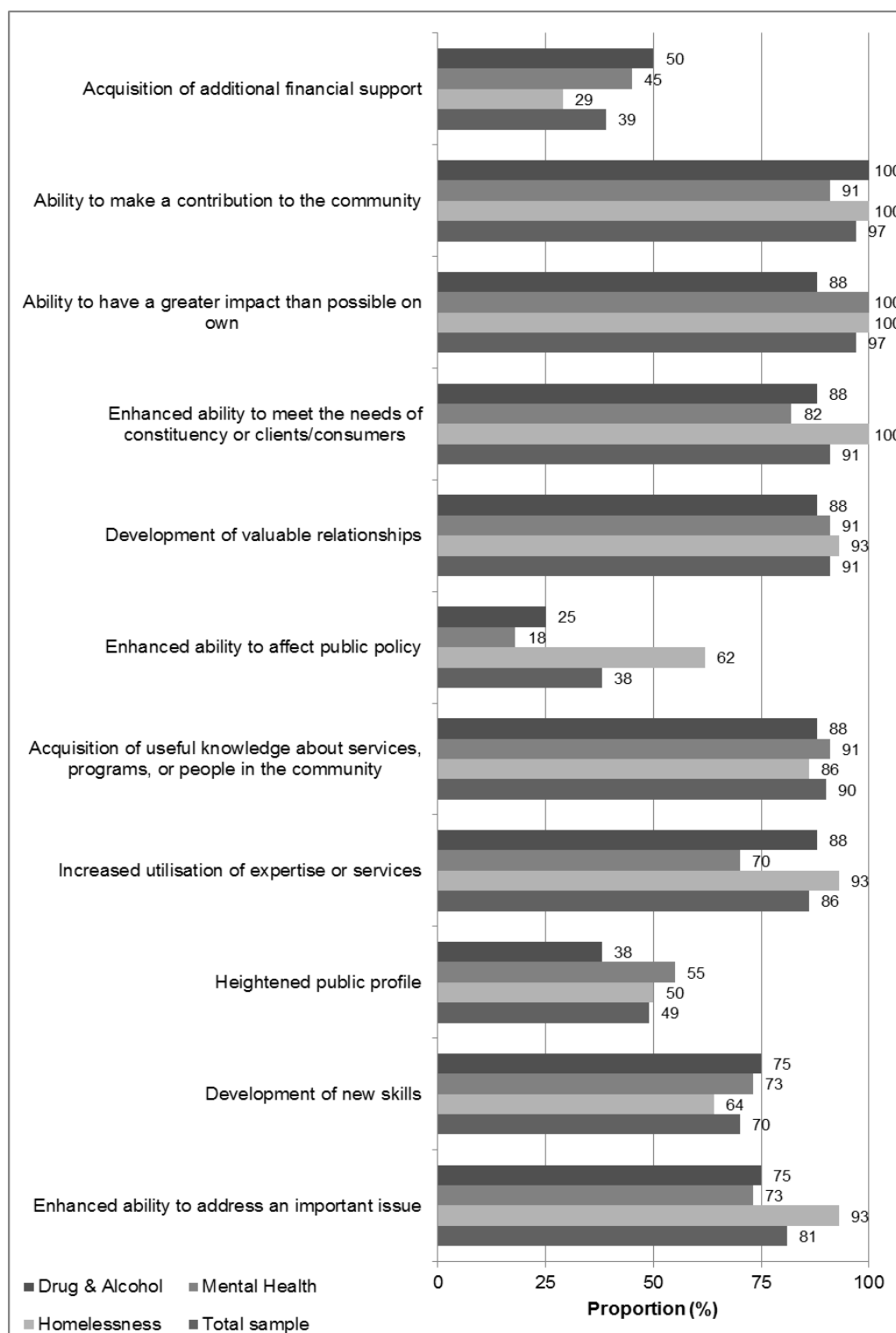
A more detailed analysis of service managers' perceptions of the benefits of participation with other services can be drawn from a series of yes/no questions put to service managers asking them whether they had received a professional benefit (e.g. enhanced ability to report a chosen issue) as a result of participating in a partnership with other services.

Figure 16 shows that for the total sample, the majority of service managers reported that they had received (*in order of benefit*):

- The ability to have a greater impact than I could have on my own.
- The ability to make a contribution to the community.
- Enhanced ability to meet the needs of my constituency or clients/consumers.
- Development of valuable relationships.

- Acquisition of useful knowledge about services, programs, or people in the community.
- Increased utilisation of my expertise or services.
- Enhanced ability to address an important issue.
- The development of new skills.

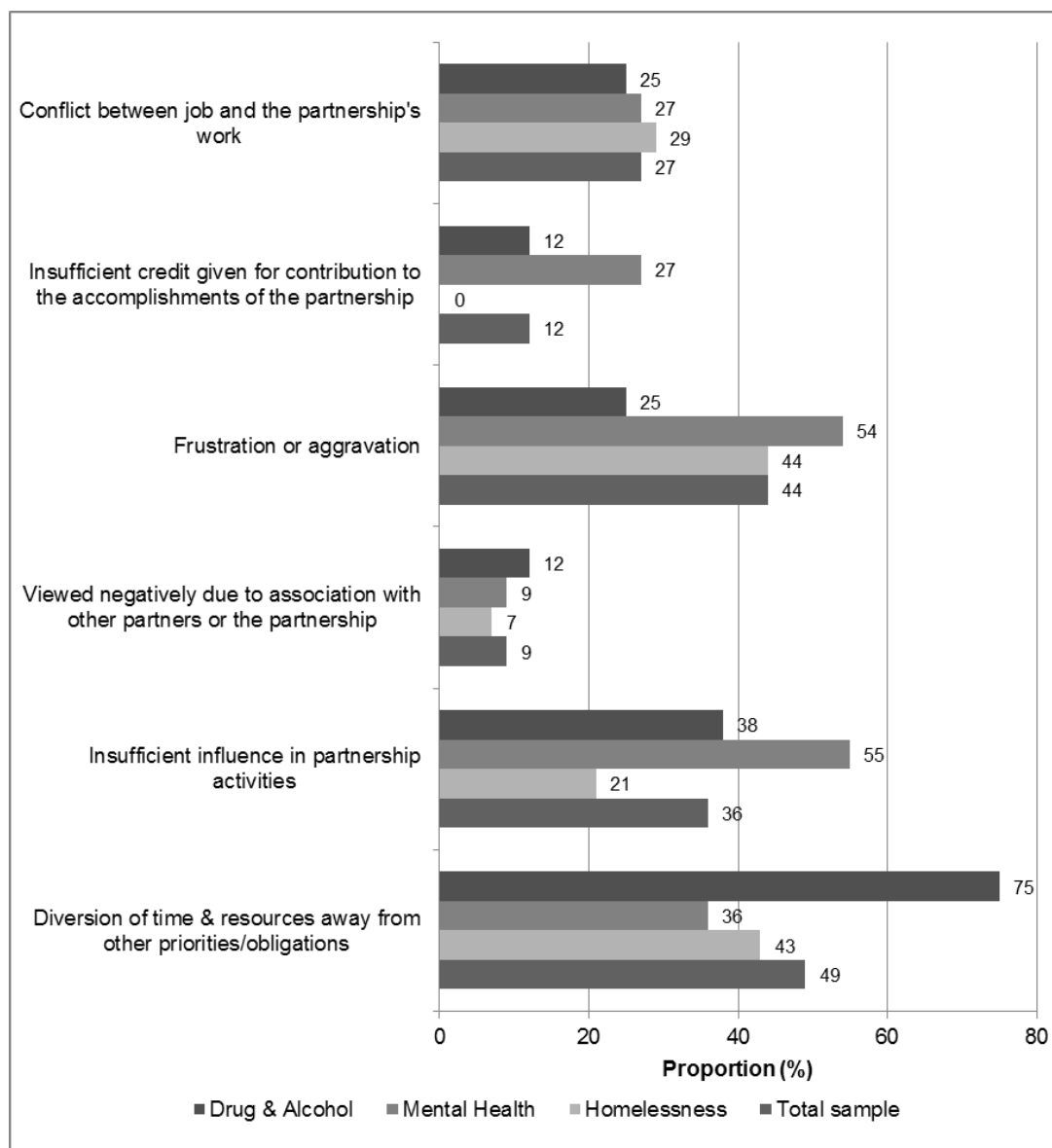
Figure 16: Proportion of service participants reporting different benefits of participation, stratified by service domain



Half of the sample experienced a heightened public profile, and only just over a third reported an enhanced ability to effect public policy and the acquisition of increased financial support.

The entire sample of specialist homelessness service managers reported that they found that participation enhanced their ability to meet the needs of their constituency or clients/consumers, gave them the ability to have a greater impact than they could have on their own, and gave them the ability to make a contribution to the community. For mental health services, all service managers reported that participation gave them the ability to have a greater impact than they could have on their own. Finally, drug and alcohol service managers reported that participation gave them the ability to make a contribution to the community. However, it appears that the experience of participation for this domain is time consuming, with most reporting that participation results in a diversion of time and resources away from other priorities and obligations (75%; see Figure 17).

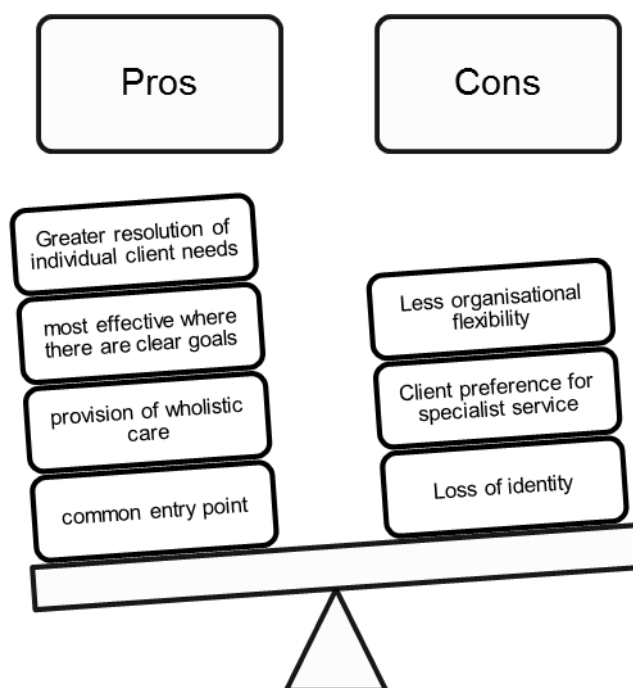
Figure 17: Proportion of service participants reporting different drawbacks to participation, stratified by service domain



In the *Integration Survey*, services also had the opportunity to provide their opinion on the organisational costs of providing integrated care and the extent to which they considered 'integrated care' to be always desirable.

Figure 18 documents the pros and cons of integration described by service managers who completed the *Integration Survey*. The benefits of integration included an enhanced ability to meet client needs, capacity to provide holistic care and a common entry point into the service system. Additionally, service participants felt integration was most beneficial when there were clearly articulated goals. The drawbacks to integration included less organisational flexibility, loss of organisational identity, and client preferences for specialist services.

Figure 18: Benefits and drawbacks to integration articulated by service participants in the *Integration Survey*



Responses from interviews with stakeholders and case study participants were consistent with these findings. Given the potential drawbacks to integration, a number of stakeholders and case study participants commented that the benefits of integration needed to be acknowledged and communicated to all stakeholders up-front in order to promote commitment and cooperation among partners. These concerns were expressed by a homelessness policy stakeholder as follows:

I think it's about properly selling the message to the services working out what these things really mean. What are the implications for them? What are the benefits? What are the sacrifices they're going to have to make and why is it useful? No one ever talks with any courage to services about the sacrifices that might go with doing any of this. You know: 'if you take this on, you might have to give this up for the greater good'. If you're going to work together as one holistic unit, in theory, it may be that actually we need to move resources away from here and put them over here because this is a better place for them. And, you know, that's where you come up against immovable forces, and I don't think you can really achieve integration if you are working against immovable forces protecting vested interests. So, how do you reassure the services?

Likewise, a housing policy stakeholder explained that the significant investment in highly integrated service responses needed to be weighed carefully against the expected benefits for the target population:

There is an element of it that is worthwhile: coalescing specialists or experts around a client, or a group of clients that need that high level of personal management of their support needs. But to make that work, there's a high level of effort and a high level of investment and responsibility and accountability. One of the reasons why I think that they're bound to fail at some stage is that you can't sustain that level of effort required for all clients. So it works because people are coalesced around a high-risk situation and therefore have the desire and the ability to put enough emphasis on making things work and doing the stuff that's hard and making the system change. This works for those few clients. It will work for 20, it might work for 50, but will it work for 500? And that's where to me it becomes unsustainable. There's a tipping point at which people cannot sustain the effort to help making change happen. That's where the systemic change needs to occur for the more 'run of the mill' cases where the person just has the general homelessness issues with a couple of key risk elements, but are not in crisis in every scenario.

One health case study participant suggested there could also be negatives from a client perspective:

I think sometimes the clients might feel it's not beneficial. So I think sometimes they're used to accessing various different services in separate ways and maybe playing off services against each other. With service communication, they get less than they're used to and they can find that frustrating because they're not inappropriately accessing services anymore. So I think that that might be the only drawback from a client's point of view.

8 SUMMARY AND POLICY DISCUSSION

Research Question 6: In what ways can the findings of this study inform policy with respect to service integration and the practice of integrated service delivery for homeless people?

This mixed-methods study on service integration brings together a rich array of evidence to further inform our understanding on current practices, experiences and attitudes toward service integration in the homelessness, mental health and drug and alcohol sectors in Australia. The results of the multi-level *Integration Survey*, interviews with key stakeholders and the case studies help to give a comprehensive and multi-layered picture of the features, challenges and opportunities of this approach to service delivery. It also covers conceptual issues as to the meaning of integration as well as evidence on the extent, scope and depth of integration, and the workings and functioning of integration and formal partnerships. The views and experiences of policy makers, agency managers and service managers were important in gathering this information. However, as the aim of a more integrated service system is to improve client outcomes we have put the views and experiences of clients at the core of our work. The inclusion of clients as participants in the study proved to be an important and useful component.

The concept of integration remains an area of debate as evident in the review of the literature presented in Chapter 2. However, it is clear from the responses of stakeholders and from the case study evidence that integration is conceptualised by key Australian practitioners and policy-makers primarily as the process of the coordination of a network of services—as ‘joined up’ services that focus on client need and client outcomes. Central to the idea of a client-centred approach to integration, as defined by the key stakeholder and case study participants, are notions of ‘no wrong door’ and the undertaking of a comprehensive needs assessment of clients upon intake, with professionals considering how the multiple needs of clients should be met, rather than dealing only with those issues that sit within their area of expertise.

The findings from the *Integration Survey* indicate the importance of service integration to clients themselves. Clients expressed the view that it was important for services to work together to deliver a streamlined service and spoke of the consequences of services not integrating well. The continual re-telling of their stories and confusion about the workings of the service system were expressed as undesirable consequences of a less integrated service system. The majority of client participants in the *Integration Survey* indicated that information sharing among service providers and effective care coordination was important to them. At the same time, however, they were also concerned with privacy issues, which indicates that the whilst information should be shared on a ‘need to know’ basis, expected principles of informed consent, privacy and confidentiality should still be applied in an integrated service system. Therefore, organisational mechanisms need to be in place to support service providers in their pursuit of service integration, particularly in the area of providing direction around how to engage in client information sharing with other service providers.

An important finding of the current study was that clients from more integrated services were more likely to report positive outcomes across a range of client integration measures than were clients of less integrated services. Clients of more integrated homelessness services, for example, were more likely to have a case manager than clients from less integrated services. Case management type approaches to service delivery are considered important components of service integration, especially for clients with complex needs as case management aims to

place the client at the centre of service delivery by working towards a seamless delivery of services and ensures that the needs of clients are being met by relevant services. As a further reflection of this type of approach, clients of more integrated homelessness services were also more likely to report that providers of different services had more frequently worked together to coordinate their care.

The findings from the *Integration Survey* in relation to the Perth and Melbourne sites suggest that services in the homelessness, mental health and drug and alcohol domains are fully aware of other services in the region and often engage in an active program of communication and informal information sharing with them. However, at the broad regional level, services stop short of more developed and structured forms of integration, including 'cooperation' and 'collaboration'. Cooperation involves services using their knowledge of other services to guide and modify their own service planning, while collaboration involves services jointly planning policies and/or services and actively modifying service activity based on advice and input from mutual discussions.

However, while services may not act in a 'collaborative' fashion with the full set of services in their region, many do have a close collaborative relationship with at least one other service in the relevant geographical space. In the Perth sample, for example, around half of all homelessness services had at least one collaborative relationship with another service with 40 per cent having a collaborative relationship with at least one drug and alcohol service, but none with mental health services. The findings from the *Integration Survey* also paint a picture of vertical integration in a number of agencies with services providing homelessness, housing, drug and alcohol and mental health services outside their direct area of specialisation. Moreover, services who do engage in formal partnerships report relatively high strong relationships across the various domains of synergy, leadership, partnership efficiency, administration and management and resources.

One of the interesting features of the study was that the desired depth of integration is somewhat higher than actual levels of integration suggesting a wish among service managers to increase the level of integration between services across relevant regions, but only by a notch. There is not a desire to increase levels of integration across the full range of services in a region consistent with full collaboration.

Services generally reported relatively low scores across critical ingredients of integration thought to be important for success in sustaining and developing service integration arrangements. Across the domains of sharing and participation between services; client referrals; relationships between staff; and, inter-agency functioning, services were more likely to respond that they 'never' engage in the practices outlined and least likely to respond that they 'always' engage in these practices.

Do services overall see a net benefit from participating with other services in the delivery of support to clients? The broad answer is that, in the main, service participants perceived the benefits of participation exceeding the drawbacks and this was true for each of the separate service domains. The key benefits from greater participation as perceived by service managers was that services felt that they were able to have a greater impact than they could on their own, make a contribution to the community, meet the needs of clients better, develop valuable relationships, and acquire useful knowledge about services, programs, or people in the community. Nevertheless, services do report drawbacks from integration, including less organisational flexibility, loss of organisational identity, time involved and the fact that clients may prefer more specialist services.

Taking into account the potential benefits and costs of integration, there are clearly some possible tipping points in terms of individual services and their participation in integrated networks of support,. Resource implications and potential issues surrounding the leadership of the network and the autonomy of individual services and agencies needs to be considered when services consider more structured relationships. There are clearly other major issues to consider as well in terms of integrated service delivery approaches. These include the role of systems-level integration, the support of government and the funding of the additional resource costs of integration, and the role that government health providers play in integrated frameworks.

This study has only touched on the question of the impact of integration on client outcomes and there remains a significant research agenda ahead before a more definitive assessment of client impact is possible. Whilst our findings do show that clients desire the benefits of what an integrated service system brings (i.e., care coordination), our research also suggests that some clients continue to experience difficulties with access to the services they need. Whilst there was evidence to suggest that greater depth of integration is associated with stronger case management and access to service benefits, wider client impacts are difficult to discern and lay beyond the scope of the present study.

Service integration has been a major plank of Australian policy discussions and settings in all jurisdictions in Australia. The White Paper, *The road home*, and subsequent homelessness plans implemented by state and territory jurisdictions refer to the importance of service integration in achieving an end to homelessness for clients. A similar focus on service integration is evident in the mental health and drug and alcohol domains.

Based on the findings of this report, there are a number of issues that can be identified as relevant for consideration in future policy settings and by services themselves.

The most important conclusion to be drawn from the study from a policy perspective is that there is a desire on the part of both clients and service managers for greater levels of service integration and that service integration is associated with improved client integration as perceived by clients. What this means is that there is significant support for the broad service integration agenda on the part of clients and services, the two 'actors' that matter the most.

However, beyond this, there are significant implications of the findings as to the form that service integration should take and the role governments may play in supporting integration.

First, it is clear that some agencies have themselves expanded the range of services they provide so that integrated responses may come from within rather than from other agencies. In other words, integrated care, provided by a single agency with multiple service functions, may prove particularly effective. Moreover, the majority of services have developed close collaborative relationships with at least one other service and so bottom-up approaches are flourishing. At the same time, some services did not have a collaborative relationship and there was greater likelihood of collaboration within the same service domain than between service domains. The evidence from the *Integration Survey* is that these close collaborative relationships and formal partnerships are producing positive net benefits. So service integration should not be viewed through a quantitative lens alone (i.e., that services are collaborating with *all* other services in a given geographical area), but rather should be assessed through the quality of integrated relationships or approaches and how these

meet the needs of the clients that they serve. Services, therefore, should be supported in the method that suits their particular situation best, and not supplanted by rigid, externally-imposed programs of integration.

Second, while services wish to increase the levels of integration across a broad set of services in a region, they wish to do so while clearly retaining their independence and not to the point of joint planning and delivery of support functions. There are limits to desired integration and these limits should be recognised in government initiatives.

Third, service integration is highest between services in the same domain rather than between services in different domains. Governments and peak bodies may play a role in increasing connections between different service domains. The profile of clients in the three service domains examined indicates significant overlap in terms of client profile and hence a need for greater cross-sectoral dialogue.

Fourth, despite the fact that services perceive a net benefit from service integration; services identified a number of issues around governance and resource support. The role of systems-level integration, the support of government and the funding of the additional resource costs of integration, as well as the role of government health providers in integrated frameworks, need to be considered.

Fifth, the evidence presented in terms of the functioning of integration suggests that integration practices remain relatively thin around sharing of information, relationships between staff in different services and so on, and may need support to strengthen them before they are effective.

Future research directions may include a deeper investigation of effective models of integration for clients experiencing homelessness, drug and alcohol and/or mental health issues in other Australian regions, especially in relation to improved client outcomes. Identifying existing structural mechanisms within networks that assist with the sharing of protocols, policies and client-care plans in order to meet the needs of such clients and improve client outcomes would be of benefit to the continued growth in integration practices in the period ahead.

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APPENDIX 1: CASE STUDIES

These case studies are examples of how good integration works in practice. Although they may look very different to each other in terms of structure and function, they are similar with respect to the attributes that enable integration. For example, they all have an ability to move clients through their service in a streamlined manner and this is not always dependent on having a single entry point into the service. Only two of the case studies have this type of set-up. All of them, however, are able to capture clients entering through a number of referral pathways (both internal and external) and move clients through their service and the broader service system by taking a facilitated referral approach. Facilitated referrals means the staff member provides whatever assistance is required to get the client into the services they need—for example, by making the telephone call with the client or walking them over to another part of the service or attending the initial appointment with the client. This is predominantly dependent on client need, but is also driven by an approach to dealing with others that emphasises care and compassion. Facilitated referrals are also heavily dependent on collaborative relationships (both formal and informal) and good communication.

Another common element across these case studies is the support and leadership of management. This is critical in allowing staff to cross role and service boundaries so they can be responsive to client need. As mentioned previously in this report, one of the biggest barriers to integration is the distinct professional roles across the sectors that create the silos and the gaps in the service system. A sympathetic and supportive management team provides staff with the flexibility to be creative about the way they deliver their services; they also trust their staff to make decisions about patient care and manage their time accordingly.

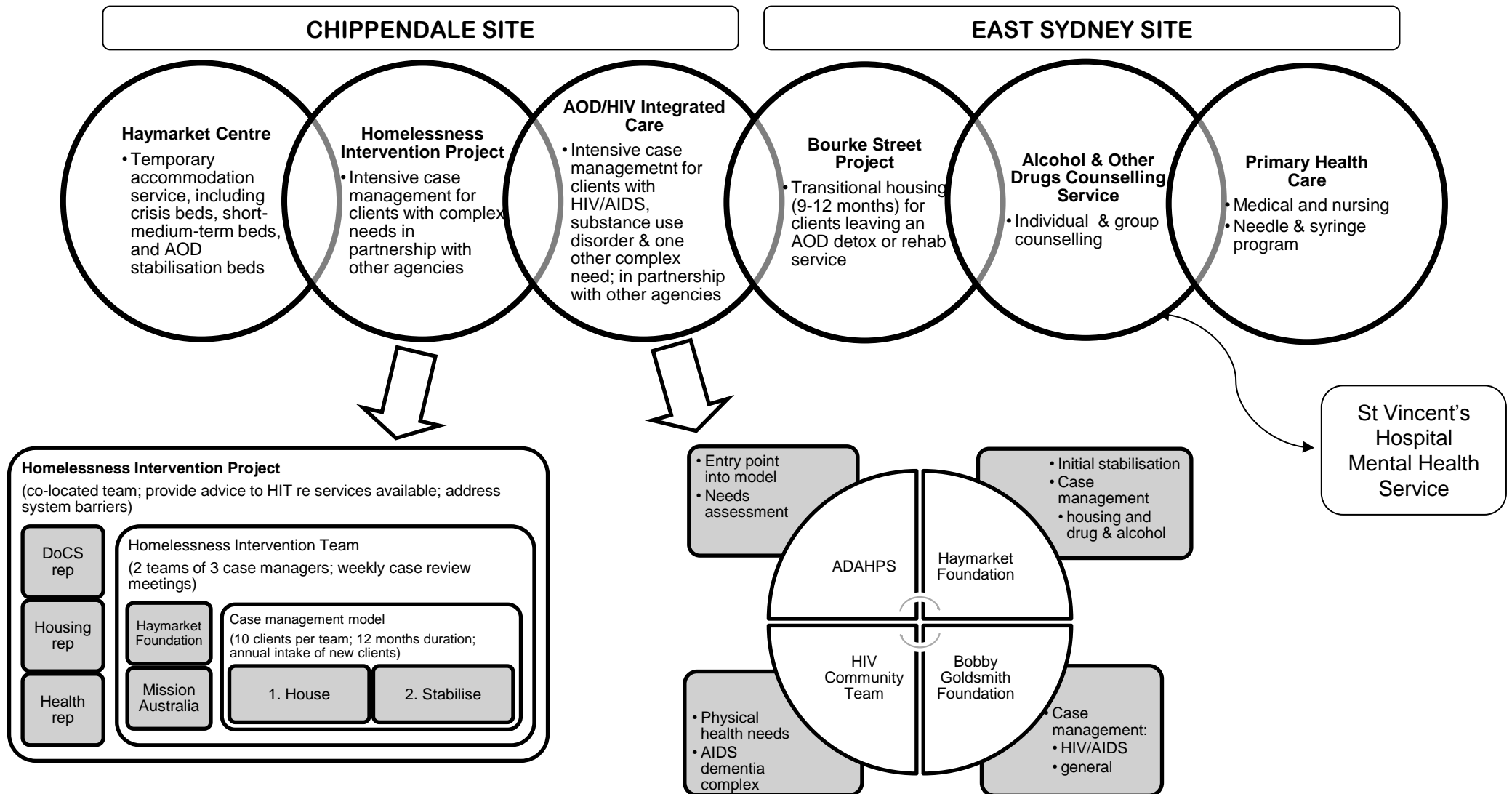
A1.1 Homelessness Case Study (NSW): the Haymarket Foundation

The Haymarket Foundation is a specialist homelessness service in inner Sydney, NSW. The case study involved the entire agency, including six services and a capacity-building program. Figure A1 shows the organisation of services within the Haymarket Foundation. The first three services are provided from the Chippendale site; the remaining services/programs are provided from the East Sydney site. Additionally, the Bourke Street Project has two transitional housing properties in East Sydney. Key features of integration practice at the Haymarket Foundation are shown in Table A1.

Table A1: Ingredients of integration: the Haymarket Foundation

Streamlined assessments
There are multiple entry points with each service responsible for their own assessments; this is in part due to the different target populations for the different services/programs.
Facilitated referrals
Facilitated referrals were evident across all clinical services, including transporting clients to appointments (including those for other Haymarket services); MOU with external agencies (e.g. local mental health team); and attending initial appointments with clients (including undertaking co-assessments). Additionally, a number of clinics are held on-site at the Haymarket Centre (e.g. Centrelink, primary health care, AOD group counselling).
Case review and supervision
Case review meetings are held within services. Additionally, clinical supervision of case management staff is provided by the Clinical Psychologist (AOD Counselling Service) and this improves mental health awareness/understanding among case management staff.
Flexibility and support
Management support staff to work outside their professional remit to meet the needs of clients.
Relationships and communication
Strong relationships are evident between Haymarket services/programs and this facilitates referrals. Strong relationships have also been developed with local GPs, local mental health teams, community health teams, and other homelessness agencies.
Staffing
Low staff turnover and retention of experienced staff were highlighted by participants. Additionally, all staff participated in co-morbidity capacity training.
Model integrity
The physical location of services across the two sites was rarely problematic, possibly facilitated by the availability of work vehicles. The different services shared similar values regarding the approach to working with clients and this was strongly linked to the leadership provided by management.

Figure A1: The Haymarket Foundation (2009)



A1.2 Health Case Study (VIC): Moreland Hall

Moreland Hall is a drug and alcohol treatment and education service provider in the northern metropolitan region of Melbourne, Victoria. The case study focused on the Clinical Services stream, the structure of which is represented in Figure A2. Clinical Services are delivered across two physical locations (not including the satellite sites of outreach services, which are shaded grey in Figure A2). Key features of integration practice at Moreland Hall are shown in Table A2.

Table A2: Ingredients of integration: Moreland Hall

Streamlined assessments

There is a single entry point into Moreland Hall Clinical Services. This is achieved by creating a separate service that focuses specifically on assessment and the development of an individualised treatment plan. This assessment follows the client through all internal referrals to Clinical Services and is updated as required as the client moves through the individual services.

Facilitated referrals

Facilitated referrals were evident across all clinical services, including walking clients between services to show them the facility and introduce them to the staff; assertive referral of clients back to the referring agency at the episode of care; and attending initial appointments with clients.

Case review and supervision

Case review meetings are held daily to discuss new assessments; these meetings are open to all staff. Weekly clinical review meetings are attended by a consultant from the Substance Use Mental Illness Treatment Team (SUMITT). Secondary consultation was sometimes formalised, e.g. Family Inclusive Practice via Family Counsellor. Additionally, there are two supervision groups that meet monthly; staff are randomly allocated to these groups (i.e. they are not team-based).

Flexibility and support

Management support staff to work outside their professional remit to meet the needs of clients. Management also support the implementation of projects initiated by staff (operational and management staff)

Relationships and communication

Informal relationships among the different service staff were prominent, including staff engaging in co-therapy with other clinical services.

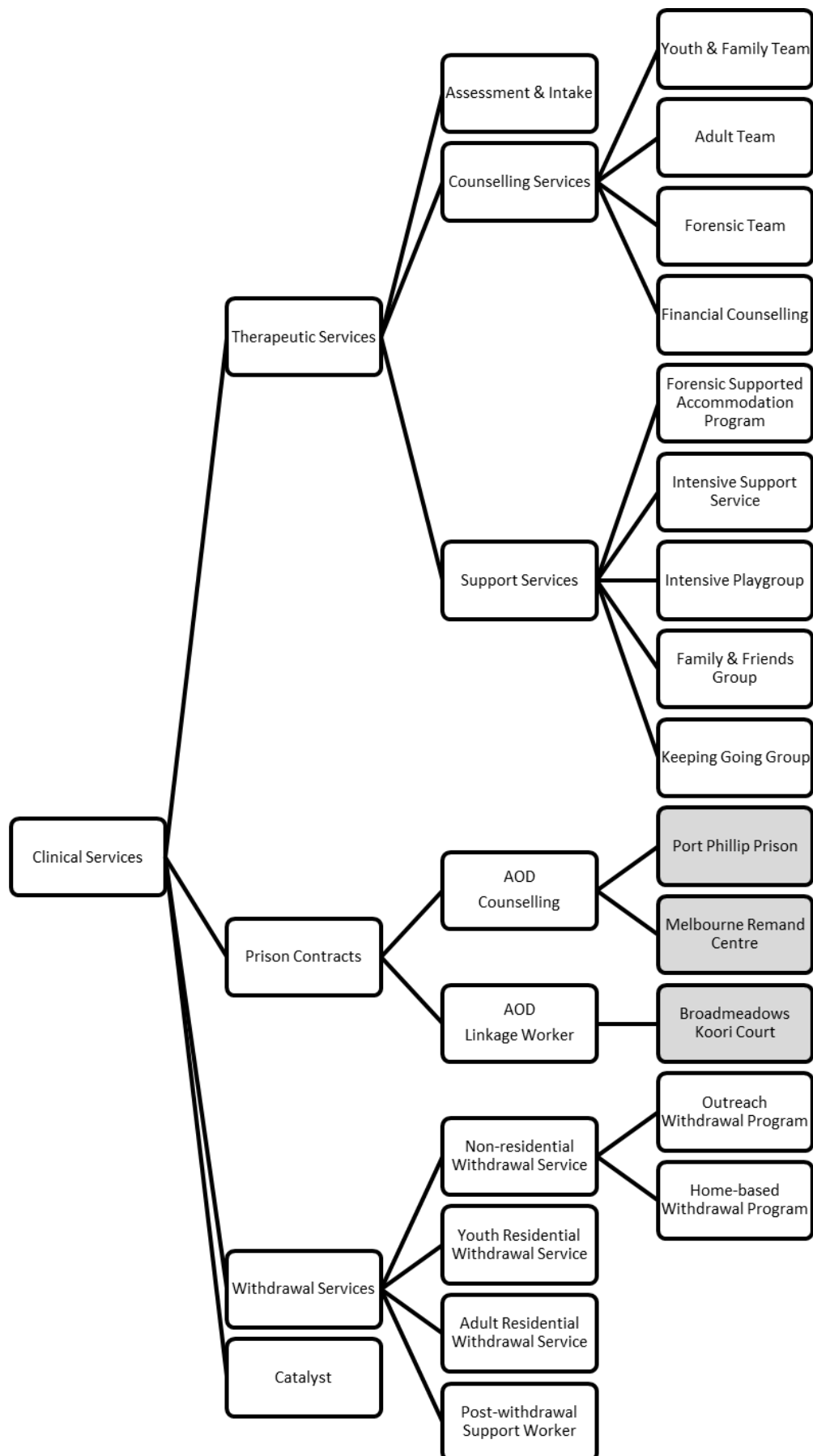
Staffing

Low staff turnover and retention of experienced staff were highlighted by participants. Additionally, all staff participated in dual diagnosis capacity training.

Model integrity

The physical location of services across two sites was sometimes challenging for services wanting to facilitate referrals across sites. The different services shared similar values regarding the approach to working with clients and this was strongly linked to the leadership provided by management. The majority of services were delivered on-site with the exception of some outreach programs (e.g. prison contracts).

Figure A2: Moreland Hall (2011)



A1.3 Health Case Study (NSW): the Homeless Health Service

The Homeless Health Service is a department of St Vincent's Hospital in Sydney. It is co-located with the departments of Community Health, Mental Health and Drug and Alcohol under the umbrella of Inner City Health (see Figure A3). Key features of integration practice at Homeless Health are shown in Table A3.

Table A3: Ingredients of integration: the Homeless Health Service

Streamlined assessments

Single entry point through the Assessment and Coordination Team acts as a one-stop shop for all enquiries from the public, community organisations, other departments within the hospital and homeless persons themselves. Provides an avenue into mainstream health care for the homeless.

Additionally, Way2Home conducts joint intake with the two external partner agencies.

Facilitated referrals

Strong emphasis on walking a client through the hospital system by attending appointments with the client or introducing clients to hospital staff prior to surgery. This approach essentially provides a client with their own care coordinator or health 'case manager'; a familiar face throughout the hospital system and someone that they trust.

Case review and supervision

Homeless Health Service has a weekly case review meeting which is also attended by staff from the other services within Inner City Health (e.g. drug and alcohol). Additional, ad hoc clinical review meetings involving staff from all services involved in a client's care are held as needed. Homeless Health staff also attend ward rounds.

Flexibility and support

The homeless health services creates flexibility in an otherwise highly controlled system; for example, negotiating extended stays in the drug and alcohol detoxification unit or the ED, or keeping staff from different departments engaged in a client's care despite repeated failures to attend scheduled appointments or inability to contact clients.

Relationships and communication

Co-location enables informal conversations to take place between Homeless Health and the three other services that make up the Inner City Health Service. Outreach staff can remotely log into the patient database and access, for example, mental health notes so that opportunistic health contacts with homeless clients can be maximised. This avoids escalation e.g. police becoming involved in enforcing requirements of community treatment orders. Regular meetings between the managers of the four services in Inner City Health (homeless health, community health, drug and alcohol, mental health) which focus on the structures and processes that maintain integration.

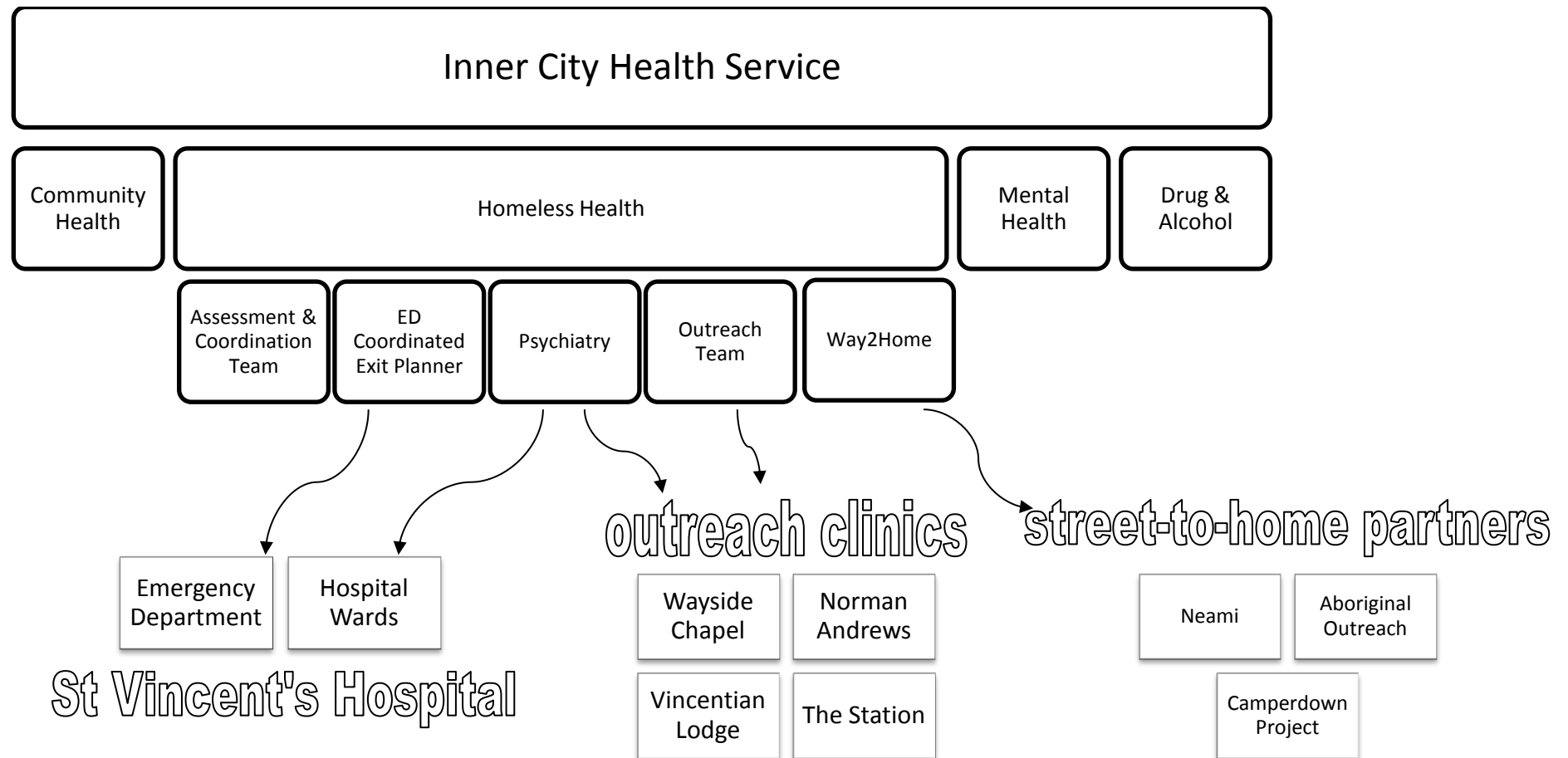
Staffing

The service was purposely developed with integration in mind hence staff were recruited with the expectation that outreach and other integration strategies would be a key component of their role.

Model integrity

Co-location facilitates knowledge sharing and a multi-disciplinary team approach to patient care. The single patient record also enabled continuity of care between the inpatient, community and outreach forms of service provision. Focus on integration within the health system (i.e. between hospital departments) as well as between the health system and specialist homelessness services.

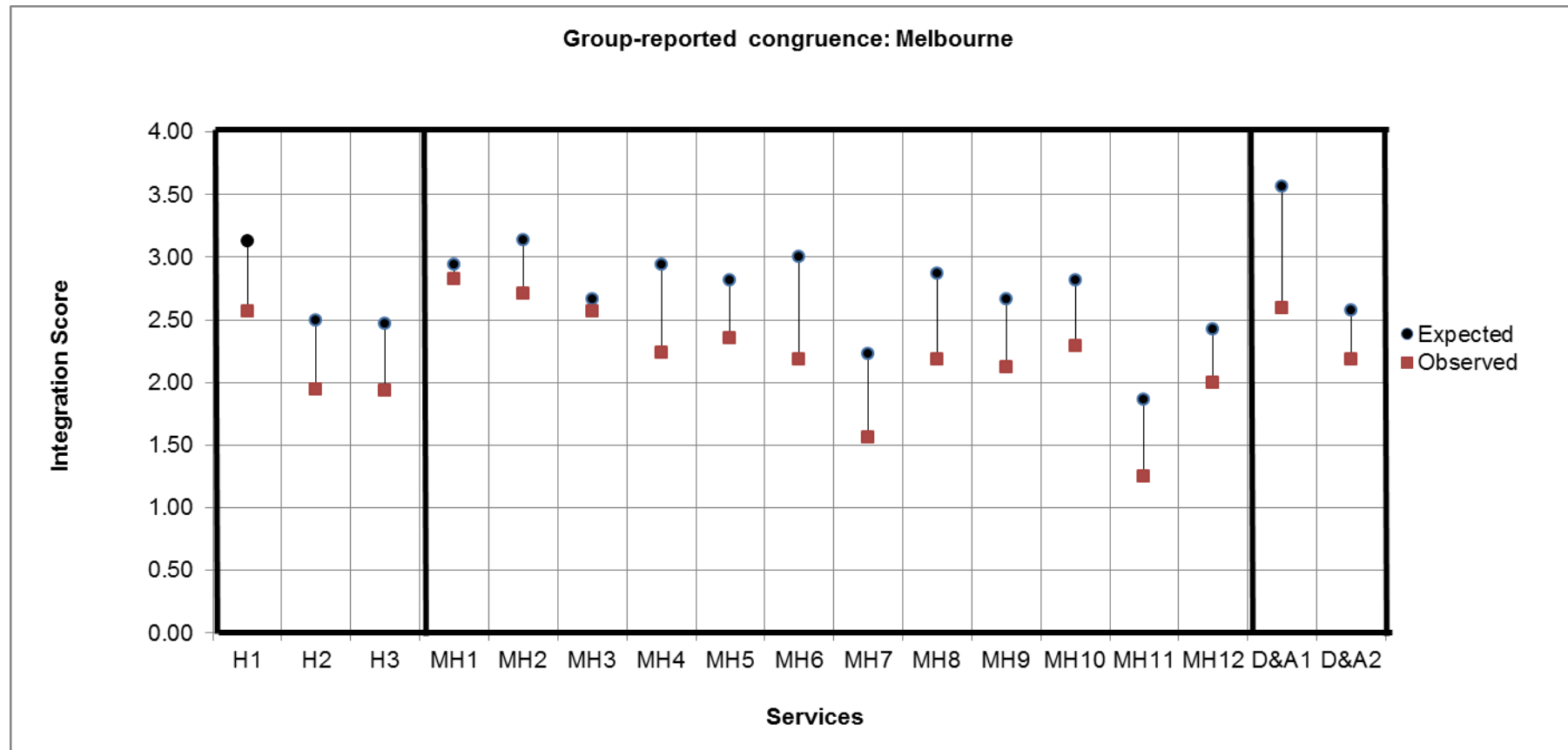
Figure A3: Homelessness Health Service, St Vincent's Health Network (2011)



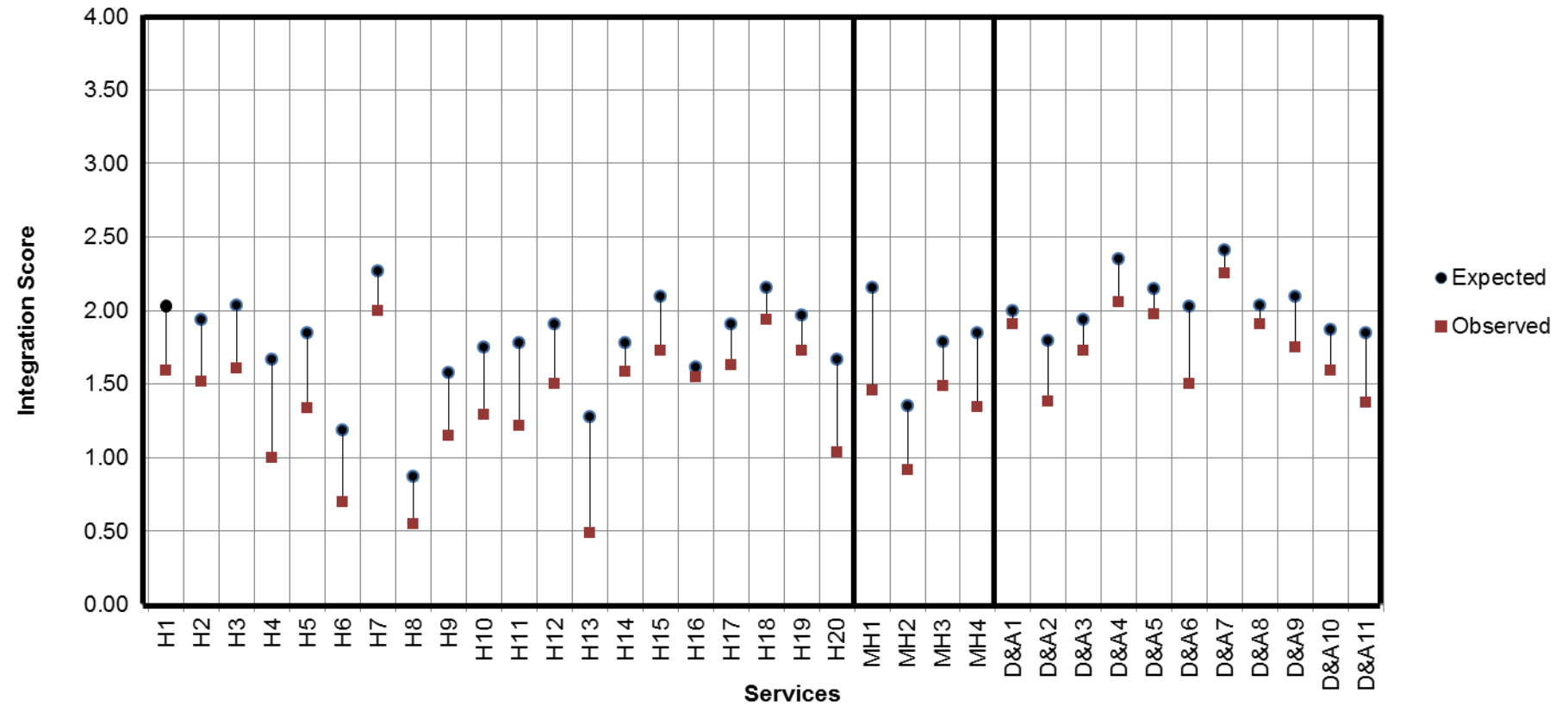
APPENDIX 2: CONGRUENCE AND RECIPROCITY

A2.1 Congruence

The following graphs present the difference between the observed and expected depth of integration scores within each individual service in the Perth and Melbourne networks (group-reported congruence). A shorter bar indicates greater agreement. For both networks, the level of expected integration is consistently higher than the level of observed integration.

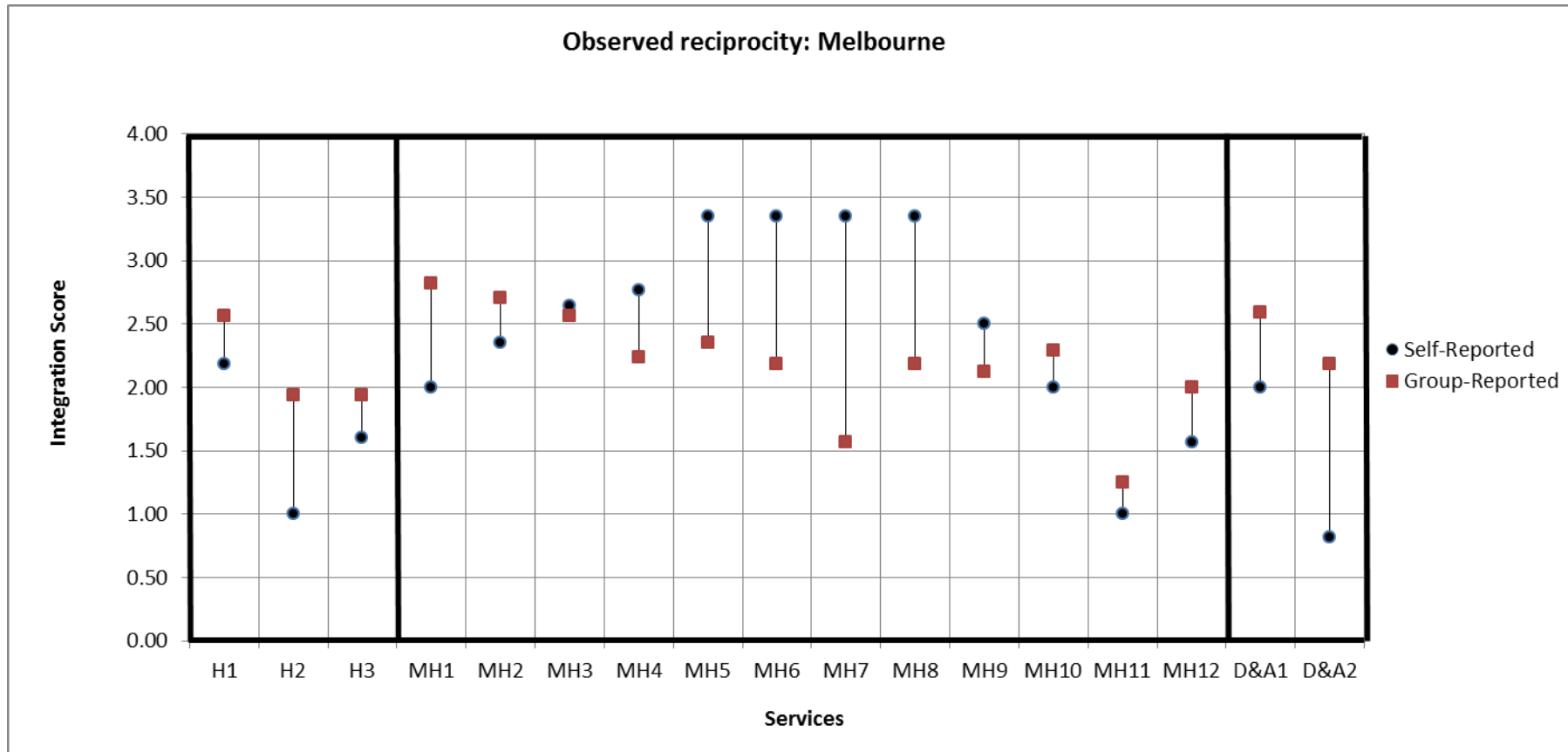


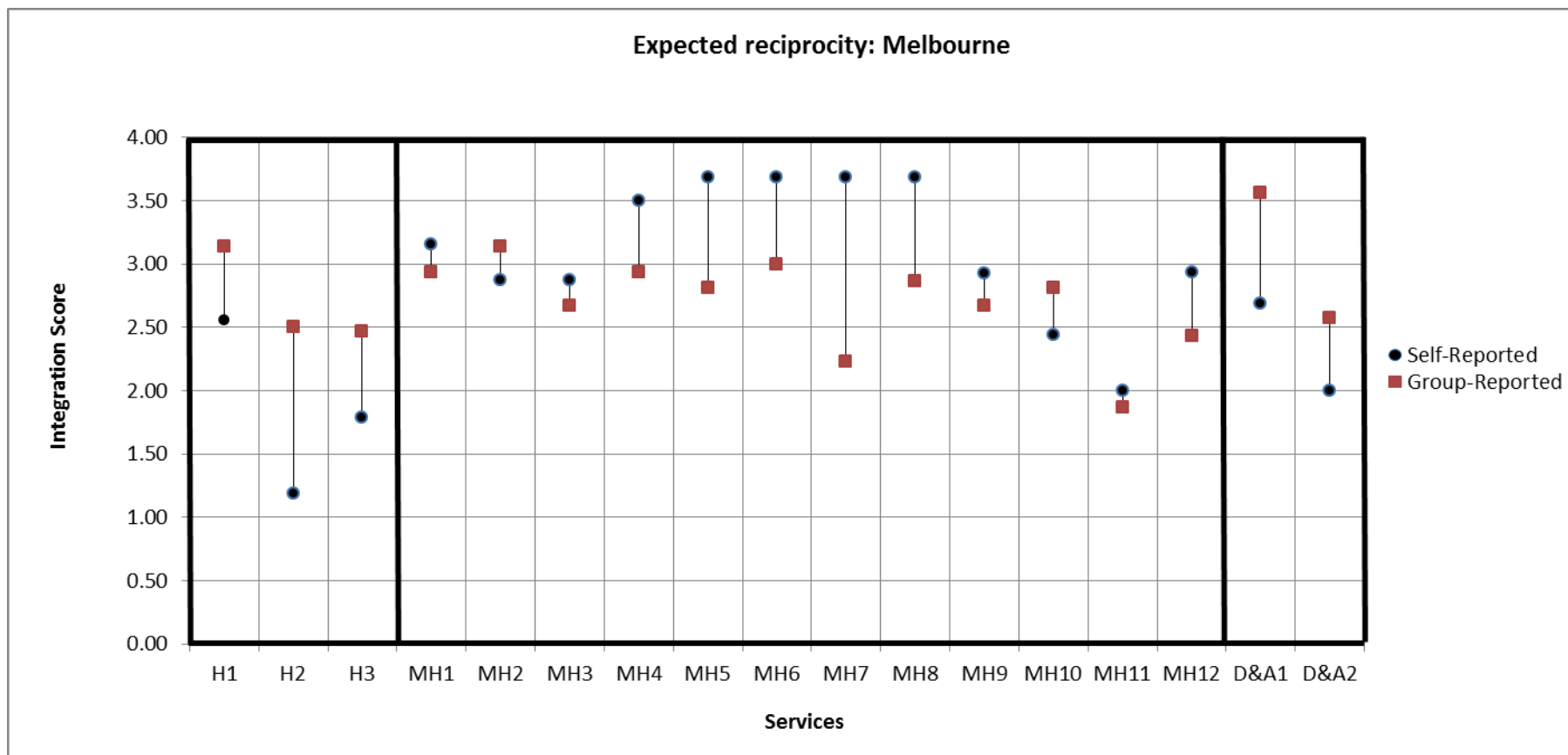
Group-reported congruence: Perth



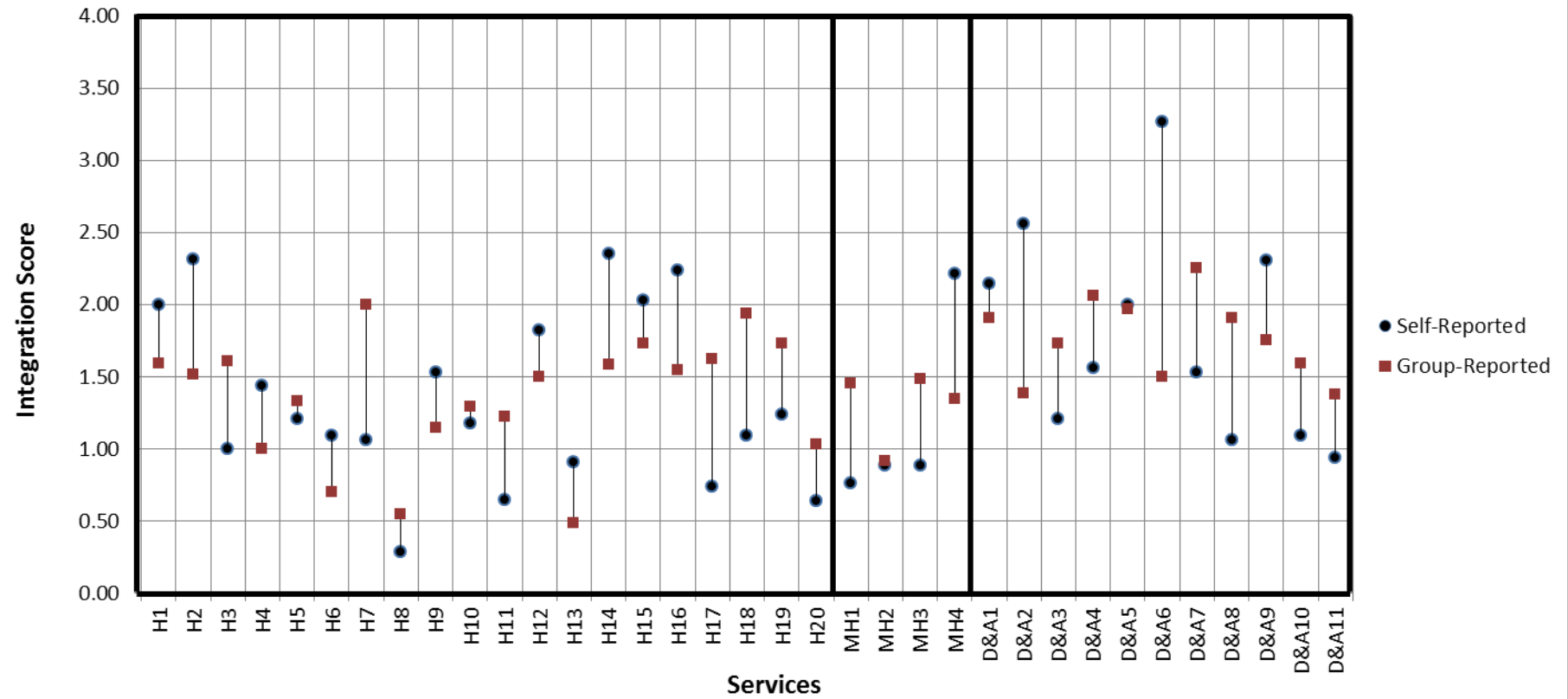
A2.2 Reciprocity

The following graphs display the difference between each individual service's self-reported depth of integration score and the group-reported depth of integration score (observed and expected reciprocity), for the Perth and Melbourne networks.

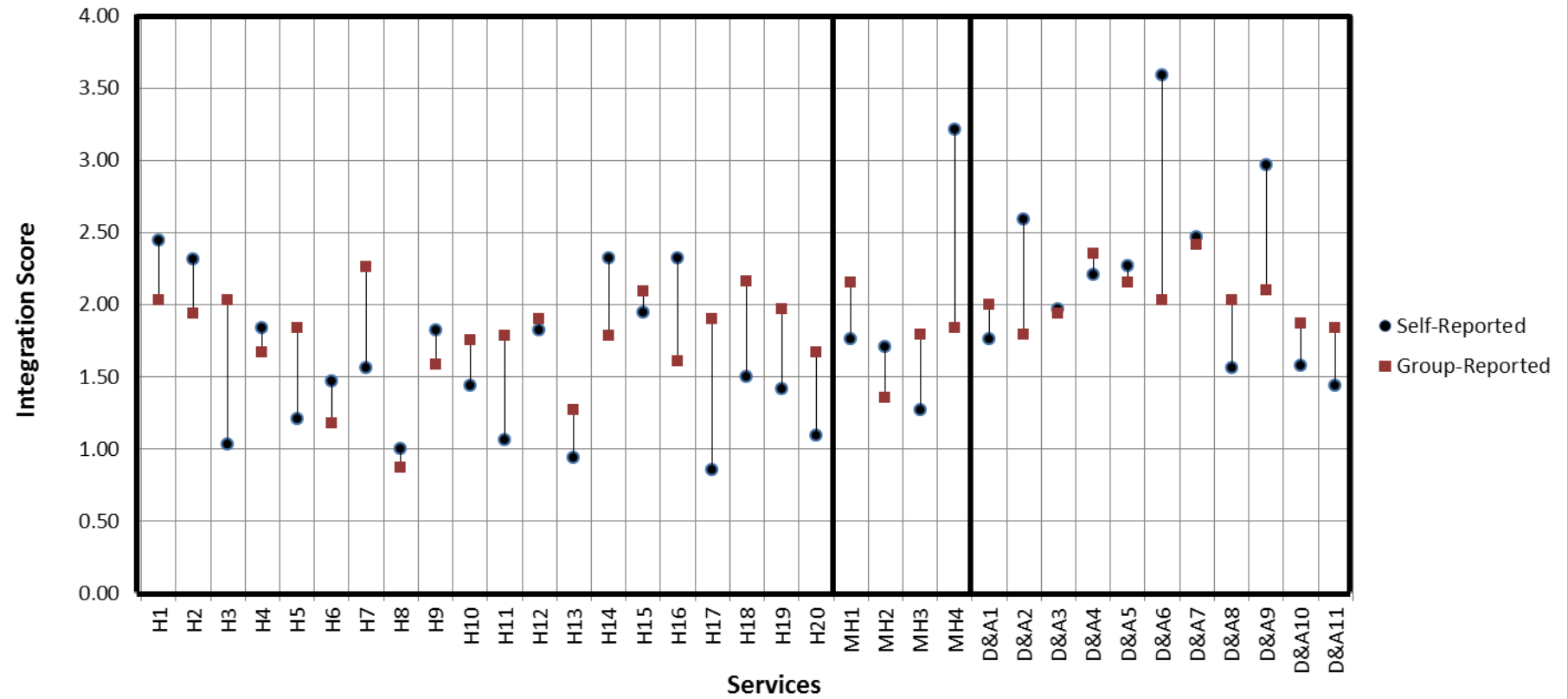




Observed reciprocity: Perth



Expected reciprocity: Perth



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