COORDINATED AND INTEGRATED HUMAN SERVICE DELIVERY MODELS

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Coordinated and Integrated Human Service Delivery Models

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1 Background

1.1 Overview of the report

This report, prepared for the New South Wales Cabinet Office, presents empirical evidence of the use of coordinated and integrated approaches to human service delivery in Australia, particularly in New South Wales, and overseas. It focuses on the evidence of successful integration initiatives involving community-based projects and those that cater to the needs of specific groups.

Details of the background to the study are presented below. In Section 2, case studies of recent initiatives in Britain, Ireland and the United States of America, as well as in New South Wales and other Australian states are presented. Section 3 outlines the conclusions which can be drawn from this experience and considers the lessons for future initiatives in New South Wales.

1.2 Background to the study

Over the course of the twentieth century, most essential human services came to be organised with clear program boundaries and a high degree of administrative autonomy. In recent years, however, there has been shift away from specialised and bureaucratic patterns of service provision towards a more coordinated, integrative approach. This more holistic approach, it is argued by advocates, can create synergies leading to innovation and streamlining of service delivery through information and skill sharing. Moves to enhance linkages between services are also undertaken to simplify consumer access to services, increase the cost-effectiveness of provision through the eradication of duplication and the inappropriate use of resources associated with poor preventative practices, and to help realise efficiencies of scale in service delivery.

This move towards coordination and integration has gained expression in NSW in a number of different contexts. But often these initiatives are undertaken without knowledge of the experience of other similar projects. To assist policy makers and service providers in New South Wales address these issues, the Cabinet Office commissioned the Social Policy Research centre to undertake this study, based on a review of published literature and documents concerning current initiatives in New South Wales.[2]

Ten current approaches to service integration were distinguished on the basis of the review carried out. Cabinet Office documents also identified twelve major initiatives that are being implemented or trialed in New South Wales at present. These have also been incorporated into this report. The list presented is not comprehensive, nor intended to be so. Approaches to service integration which were either well known or were not found to be supported by the materials obtained have not be reported. Other recent initiatives in New South Wales, such as the Demonstration Projects in Integrated Community Care (Fine, Thomson and Graham, 1998), which ran successfully until 1998, were also not included. Further details of the materials obtained, and the typology of current integration approaches developed as part of this study, are set out in Section 2.

[2] An overview of the methodology used is presented in Appendix 1.

1.3 Why integrate?

Over the twentieth century, human services came increasingly to be organised along specialised lines. Professional expertise and a more targeted approach developed, along with increased government support. Services also came increasingly to be provided from within the structure of government. Most programs also came to be structured along the lines of government authorities, whether provided by government departments, by statutory authorities, or by independent providers supported by government grants.

In the recent past there has been some shift away from these patterns, towards coordinating and integrating services that are complementary. This has taken two major forms, integration by geographical location (involving regional planning authorities and community level projects) and integration of a variety of different services used by particular clientele. People most vulnerable in society, with multiple needs who use services that are funded by the state and federal government, and people within particular geographical areas or catchments have been identified as those most likely to benefit from such a holistic approach.

In essence there are three main sets of arguments for improved integration: improved access for consumers; increased efficiency, achieving more from the use of limited resources; and enhanced effectiveness, resulting in enhanced outcomes for consumers and funders (Fine, 1997).

Typically, calls for improved integration are intended to address problems that arise in the ‘interorganisational field’, that is, the relationships between different services as consumers are required to make use of assistance that is only available from a variety of otherwise autonomous, or independently functioning, agencies (Bruner, 1992). From an inter-organisational perspective, the main problem that integration aims to eliminate is the elimination of duplication of tasks such as intakes, eligibility, assessment, diagnosis, and personal and social history taking (O’Looney 1993). A holistic or an integrated approach to human service delivery is argued by its proponents to generate greater effectiveness, efficiency, and increased agency sensitivity to client needs, eliminating the deficiencies encountered with a ‘fractured bureaucratic system’.

Other inter-organisational arguments in favour of integration include:

- Consumers will be able to access assistance more effectively in their ‘one stop family centres’;
- Access to services will be assured through program hooks (improved referral patterns and consumer access mechanisms);
- Coordinated systems planning will make a more comprehensive set of services available;
- There will be a better fit between consumers and community needs and the array of services made available because of more coordinated planning, information sharing, and pooling of agency funds;
- Direct service workers will be more knowledgeable of the entire array of services available and become more capable in delivering a wide range of services; and

- The synergies from an integrated approach is argued to lead to innovation and a streamlining of service delivery through information and skill sharing.

Another factor behind the call for integrated services arises from a critique of the internal workings of traditional agencies. This is well described by O'Looney (1997) who notes how many large public welfare services, as well established non-government providers, continue to operate as traditional 'Fordist' organisations. The organisational structure involves a small number of professionally skilled staff supervising the work of large numbers of relatively poorly skilled staff, or staff who are treated as if they are unskilled. To control the process, the tasks of the direct service workers are standardised, often narrowly defined and highly regulated. The result is that service provision may become rigid and inflexible, with internal referrals required for often quite simple, even repetitive matters, such as reassessment. The response to this sort of problem, is not necessarily to enhance inter-organisational links, as this might in fact exacerbate problems arising from organisational rigidities, but to seek workplace upskilling through the introduction of 'flexible specialisation'. This process, well known in Australia from industrial reform over the past two decades, enhances the professional skills of workers and enables them to become more multi-skilled and able to perform a range of tasks that otherwise would involve a number of different staff members or agencies.

The costs of integration: cautions and limitations

Although integration is often seen as a way to increase efficiency and hence to save money, efforts to improve the integration of services need to be understood as having a cost. This cost can be measured, in economic terms, as the 'transaction costs' involved. These may be thought of as the administrative and organisational costs involved in buying or maintaining different kinds of help. Often it is cheaper to reduce direct transaction costs by providing the help needed from within an organisation. When a client's needs are complex and ongoing, for example, it may be cheaper to reduce transaction costs by employing all the different staff involved in the one organisation (as occurs in a hospital). However for those who require simpler treatment or support, such ongoing transaction costs can be unnecessary, even wasteful overheads. It may be more effective to incur them sporadically as needed, by for example, using a case management/brokerage arrangement, or by establishing informal links with a reliable other. The important fact to focus on is that the cost-benefit ratio of integration is not fixed, but will vary with the type and number of clientele, the extent and character of integration, and other factors that will enter into the planning decision.

Whilst the goals to be pursued through improved integration appear to be widely agreed, it is difficult to know, *a priori*, whether problems experienced by a particular service or service system arise from poor inter-organisational links, from inadequate or poorly directed funding, or from other sources. It is also difficult to measure the extent to which the outcomes sought are actually achieved as a result of the integration initiatives taken. A number of the main writers in this field (eg. Leutz, 1999; Moscovice, et al., 1997) have openly lamented the pursuit of costly integration programs despite lack of generic evidence of improved outcomes for consumers or funding agencies.

What is required, this suggests, is not the promotion of the goal of service integration as an end in itself, but a more differential approach. Clear evidence of the nature and extent of problems in particular spheres of service provision together with evidence of

the value of specific initiatives to address these difficulties is necessary before an ongoing commitment is made to new initiatives (Farland, 1998).

1.4 Understanding Key Concepts

Given the level of interest in improving coordination of human services, it is surprising to discover how much vagueness, indeed fundamental disagreement, there is in defining even the most frequently used concepts such as 'collaboration', 'coordination' and 'integration' which have been used frequently in this report, as they are currently in policy discussions, service provision and in everyday language. An increasingly widely accepted way of thinking of these phenomena is to understand the integration of services as a sort of continuum or scale, as set out in Figure 1.1. The continuum extends from the complete autonomy of the separate parties at one extreme, through a series of graduated steps involving more intensive forms of linkages between the agencies, to the full integration of the separate parties at the other. At least two intermediary forms of collaboration can be identified which fall between these two defining possibilities. The first we have labelled 'cooperative links'. Leutz (1999), refers to this as service 'linkages' or more simply, 'links'. This represents a state in which each of the parties remains independent but communicates with others and cooperates with them in a voluntary way with specific activities which may involve common beneficiaries or goals.

A further step is represented as 'coordination'. This represents a planned and deliberate meshing of the activities of the separate agencies in a more systematic way. Coordination implies the surrendering of a significant degree of autonomy by each of the agencies involved, with plans being fixed according to a plan or protocol, or decision making being vested in a third party (for example a case manager) with responsibility for coordination.

Figure 1.1 The Continuum of Integration: A Basic Schema

⇦Autonomy			Integration⇨
Autonomy	Cooperative Links	Coordination	Integration
Parties/agencies act without reference to each other, although the actions of one may affect the other(s).	Parties establish ongoing ties, but formal surrender of independence not required. A willingness to work together for some common goals. Communication emphasised. Requires good will and some mutual understanding.	Planned harmonisation of activities between the separate parties. Duplication of activities and resources is minimised. Requires agreed plans and protocols or appointment of an external coordinator or (case) manager.	Links between the separate parties draw them into a single system. Boundaries between parties begin to dissolve as they become effectively work units or sub-groups within a single, larger organisation.

Source: Fine, Thomson and Graham, 1998; Leutz, 1999.

Full integration creates new programs (eg managed care services) or units (such as hospitals) where resources are pooled. The fully integrated program gains control of resources to define new benefits and services that it controls directly, rather than better coordinate existing services. One of the lessons Leutz (1999) drew from his review of attempts to integrate medical and social services in the United States and United Kingdom, is that the level of integration required should be determined by the degree of need amongst clients. For those with the least severe needs, linkage and perhaps coordination should be the preferred options. For more severe cases, more expensive forms of coordination and perhaps full integration are likely to be preferred.

Different Levels at Which Integration May Take Place

The basic schema set out above may be elaborated in a range of ways. One useful dimension to identify is the level of integration. Waldfogel (1997) argues that the failure to consider the levels at which coordination needs to be effective, was one of the major reasons for the disappointments of what she calls 'the first wave of service integration' undertaken in the United States in the 1970s. A simple two dimensional schema, combining an awareness of the level of integration with the schema for the degree of integration, is presented in Figure 1.2.

Figure 1.2 Level of Integration

Macro level	**National and State Government**	Policy, planning, finance and administration of different programs and service types
Meso level	**Local Services**	Links between regional services at management level
Micro level	**Individual consumers and staff**	Teamwork between different service providers assisting the same individual
		⇦ Autonomy Co-operation Co-ordination Integration ⇨

The top or macro level of integration involves the level at which policy, planning and financing decisions are made. In public services in Australia this task is usually undertaken by the Commonwealth and/or State governments. The next level down, the meso or middle service level, involves relationships between services within a region and the relationship between one service and another in the local area. A third level, the micro level, may also be identified. Integration activities at the micro-level concerns the inter-personal relationships between different service staff and between staff and consumers. It involves the direct relationship between services and the individuals they assist.

Loosely and Tightly Coupled Frameworks

It is also possible to distinguish between 'loosely coupled' and 'tightly coupled' approaches to integration (O'Looney, 1993). The former involves a set of independent decentralised organisations interacting as the occasion arises, although lacking of any ongoing formal ties. The latter involves a set of centralised independent organisational units acting in a coordinated or collaborative way. Loosely coupled systems tend to be more responsive and adaptive to the individual and environment needs, innovate more rapidly, maintain a high degree of reliability, and allows for specialisation and choice, he claims. The tightly coupled approach, on the other hand, is argued to enable the better use of technology, provide a more comprehensive set of services in a more equitable way, ease and promote access, result in economies of scale, and create ongoing networks.

It is helpful to recall, in this discussion, that one of the justifications for moving away from the provision of care in large, integrated institutions such as orphanages, long stay mental hospitals and homes for the disabled towards a more community-based approach was the lack of flexibility and responsiveness in the integrated settings.

Five 'Laws of Integration'

Finally, before turning to reconsider the case studies, it is helpful to report briefly on what Leutz (1999: 83-87) has termed the 'five laws of integration'. These are spelt out below.

1. 'You can integrate all of the services for some of the people, some of the services for all people, but you can't integrate all of the services for all of the people'. Determining who needs what level of integration is important. It can be done with the aid of empirical indicators, including the relative costs of providing some services in integrated settings and delivering the same services externally.
2. 'Integration costs before it pays'. This cost is both financial, relating to the transaction costs involved (eg the costs of case management, the costs of meetings, legal agreements, and so forth) and human. Leutz identifies three areas in which costs are likely to be sustained by agencies that tread the integrated path. These relate to costs to staff and support systems; ongoing costs to services; and start up costs, which are high to staff with, but decrease with time.
3. 'Your integration is my fragmentation'. An agency's commitment to the integrated approach will result in staff experiencing greater pressure, and undertaking tasks of greater complexity requiring more training and expertise, time and effort, if their resources do not expand. Front-line staff, for example, may find their work more fragmented as a result of a need to attend more meetings, fill in more paperwork and referral documentation, undergo special training, and so forth.
4. Certain non-complementary services are better left not integrated. Sometimes, one-off services need to have such a different approach that attempting to integrate them could lose their value.
5. 'The one that integrates will call the tune'. This alerts us to the potential for conflict involved in moves towards integration. Conflict is particularly likely to be evident in any arrangement involving proposals for budget-holding and/or transfer of authority.

As the case studies presented in Section 2 make clear, it is evident that there is no 'science' of administration, or even a consensus about the 'state of the art' that could provide a fail safe blueprint for the reform of fragmented patterns of service delivery. There is however, a sufficient degree of agreement amongst experts that, properly applied, integration initiatives can bring considerable benefits to those who depend on the assistance provided.

2 Models of Service Integration: International Case Studies and NSW Initiatives

This section of the report presents ten models of service integration of varying types and levels of human service integration. The research on which this report is based was confined to secondary sources. Drawing on a literature review and review of current policy documents, where available, various Australian and international materials were obtained and analysed. The sources of information for the models are located in Appendix 1.

In the first stage of study, three methods were used to identify source materials and for compiling the case studies required. These were i) the use Internet and Library Databases including Ageline, APAIS and the Families Studies Database, ii) the use of the Social Policy Research Centre's contacts in the United Kingdom, and iii) use of New South Wales Cabinet Office Contact list.

In the second stage of the search, key words and references from existing materials and from the bibliographies in the documents identified in stage one of the study proved a rich source of information. Further acquisitions were undertaken on the basis of the literature and other material identified. Examples from initiatives in NSW are also included in this section. These examples are based on information supplied by the NSW Cabinet Office.

The ten different service integration models identified included : Service Hubs; Multi-Purpose Services; School linked services; One stop Shops for Information and Referral; Innovative Case Management Approaches; Social Partnerships; Formal Networks; Community Level Integration; Collaboration Approaches; and The Merging of Government Departments. Table 2.1 provides an overview of the main feature of each of the models and indicates which of the NSW initiatives are related to the different service integration models.

In compiling Table 2.1 it became evident that the NSW initiatives did not fit neatly into each of the case study models. All of the NSW initiatives have a number of elements in common with one or more of the models of service integration. For example the Claymore Integration has some elements of the Service Hub Model, however, it is more strongly aligned with the concept of Community Level Integration, discussed later in this section. In additional some of the initiatives are directly comparable to a particular model of integration for example the Schools as Community Centres Program is directly comparable to the service integration model of Schools Linked and Full Service Schools. Table 2.2 illustrates the way in which the NSW initiatives incorporate elements from each of the different service integration models.

Table 2.1: Current Models of Integration

Models	Operational Scope	Type of services	Organisational Arrangements	NSW Example	Evaluation and Outcomes
Service hubs	Inner-city neighbourhoods Homeless people with a mental illness	Heterogenous groups of welfare services	Informal links based on local proximity and complementarity Spatial location rather than auspiced by an agency		Not available
Multi-Purpose Service Centres	Regionally based, although located in different towns. Women's health needs or older people	Hospitals, GPs, health and extended care services	Multi-disciplinary organisational and management structure; Management boards with key representatives. Administratively centred around hospitals		The MPS provided improved quality of care for the aged through: expanded services, improved access to services; and improved inter-agency relationships.
Schools linked services and full service schools	Schools. Youth and children at risk	Schools	Collaborative inter-organisational relationships. Project coordinator. Social workers closely liase with teachers to identify students who are more likely to be categorised as being 'at risk'.	Schools as Community Centres Program	Evaluation showed that the service was important but problems with lack of clearly defined goals and short term funding
One Stop Shops	Place and by clientele	Income and family support	Autonomous, shop window; Organise an array of services.	Government Access Program	Evaluation limited to comment carers and focus groups
Case Management	Place and/or group (ie those with complex care needs)	Varied	Organisationally specific.	Coordinated Care Trial , Illawara, Hornsby/Ku-ring-gai	Final evaluations of the Australian trials will be available in mid 2000
The Social Partnership Approach	National Institutions including government, employer organisations and trade unions.	Socially disadvantaged groups	Managed at the national level by Area Development Management Group Local companies consisting of representatives of the community, statutory agencies and social partners	The Premier's Forum	
Service Networks	Rural areas-health service networks Mental Health Services Children, adolescents and families	Health services	County Human Service Boards, non profit organisations and health insurance organisations Autonomous organisations with shared links	Families First	Not available

Table 2.1 (continued)

Models	Operational Scope	Type of services	Organisational Arrangements	NSW Example	Evaluation and Outcomes
Community Level Integration	Geographically based, LGAs or a cluster of LGAs or a regional level Youth at risk	Different types of service for young people	Community management board or oversight council Working partnerships between local people, agencies and organisations	Claymore Integration Project, Community Participation and Development Project, Kings Cross Place Management Project, Woolloomooloo Crime Prevention and Safety Program	Not available
Interagency Collaboratio n	Complimentary services, joint decision making	Health and social care services	Collaborative agreement between housing, health and social care	The Joint Investigation Program, Regional Coordination Program, The NSW Strategy to Reduce Violence Against Women	Not available
Merging Dept	Government Departments	Health and social services	Central Office responsibility for funding and organisation		Not yet completed

Table 2.2: Matrix of Integration Models and NSW Initiatives

	NSW Initiatives											
Models of Integration	Schools as Community Centres Program	Government Access Program	Coordinated Care Trials: Illawarra & Hornsby/ Ku-ring-gai	The Premier's Forum	Families First	Claymore Integration Project	Community Participation and Development Program	Kings Cross Place Management Project	Woolloomooloo Crime Prevention and Safety Project	Joint Investigation Program	Regional Coordination Program	Strategy to Reduce Violence Against Women
Service Hubs	X	X				X						
Multi-purpose Service Centres												
Schools Linked and Full Service School	XXX											
One Stop Shops	X	XXX				XX				XX		
Case Management			XXX		X							
Social Partnerships				XX	X	X	X	X	X		XX	X
Service Networks	X		X		XXX	X		X		X	X	XX
Community Level Integration	XX	X	X	XX	XX	XXX	XXX	XXX	XXX		X	X
Inter-agency Collaboration	XX	X	X	XX	X	X	X	X	X	XXX	XXX	XXX
Merging Departments												

X one element in common
XX some comparable elements
XXX directly comparable

2.1 The Service Hub Concept

The service hub is based on the observation that particular geographic locations often become the central 'hub' of activity for particular client groups, such as homeless people and deinstitutionalised people with mental illness. It is argued that clients tend to be concentrated around such localities not only because the amount and variety of different formal services in these areas is higher than elsewhere, but because informal support networks, which function as mutual aid structures, also develop in such settings. In some cases service hubs emerge over time to support client groups within a particular neighbourhood or defined geographic area. The approach may be extended, however, by promoting the principles of spatial proximity and the co-location of related services to enhance the integration and effectiveness of support for clients (and potential clients), while also promoting the effectiveness of the locally based informal support networks. This can be done by the purpose design of new facilities, or the adding-on of additional services to an existing base. Two forms of integration are required: horizontal integration between different services providing specialised sorts of support at the same level of need, and vertical integration, between services and supports dealing with different stages or levels of expertise and intensity.

According to Dear, Wolch and Wilton (1994: 187), the service hub approach is based on the following three principles:

- 'the human problems of disability, deprivation and need may (in part at least) be addressed through the direct provision of human services delivered from a set of physical facilities in geographically favourable locations.
- Such facilities will tend to have associated with them a range of positive and negative external effects, which extend over a geographically finite area.
- The wellbeing of the service dependent population may be improved if as many as possible of the positive external effects are 'captured' by siting the facilities such that they are geographically proximate'.

To properly address the needs of the population, facilities should not only provide direct care, but also be located close enough to each other that 'localisation' and economies can be realised.

The authors define service hubs as 'a diverse collection of facilities for aiding the service-dependent. It consists of relatively small-scale, community based facilities [and service agencies] which are in such close physical proximity that interaction between them is feasible to the extent that the set of facilities functions as an integrated unit. The service hub will typically consist of a set of heterogenous group of services, including some generic community functions, and typically is capable of addressing the needs of a variety of client groups' (Dear, Wolch and Wilton, 1994: 188).

The service hub concept focuses on the principles of a support network. It is based on developing the principles of 'community-based, local-level elements of the caring hierarchy; decentralising responsibility for care to local communities; and building local ecologies that will integrate and support the service dependent population' (Dear, Wolch and Wilton, 1994: 189).

Population characteristics and client needs

An important part of the planning process is a review of population characteristics and the determination of client needs. Service hubs need to cater for local needs and to allow for varying patterns of client need. One element of this is the diversity of need and the likelihood of the needs of individual clients changing over time. Any adequate

service system, the authors assert, must be designed to identify opportunities such adjustments, and not be planned around a single mode of service delivery. More specialised, higher level services, may be required, perhaps in a centralised facility. These can be linked through a screening and referral process to the more basic service hubs.

Service characteristics

There needs to be a sufficient range of services to meet the diversity of client needs. Hence a service hub access should offer access to what the authors call 'a continuum of service settings', from open, unrestricted sorts of support which large numbers of people can access with little effort, through to more intensive, 'closed' forms of services. What is important is that the service hubs operate as both a localised agglomerations of services and as part of a larger network of support, extending upwards through a referral system and downwards and outwards through their entanglement with and support of informal networks of support[3].

The question of the governance or auspice of the services that would constitute a service hub was not addressed. The approach implied in emphasising spatial location, rather than the auspice of agencies, is that different mixes of agency ownership types, from state government and municipal services, to church based charities and other non-profits and possibly even contracted private agencies, may be involved.

Evaluation

The authors do not provide a formal evaluation of the service hub concept. However two case studies are presented. The first concerns the service hub that has developed around Rose Avenue, at Venice Beach, Los Angeles. Their description makes clear how three independent charitable welfare services located in close proximity - St Josephs Day Centre for homeless people, the Bread and Roses Cafe (a centre for free hot meals) and the Venice Family Clinic - have formed the nucleus of the hub. Other facilities which contribute to the functionality of the hub are public storage lockers, public toilets and showers and low-cost motels which appear to operate as a form of boarding house, all of which are located nearby.

The second case study is of Raymond Avenue, Pasadena, which is based around Union Station, a purpose designed centre for homeless people. In addition to offering meals, accommodation for some and assistance with access to accommodation for others, the centre offers a substance abuse recovery program and other services. Other programs help stimulate the interaction and (re)integration of the homeless into the community. These include the 'Adopt a Meal' program which matches homeless people and volunteer host families for meals and shelter, a monthly car wash program, which provides employment opportunities, and a neighbourhood clean up program, staffed by homeless patrons.

2.2 Multi-Purpose Services

The Multi-Purpose Services (MPS) approach combines services to meet the immediate and extended health and community care needs of a particular client group through the pooling of funds from a range of otherwise distinct Commonwealth and State joint funded programs. MPS arrangements can be sited in a particular location or tailored to meet the needs of a specific group. Across Australia, MPS models have been gaining

[3] Here, it is possible to imagine the use of a service hall for the holding of community education or exercise classes or for the use by choirs or community groups in the evening, or for christmas dinners for the homeless.

popularity to meet the needs of older people in rural and remote locations. MPS try to improve service delivery by simplifying funding, enhancing accountability and coordination, increasing flexibility and improving cost effectiveness. Hospitals tend to form the nucleus of the MPS models, with allied health and community services being co-located.

The auspicing body of an MPS is charged with the coordination of services to meet local needs, rather than the criteria of centrally defined programs. The overarching body of the MPS is the Contact Group. Within states nominated Project officers from the Commonwealth and State hold a liaising role with the individual MPS (Andrews, et al, 1995).

The Target Population

The MPS model targets older people in remote and regional areas who require immediate and extended community and health care. These regional areas tend to have lost services and infrastructure with a high degree of economic soci-economic disadvantage, poor health compared to metropolitan communities and with under utilised traditional hospital services.

Features of the Model

Innovative and flexible funding arrangements, a multi-disciplinary organisational and management structure, and physical placement (sited at a single location or in multiple locations) are key features of the MPS model. MPS models incorporate Commonwealth, State and other sources of funding. Even though the MPS program tends to be lead by the Commonwealth Government, the pooling and redistribution of funds to meet the needs of the target population requires the joint commitment of both Commonwealth and State governments (Evans and Hoodless 1999, 1). The pooling of funds (funding flexibility) are argued to facilitate service flexibility by enabling the specific needs of individuals to be met.

The Victorian equivalent of fund pools is called the 'Healthstreams Program'. Healthstreams provides acute casemix funds and other funds which may be 'cashed out' to form a flexible funding pool.

The organisational and management structures are also key features of MPS models. The MPS Management in Dalwallinu is comprised of the Dalwallinu Hospital Board Members, nine individuals elected by the community and approved by the State Minister. Andrews et al. note that a distinctive feature of the MPS model in Dalwallinu was the five Sub-Committees in the areas of Aged Care/HACC, Continuing Care, Community Health, Hospital, and Mental Health and Public Health, with each Chairperson being a member of the MPS Hospital Board.

Services that were previously offered independently of the hospital, such as HACC and Child Health Services were brought under the Dalwallinu District Hospital MPS umbrella. Hence the hospital effectively operated as the 'command centre' for the MPS model, with the relevant coordinators being based at the hospital. The recently built hostel – Pioneer House – is the other important facility through which MPS are provided.

The MPS model operating in Victoria – the Upper Murray Health and Community Services (UMH&CS) model (also known as the Carryong Model, on which we currently have less information), achieved a high degree of integration through bringing together a number of services under the one management structure. After integration, the number of services that were provided through this MPS program

increased by roughly 20 between 1995 and 1999. The key operational strategies adopted in the UMH&CS model include:

- 'point of entry advocacy' whereby employees are provided with the skills and information to help people gain greater control over their life by helping them to identify and facilitate access through the numerous entry points;
- 'Standardised Multi-disciplinary Assessment & Outcome based Planning' which combines multi-disciplinary assessment and care planning with the client and/or family;
- 'Care Coordination' which is coordinated through an Occupational Therapist operating across different care settings.

These organisational innovations are reported to have been greatly benefited by the close physical proximity of service providers.

Evaluation

The evaluations of the MPS found that the overall model of the MPS provided positive opportunities for improved service delivery in rural and remote communities. The MPS model demonstrated, to varying degrees, the provision of an appropriate mix of services to meet individual client needs. The MPS provided improved quality of care for the aged through: expanded services; more appropriate facilities (including new and renovated buildings); improved access to services; and improved inter-relationship of services. The MPS sites contained overall administrative and infrastructure costs within the budget allocation (up to 5 per cent variation). Where MPS sites were able to commence capital works programs, there appear to have been an appropriate mix of recurrent and capital expenditure. Considerable progress was made in the flexible use of staff undertaking a variety of roles, including deployment between institutional and community institutions. At the time of the final evaluation visit, savings gained from a more cost effective staffing mix was redirected to the provision of direct services. Some sites were financially disadvantaged by the lack of funding mechanism to compensate for unanticipated local circumstances such as an increase in the level of dependency of the frail aged in a particular year (Andrews, et al, 1995).

The evaluation recommended the MPS concept and related strategies be extended and that the central Commonwealth-States MPS Contact Group should be maintained. However, it found that cooperation in setting overall reporting requirements could lead to more efficient practices and that further clarification, at the national level, of the role of Home and Community Care Program was required. It also recommended that a critical evaluation of newly revised reporting procedures was necessary (Andrews, et al, 1995).

2.3 School Linked Services and Full Service Schools

Schools linked services and full service schools are concepts that use primary and secondary schools as the basis to deliver an array of human services to children and youth in need. Schools in this sense are comparable to hospitals that have been used to target elderly frail people in the coordinated care trials. The goal of integrating services to children with the education system is not only to make service delivery more effective, but to make services responsive to the needs children and families who are identified as being 'at risk' (OECD 1996, Cullen 1997). It is also hoped that integration will result in a better matching of resources and services to the needs of individuals, leading to better educational and developmental outcomes for children (Cullen 1997, 13). Indicators of being 'at risk' is argued to be reflected through the

child's or youth's behaviour in school which is detectable by specially trained teachers.

Example 1: New Beginnings – San Diego – California – USA

The New Beginnings (NB) program in the San Diego County in the state of California was started by senior administrators in the Department of Social Services in the County of San Diego and San Diego City Schools in 1988. The program attempted to make family social services, child welfare case management, and an array of child health services more accessible. It developed in response to senior administrators feeling that the pre-existing service systems were uncoordinated, inconsistent and often ineffective, particularly to low income families.

Features of the Model
The project was developed initially by the Hamilton Demonstration Centre. Funds were allocated to support inter-agency collaboration and empower collaborating agencies to have increased authority enabling them to solve problems by having more in-depth involvement with a smaller caseload of families.

The New Beginnings program operates on three levels. First within the school, second within the Centre, and third external team of contacts.

- In School: Trained teachers in problem identification and supportive techniques refer children who are experiencing academic, behavioural, attendance or health problems to the Centre. A 'feedback loop' between the Centre staff and teachers operates to insure that benefits to children are being made.
- In the Centre: The Centre operates as the link between the school and specialist services and training programs. The staff of the Centre includes a Director, family service advocate and an administrative secretary. The child's and family's needs are assessed and referrals to specific, self help and other programs are made accordingly. Physical examinations, immunisations and common childhood conditions are treated within the Centre.
- External Team: Specialist tasks are undertaken by an external team of workers in the areas of child guidance, housing and probation.

New Beginnings is coordinated by an executive committee made up of the funding parties. The funding parties appear to be the County of San Diego, the City of San Diego, San Diego City Schools, and the San Diego Community College. However this not explicit in Cullen's (1997) account. The funding parties make contributions into a pool of funds that pay the Director's and the family advocate's salaries. Other personnel are funded and employed through individual agencies. There are in total eight full time staff – at the Centre and as part of the extended team – that are employed.

Example 2: Port Phillip Cluster – Victoria

Features of the Model
The integrated services model operating in the Port Phillip cluster reorganised multiple health and welfare services to children into an single service system. Primary stakeholders were the Victorian Department of Education (DOE, Pahran District); the Department of Human Services (DHS, Cheltenham); the City of Port Phillip, Port Phillip Special School, Graham Street Primary School (in Port Melbourne), South Melbourne Primary School and Hobson's Bay Secondary College. Both, the primary and secondary schools were chosen on the basis of the number of pupils they

considered to be ‘at risk’ because of socio-economic factors and social emotional problems.

The driver of the model was a working party comprising of representatives from DOE, DHS, the Royal Children's Hospital, The University of Melbourne and Principals from a number of different schools.

At a service level, it was felt that an integrated approach would enable important health and welfare services to be delivered to youth who are most at risk of youth homelessness, drug abuse and misuse, violence, youth suicide and youth unemployment. Ideally, integrated service provision would not be confined to the co-location of services within the school. Rather, an attempt is made to link schools with community agencies to engender collaboration in service delivery, with individuals schools serving as access points to those most ‘at risk’. But a potential problem that was identified was that these concepts may infer that the schools involved are ‘at risk’ schools, further alienating their students (Semmens 1998).

The project was jointly funded by the Department of Education and the Department of Health to employ a Project Officer from Jan 1997 to Jan 1998. The project officer’s role was to try to implement case management procedures within the four schools. Schools themselves provided resources, which would have included access to telephones and information technology.

Evaluation Results
All evaluation respondents agreed that the service played an important role in providing support and services to young people. Only a few had an understanding of what their organisation’s role in the process. An evaluation of the Port Phillip project began 6 months after its it became operational. The duration of the project was initially going to be 12 months and it was thought by the Departmental representatives that measurable outcomes were important to demonstrate the results of integration in practice. The evaluation was funded through a $5,000 grant from the University of Melbourne. The initial evaluation was descriptive, involving interviews with students and parents at six monthly intervals. Interviews with key service workers, school principals and welfare workers, social worker for the region, project coordinator and selected members from the working group were also undertaken.

Example 3: Towers Hamlets Borough – London – UK

The Model
An Education Social Work Service is a linkage service mechanism administered by professional social workers to address unauthorised truancy and absentees in schools operating in the UK. The Education Social Work Service (ESWS) is organised into teams. In the Towers Hamlet Borough, there are different ESWS teams operating, with each being responsible for one of the seven neighbourhoods.

The fundamental aim of ESWS teams is to get children to attend school by forging a link between home and school. ESWS teams operate with schools from which they receive the greatest amount of referrals. Weekly meetings with head teachers and regular visits to schools are made by ESWS teams. In high schools, ESWS teams may have a base where they see students, parents and teachers.

ESWS teams vary in style – dependant on the leader. However, common to all teams is the fortnightly meeting to compare notes, share information, workshop particular issues and discuss institutional difficulties.

NSW Example: Schools as Community Centres Program

The Schools as Community Centres Program aims to influence the planning and integration of service delivery to better meet the needs of families with children from birth to eight years of age. Children at risk of disadvantage on entering school are of particular concern. The Program is operating in NSW in Chertsey on the Central Coast, Coonamble, Curren, Kelso, Kempsey West and Redfern Public Schools. The Program is jointly funded by the Departments of Education and Training, Community Services, Health and Housing. The model employed in the Program is a community centre based within a school. Community involvement is through the establishment of a community advisory group. The School is promoted as a community centre by providing services and activities at the school that link families with the education, health and community services available to support their children's development (Cabinet Office, NSW, 1999).

The Directors General of the four State Departments involved approve the continuation of funding. A Steering Committee comprising senior managers from the four funding Departments are responsible for statewide policy. State coordinators based within the Department of Education and Training provide professional supervision and training and maintain the overall integrity of the program. There are Local Management Committees comprising senior managers of the four departments, the local facilitator and the school principals. School Principals provide the day to day supervision of the Program. There is also a Community Advisory Group, which consists of representatives from local agencies and community members. The model employed in this program is client focussed, based on a planned community development approach to preventing disadvantage, using an integrated service delivery model with a view to preventing disadvantage for children entering school (Cabinet Office, NSW, 1999).

An evaluation was undertaken in four pilot areas. Qualitative and quantitative data was collected from questionnaires and other sources. The results of the evaluation found that the Program exceeded expectations through promoting an integrated response to families and young children in disadvantaged communities. Families felt supported in their parenting role; parents had a greater understanding of their children's needs and children were being effectively prepared for school (Cabinet Office, NSW, 1999).

2.4 One-Stop Shops

The Commonwealth Department of Social Security undertook a series of pilot projects in 1996 and 1997 to improve the flow of product and service information to their clients. These pilot projects are called Family Service Centres (FSC) and arose in response to the difficulties experienced by customers in accessing a wide range of benefits that were being administered by numerous autonomous service units. Parents who use the Department of Social Security's services also felt that the offices had to be more accommodating of children.

Example 1: Family Service Centres for Information and Referrals

Description of Models and Outcomes

Common to all the models of FSCs are having better informed and well trained staff, the creation of a family environment, improving the links with government and community agencies, focus on enhancing customer satisfaction, and embarking on innovative work practises.

A central aim of staff training is to orient staff to become more customer focused, more informed about community agencies and services, and to be more open to

innovative ideas and work practices. Training involved, attending workshops developing a handbook and encouraging staff to take initiative. A new position – Family Assistance Officer – was also created to oversee the advice and referrals, and to take responsibility for liasing with staff from specialised DSS services. FSC make referrals to Commonwealth, state, local government and community agencies.

The 14 FSCs have taken Four Forms.

1. **Co-location with Department of Social Security regional offices**:- According to Forman and Ryan (1998) this was the least expensive way of setting up are FCS. The staff of the FSCs profited from the high level of administrative support they had available to them from DSS staff. Similarly, DSS staff were able to tap into the FSCs network but it was difficult to create a separate and distinctive identity.
2. **Location in shopping centres:**- Location in shopping centres was by far the most expensive option, owing to the costs of rent, fit-outs and overheads. The advantages of FSCs taking this form. were the distinct identity and convenience.
3. **The community house:**- The community house concept within close proximity to a shopping centre was another form a FSC took to create a homely environment. Even though the initial renovations to the house was more expensive than the fit out to the shopping centre, the low costs of renting made it less expensive over time.
4. **The mobile van:**- A mobile van was also used to deliver FSC services in Mt Gambier, South Australia from June 1997. This form of FCSs is seen as an innovative way of providing services to rural and remote communities.

Evaluation

Detailed evaluation results and a detailed description of the process of acquiring information were not reported. Foreman and Ryan (1998) report on some customer focused 'comment card' responses and focus group research results. In relation to the availability of information, 97 per cent of respondents appreciated the new way of acquiring information.

NSW Example: Government Access Program

Seven Government Access Centres (GAC) were established in Northern and Western NSW. The centres were located in Dorrigo, Gilgandra, Grenfell, Kyogle, Maclean, Nambucca Heads and Oberon.

The overall aim of the Government Access Program (GAP) is to improve access to government services in rural and remote communities in NSW and to trial the integrated delivery of government services through a 'one stop shop' concept with an emphasis on face to face service delivery facilitated by electronic support systems. The GAP aims to be a cost-effective method of improving access to government services by diffusing costs associated with dedicated staff and infrastructure over a number of agencies. GACs provide services on behalf of government and other community related organisations on a fee for service basis, which offsets the Centre's operating costs. The remaining cost is subsidised by the Premier's Department. Service agencies benefit by providing their clients with improved access but only pay when transactions are conducted. It is envisaged that the Centres will become increasingly self funded (Cabinet Office, NSW, 1999).

The Centres provide face to face delivery of government information and over the counter types of services. The Program is coordinated by the Premier's Department and is overseen by a Steering Committee comprised of representative from the Cabinet

Office, Treasury, Attorney General's Department, the Government Information Office and is chaired by the Premier's Department. There are a number of other stakeholders including, the Departments of Housing, Fisheries, Fair Trading, Community Services and Juvenile Justice, Area Health, Local Councils, Centrelink, National Employment, The Australian Tax Office, Legal Aid and Community Transport. Each Centre has an officer and is managed by a host Agency, most often an existing State Government agency or a Council (Cabinet Office, NSW, 1999).

The Program is currently being evaluated. And while the overall results will be determined in the evaluation, the GACs appear to have increased their towns' access to government information and services and there is widespread community support for the Program (Cabinet Office, NSW, 1999).

2.5 Case Management

Case Management (CM) refers to an interactive coordinated process followed by front line specialist service providers to secure the most effective, efficient, supportive and cost-effective service outcome for their clients. CM is a form of integration at the point of service delivery. It is important to bear in mind that CM is organised around the client. As a result, evaluations of CM programs focus on client outcomes, rather than on the effectiveness of organisational and funding arrangements.

The Target Population

The Case Management program operating at the Center For Vulnerable Children (CVC), targets drug-exposed infants living with their biological mothers, as well as foster children, adolescent mothers and their infants. Child welfare workers have found that these groups of people were exposed to what has been termed 'new morbidities'. New morbidities refers to children being exposed to different forms of abuse, drug use and exposure, teenage pregnancies, failure at school and in the family, family violence, behavioural conduct disorders and other problems arising from complex social factors. These new morbidities are deemed to require complex responses.

The CM operating at the San Francisco General Hospital (SFGH) seems to target an older multi-cultural population with complex needs and/or continuing care needs to relieve the stress on the hospital emergency system. Winder (1988) argues that the two main reasons for the establishment of such a facility are to:

- Improve the continuity and quality of care provided to clinical patients with complex medical problems and/or treatment regimes, and
- Contain costs by helping medically unstable patients to avoid costly hospital stays and emergency care.

Features of the Model

Registered Nurses coordinate CM at the SFGH. Registered Nurses received training on how CM can be incorporated into their nursing practice. They were instructed on client identification and assessment, care planning, resource identification, referral of clients to appropriate services and documentation of case management activities.

CM at the SFGH involved identifying patients, followed by the nurse collaboration with the nurse's physician to formulate patient care goals and a timeframe in which these goals can be achieved. Following this, an appropriate care plan and a monitoring plan are developed.

At the CVC, CM is coordinated in a similar way. All the services seem to be dispensed from the same facility. Case Managers are involved in the assessments of their clients, development of care plans, brokering of services, the monitoring of care plans and client's progress and play an advocacy role to assist in community resource development. After an initial six-month start up program, clients were enrolled in one of three clinical service programs with constant monitoring. Child welfare is noted by Halfon, Berkowitz and Klee (1993) to be a new area in which CM has been applied. Their account of CM at the CVC does not provide a detailed account of the factors that lead to the ultimate implementation of CM. Rather, an account of the clinical developments, which recognise the complex needs of children exposed to complex needs is provided.

Evaluation

The evaluation of CM in the SFGH is based on the success of the program in reducing emergency room visits and hospitalisation among patients selected for management. At the SFGH, a conclusive outcome is not reported, although studies of several urban facilities have reported reduced patient hospitalisation due in part to case management.

The evaluation of the CVC CM program, used in this case study, was descriptive. Characteristics of service users are given, rather than any conclusive evidence as to the effectiveness of Case Management.

NSW Examples: Coordinated Care Trials in the Illawarra and Hornsby/Ku-ring-gai Areas

People aged 65 years and over with complex care needs are the target group of this initiative which, aims to improve health outcomes and social well-being of people with multiple service needs while maximising their ability to live independently by coordinating care from community and health services within existing resources. A care coordinator acts as an agent for the GP and their patients. The coordinator identifies non-medical issues and the GP and patient construct a care plan from which to purchase services in the health and community service system. Information technology links the general practice and local service providers as well as creating an electronic Health Record of the patient (Cabinet Office, NSW, 1999).

The Illawarra Coordinated Care trial is sponsored by the Illawarra Area Health Service, the Illawarra Division of General Practice and the Home Care Service of NSW. The Illawarra Health Service is the lead agency. Funds are provided by the Commonwealth Department of Health and Family Services, the Department of Veterans Affairs. Area Health services provided credit for services and funds. The Home Care Service provided funding all of which had to be spent on Home Care Services. A small amount of funding of funding comes from volunteered participants' contributions (Cabinet Office, NSW, 1999).

In Hornsby/Ku-ring-gai trial is sponsored by the Northern Sydney Area Health Service (NSAHS). Other agencies involved include the Northern Sydney Home Nursing Service, Home Care Service of NSW, Mercy Family Service, GPs, private health insurers (MBF and HCF) independent health professionals and a number of health and community service not affiliated with the NSAHS (Cabinet Office, NSW, 1999).

Both trials use care planning, case-management along with pooled funds. The funding pool is contributed to by a number of agencies including: the Medical Benefits Scheme, the Department of Veterans Affairs, NSAHS, Home Care Service of NSW, and major services particular to each area. Funding for each contributor is estimated on an agreed capitation payment (Cabinet Office, NSW, 1999).

The NSAHS sponsors the trial and bears the financial risk for the pool expenditure and infrastructure for the trial. Overall policy decisions for the trial are made by the Management Committee which includes representatives from the Division of General Practitioners, the Home Care Service of NSW, North Sydney Home Nursing, ADD, Mercy Family Service, ADD and consumer representatives. Three working groups make recommendations to the Management Committee. A Memorandum of Understanding covers the management of the trial including the relationship between the Management Committee and the Working Groups. There is no formal accountability structure covering the role and responsibility of the care coordinators (Cabinet Office, NSW, 1999).

The evaluations of these trials will be completed in March 2000. The mid trial reports showed that the trials were operating within budget but with few outcome gains for the intervention groups despite the outlay of significant additional costs (Cabinet Office, NSW, 1999).

2.6 The Social Partnership Approach

The term 'Social Partnership' describes mechanisms used in Ireland, since 1989, to manage issues of national economic and social concern. The social partnership approach is based on involving government, trade unions and employers in the development national agreements in matters concerning national social and economic planning.

Although originally national in scope and focussed on issues such as wage and salary levels, industrial relations and economic development priorities, the approach has been successfully extended to the local level, providing a means for dealing with local problems in an integrated way through the Operational Programme on Local Urban and Regional Development.

Perhaps the most visible expression of this approach to local partnerships has been the development of sub-programme 2, one of three sub-programs. This involves the establishment of area-based partnership companies in the Operational Programme on Local Urban and Rural Development, and is explicitly intended to lead to the integrated developments in disadvantaged areas through local development partnership companies. The program is jointly funded by the Irish government and the European Union.

Features of the Model

There are three important features of the local development programs as they currently operate (Cullen, 1998: 3-6).

First, the program is targeted at socially disadvantaged areas and groups. It is aimed particularly at sub-groups, such as Travellers (ie homeless people), persons with disabilities, the long-term unemployed, and others perceived as at risk of becoming long-term unemployment.

Second, the local companies set up to manage it consist of representatives of the community (including, presumably, local government), of statutory agencies and the social partners (employers, trade unions and government). At a national level, the program is managed and coordinated by the Area Development Management (ADM), an independent, non-government partnership company which has similar structures to local companies.

Third, the funding of local companies requires them to develop comprehensive 3-5 year plans in partnership with other relevant local interests. These plans are assessed

for their suitability of the funding measures, the implementation structures and the procedures for monitoring performance.

Evaluation

Although it is likely that evaluations of existing initiatives have been undertaken, we do not have access to detailed results. A careful but brief description of the operation of the approach in dealing with unemployment is outlined in Cullen's 1998 monograph. The child welfare proposal is, to the best of our knowledge, still a proposal that has not yet been implemented.

NSW Example: The Premier's Forum 'Working Together in Strengthening Rural Communities'

The objectives of the Premier's Forum are to develop a shared strategic approach to the socio-economic problems such as crime and safety issues faced by communities in the Western NSW local government areas; develop short, medium and long-term actions that could be implemented by the Western Communities in partnership with Government agencies and the formation of a representative group from the forum to drive strategies and provide ongoing feedback on implementation. The majority of strategies emanating from the Forum have been funded within existing outlays by agencies, Local Government and community groups. The Forum is facilitated by a Regional Coordinator and working groups. Participants in the Forum include the Premier, the Minister for Local Government, the Minister for Regional Development and Rural Affairs; the Directors Generals of the Department of Health, Education and Training, Aboriginal Affairs and Community Services, Premiers and the Assistant Commissioner of the NSW Police Service, Mayors and Local Council General Managers, Aboriginal community representatives, community groups and regional and central office staff of Government Departments. The Forum was informed by a series of visits by members of the Council on Crime Prevention and talks with community representatives. Eighty per cent of respondents' thought that the Forum had been successful in achieving its stated aims to identify priority issues, build networks and develop solutions (Cabinet Office, NSW, 1999).

2.7 Service Networks – New Perspectives

The concept of networks is one that has been widely used in the organisation of human services. The term social network is used in many contexts to refer to the social relationships that link family, friends, neighbours and acquaintances. In the Australian context, the term has been used since the 1970s in the field of community services in a similar way, referring to patterns of loose interpersonal ties between individuals working in different services or settings. Informal networking activities linking individuals, in this sense, is often the most recognisable form of inter-organisational linkage in many fields of human service provision.

One of the apparent reasons for the enduring popularity of the concept of networks is its flexibility. It is an appropriate term to apply to ties that develop between organisations from the bottom-up, as it were, rather than those which are imposed by rules or regulations from above, as it offers participating organisations many of the benefits associated with belonging to a fully integrated system, whilst avoiding some (although not all) of the heavy costs, both financial and a loss of organisational autonomy. As the following case studies show, the concept also provides a useful, adaptable and practical bottoms-up approach to developing more integrated service delivery systems.

Because the integration of services has significant costs, as well as potential benefits, it is important that the service agencies that are involved are supportive of the process. This is particularly so if the different agencies are independent, non-government entities, with financial, organisational or other reasons for wishing to maintain a degree of autonomy and self-identity.

Both lateral regional networks and 'vertically integrated' networks offer useful tools for the achievement of many of the aims of integrating services, without placing too high a burden or risk on member organisations. Furthermore, it a flexible approach, capable of evolving to a relatively high degree of integration if circumstances, leadership and other conditions are favourable, but also able to operate with many of the benefits to both members and clients at a relatively low level of intensity. Because the process of network formation and the pace of change remain largely in the hands of participating agencies, it is also one that has some political credibility.

An important refinement of what is traditionally understood as the networking of services, evident in the cases outlined above, is the use of formalised protocols and procedures to help give some permanence and to strengthen commitment of the participating organisations to the achievement of common goals.

Example 1: Integrated Rural Health Networks. USA, 1997

Moscovice, Wellever, Christianson, Casey, Yawn and Hartley (1997) recently published a study of six health service networks in rural areas of the United States. The networks studied were quite diverse in character. One, Itasca Medical Care, in Minnesota, was operated by a County Human Services Board. Others were administered by non-profit corporations or operated on a for-profit basis by the practitioners. One was controlled by a health insurance organisation and was operated as a managed care organisation. Some offered a full range of care, from primary care to hospital services, but one was focused on what in Australia might be called extended or aged care. In another case the emphasis was on linkages between primary care and community services.

What is perhaps most significant is that the formal network form has emerged in a range of quite different physical and financial conditions as the preferred model for the conduct of joint operations. Rather than this being the result of a government plan or regulatory requirement, the formation of integrated networks appears to be a reaction to the market and other conditions in which the various participating services operate.

A detailed evaluation of the operation of integrated rural health networks is not available. Nonetheless, the authors identify and describe the means used to integrate the different services into the network in a helpful way, drawing on a schema which outlines the networks' structures for governance and management, the services and functions covered, their sources of financing, and the networks' level of integration, its complexity and the 'assumption of risk', which concerns the financial arrangements pertaining between the participating units in each network.

Example 2: A Lateral Network as a Learning Organisation

Kurtz provides a case study of the operation of the Southeastern Network of Youth and Family Services (SEN) which links 80 member agencies in eight Southeastern states of the USA. Member agencies vary in size and complexity, but all share a common commitment to serving runaway and homeless youth. Such regional human service networks differ in a number of important respects to the integrated networks outlined above. For example, while integrated rural health networks link specialised clinical services that are non-competitive and inter-dependent, in that none provide the full

range of care required by the population of users and referrals between agencies are required, the SEN network draws together agencies that are essentially similar in function. Networks of this kind also enable a different form of coordination to that of a form of vertical integration. Membership of different services in a regional network enables the sharing of information between members necessary to prevent unnecessary duplication of services. It can also assist by such activities as developing registers of vacant beds for referral purposes when one facility is full, as well as for joint planning, political representation, advocacy, and training purposes. The central office and organisational structure of SEN is financed partly by contributions from member organisations, and partly by contracts and grants from government and private benefactors.

According to the evidence presented by Kurtz, SEN is particularly highly regarded by its member organisations because of the excellent job it has achieved, over the past decade, in improving the conditions under which services for homeless youth are provided. This has been achieved, effectively, as a result of the impact of training, information exchange and advice shared among member organisations. The author comments that the service managers believe the evidence of the networks' success is best expressed in the transformation of their services that has taken place since the establishment of SEN. They were highly enthusiastic about its operation, as it had both enthused them with ideas and ideals for service improvement, and provided much needed support and coordinating linkages with other similar services faced with similar problems to those which they were faced. It had enabled funding to be increased, but more importantly, SEN had helped the member organisations rethink the way they operated, enabling them to become far more effective.

Example 3: South Shore Mental Health Centre

In 1984 the United States Congress created the Child and Adolescent Service Systems Program (CASSP), which made a modest amount of money available to strengthen state leadership to develop a 'systems of care' approach to children and families.

The South Shore Mental Health Centre (SSMHC) is a non-profit agency. Other agencies involved in delivering services to children and their families includes the Department of Social Services, the Department of Mental Health, the Office for Children, public schools, adolescent residential programs and satellites for other child guidance and child welfare organisations.

The Target Population

The Child and Adolescent Service division of the South Shore Mental Health Service targets children, adolescents and families who have been affected by severe behavioural, psychological or emotional turmoil.

Features of the Model

The 'systems of care' approach is formally defined as 'a comprehensive spectrum of mental health and other necessary services which are organised into a coordinated network to meet the multiple and changing needs of children and adolescents who are severely emotionally disturbed and their families'. Systems of care involves strengthening the range of non-residential services to children and their families that are child-centred, family-centred, and 'function specific'. Attempts are also made to incorporate 'cross-systems', whereby parents and community members are involved in the process.

The systems of care approach tend to operate at two interconnected levels – the case level and the inter-agency level. The case level includes joint referrals between agencies, networking, and case management. At the inter-agency level, the systems of care approach include service contracting, affiliation agreements for back up or crisis services, and may involve joint funding between agencies.

The South Shore Mental Health agency is described as being decentralised and complex. Decentralised in the sense that the various divisions, such as Child and Adolescent Services and outreach programs operate independently of other service areas. Middle managers are assured a high degree of autonomy to be flexible and creative in conceptualising new opportunities for collaboration with external agencies. But this degree of decentralisation also requires greater coordination to avoid internal conflicts between Divisions surfacing in negotiations with external organisations. The key role played by Administrators by moving beyond their program areas is documented.

The success of the CASSP model at the Child Adolescent Service of the South Shore Mental Health Service has been attributed to four principles:

- Mobilising of concerned and influential community and agency members;
- Respect for the autonomy and the interdependencies of the 'system';
- An appreciation of divergent perspectives; and
- A commitment to shared goals.

Evaluation

The CASSP, operating through the South Mental Health Center is qualitatively evaluated with reference to the above principles. Even though a passing reference is made to the collection of outcomes data, the evidence on which this case study is based, is unfortunately anecdotal, lacking in being comprehensively quantitative or qualitative.

With respect to mobilising concerned and influential community and agency members, an example is provided where the South Shore Mental Health Crisis Team's actions avoided unnecessary psychiatric hospitalisation of a child.

NSW Example: Families First

The objective of Families First Program within NSW is to raise healthy, well-adjusted children and to achieve better functioning families, a reduction in conditions leading to mental health problems, child abuse and neglect and juvenile and adult crime. The initiative targets families with children under eight years old. The budget for Families First is drawn from existing resources for government and non-government services to support families in addition to new funding of $54.2 million over the next 4 years (Cabinet Office, NSW, 1999).

The strategy builds on existing services across the government and non-government sector of early intervention, prevention and community development programs and coordinates them into identified networks in communities. The local service networks are to provide a range of supports for families. The establishment of the strategy is facilitated by the NSW Cabinet Office. Other agencies involved include: Area Health Services, Departments of Community Services, Education and Training, Housing and Health and the Ageing and Disability Department, various non-government organisations and professional associations. DoCS and Health are the nominated budget holders. The resources are allocated to the implementation plan and an

allocation scheduled is agreed regionally by department heads and endorsed by the Human Services CEOs. Local planning and implementation decisions are made by the Regional Executive Officers Groups (REO). REO Group are responsible for ensuring local participation and consultation. Regional project leaders are responsible for facilitating processes for decisions made by the REO Group. The evaluation is currently being developed (Cabinet Office, NSW, 1999).

2.8 Community Level Integration

Integrating service delivery within a certain geographical precinct is known in the published literature as 'Community Level Integration' (CLI). The community, may be a specific Local Government Area (LGA), a cluster of LGAs or even a regional area. A distinctive feature of community level integration, in contrast to other forms of integration, is the commitment of the community/neighbourhood to the project. . The family and the local community is seen to provide the building blocks for nurturing, supporting and protecting its members in order develop effective and responsible social systems (Cousins 1998). Community participation takes place through citizens of the local community representing their constituency on management boards and other activities in a systematic way, rather than on an *ad hoc* basis.

Example 1: Communities That Care – United Kingdom

The Communities That Care (CTC) initiative is a long-term preventative program that addresses the disillusionment and pessimism felt by youth in disadvantaged areas. The CTC program will take an integrated approach by first identifying the domains that give rise to disillusionment and pessimism and then proceeding to strengthen these domains by linking specialist agencies providing services. The CTC scheme encourages working partnerships between local people, agencies and organisations to promote healthy, personal and social development among youth and thereby reduce the risks of behavioural problems. The long-term objective is to build safer neighbourhoods (Communities That Care, 1997).

Target Population
The CTC program will use a mapping technique to identify youth most at risk of developing behavioural and health problems.

Aims and Features of the Model
The CTC program has two aims. First, it sets out to reduce the *risks* faced by children and youth developing behavioural and health programs and second to increase *protection* to those most vulnerable to developing these problems. The program aims to achieve these objectives by taking an integrated approach to strengthening social behaviour in four domains. The domains are: families, schools, communities, and individuals and their friends (peers).

The CTC program aims to reduce risks across all these domains through the development of integrated 'local action plans'. Local action plans are designed in four stages or phases. Crucial to these action plans are the links that are forged between different agencies and community groups. The four phases of the action plans are: community involvement, risk and resource auditing, action planning and implementation, and monitoring and evaluation.

The CTC program is said to be a first in taking a systematic approach to reducing risk and enhancing protective measures available to youth. Some of the characteristics of the CTC program have been identified as taking a step by step approach, flexibility and adaptability, effectiveness by being rooted in understanding of best practice, and relegation accountability.

Example 2: Juvenile Crime Prevention Program – Long Beach, California, USA

The Juvenile Crime Prevention Program (JCPP) aims to reduce juvenile crime in a 'high-risk' neighbourhood area. The JCPP is a large state funded collaborative initiative involving 20 community-based organisations, city and country agencies, public schools, and a university. All stakeholders are involved with governance and service delivery, giving expression to the democratic philosophy of self-determination.

The JCPP aims to reduce juvenile crime through a range of mandated direct service programs by building 'community bonding' and cohesiveness. An oversight council, called the Community Oversight Council (COC) comprising of agency representatives and residents, was integral to steering the JCPP. This account of the JCPP concentrates on some of the practical issues to arise from the relationship between agency staff and residents in the COC – 14 months after it became operational.

The Model of Community Involvement

The original proposal for the JCPP was developed by university and agency representatives with some public meetings involving residents. Community resident involvement was initially minimal. The JCPP is sited in a low income, culturally diverse, densely populated urban area. Approximately 50 per cent of the residents are Latino, 22 per cent Asian American, 16 per cent African American and 11 per cent European American. The neighbourhood is notorious for high rates of poverty, unemployment, violent crime, child abuse reports, homicide and school drop-out.

The COC in 1995 was composed of 36 members. One third of the members came from the community. By December 1996 the COC had expanded to 39 members, with a community representation of 59 per cent. The partnership is said to have been successful in recruiting and retraining community residents. Some of the challenges that were experienced are discussed below.

This account of the Juvenile Crime Prevention Program and the Community Oversight Council by O'Donnell et al. (1998) is an evaluation that focuses on some of the practical difficulties that were experienced when community residents are involved. The research method seems to have been informal interviews.

NSW Example 1: Claymore Integration Project

The aim of the Claymore Integration Project was to develop, implement and evaluate an initiative, which provided a variety of services from multiple providers in a coordinated and planned manner in the Claymore community located in Western Sydney. The project was auspiced by the Campbelltown City Council and the Department of Housing is the lead agency and a coordinator was appointed to the project (Cabinet Office, NSW, 1999).

The integration model adopted for the project involved five key elements: integration of Claymore into the whole community, integration of services with community needs, integration of services with each other, community accessibility and accountability to the community. Co-located services and community outreach services are run from Gumnet Cottage and Glenroy Cottage including NSW Department of Housing, Macarthar Area Health Service, Community Justice Centres, NSW Police Service and Centrelink. Outreach activities include Department of Housing (Basic Home Maintenance Program), Burnside and Health and the Police and the Benevolent Society. All organisations involved in the project are represented on the Steering Committee. The Steering Committee guides the delivery of the project. A regional CEOs' Interagency provides strategic direction and support to the Steering Committee.

The project has been jointly funded and resourced by the nine participating agencies (Cabinet Office, NSW, 1999).
No formal evaluation of the project has been conducted as yet but there has been an increase by 82 per cent in the referrals from Claymore to the Domestic Violence Team (Cabinet Office, NSW, 1999).

NSW Example 2: Community Participation and Development Project

This project is in operation in the towns of Boorowa, Harden-Murrumburrah, Young and Yass located in NSW. It is based on 'place focused' integrated planning and community consultation process to identify areas of need and to encourage joint projects. Local Government Social Plans were used as vehicles for planning for local government. The project is managed by the Young Community Health Centre. Existing structures are used to achieve the joint planning outcome. Agreement is required amongst the stakeholders including state agencies and local councils at the different stages of the process. A number of new projects resulted from this initiative including a community information project and a men's health project. No formal evaluation was undertaken (Cabinet Office, NSW, 1999).

NSW Example 3: Kings Cross Place Management Project

While this initiative's core business has not integrated human service delivery, it has facilitated the design and management of integrated responses to pressing social issues. The aims of this initiative included enhancing the amenity and prosperity of one suburb in Sydney, Kings Cross, improving safety and security in the area and building a more harmonious and responsible community. A project-based approach has been used to address social, economic and environmental issues. The initiative was managed by the Premiers Department and South Sydney Council. The project had a Reference group consisting of representatives from South Sydney Council and the Premiers Department and Office. The agencies involved included State, local and Commonwealth agencies, non-government organisations and business and other community stakeholders. The evaluation of the project recommended that place management interventions be considered to identify discrete areas with complex social and economic problems that had been unresponsive to interventions in the past and where there was potential to achieve outcomes through government and non-government agencies working collaboratively. Also, it was recommended these projects be time limited strategic interventions working towards the achievements of pre-defined outcomes (Cabinet Office, NSW, 1999).

NSW Example 4: Woolloomooloo Crime Prevention and Safety Initiative

The Woolloomooloo Crime Prevention and Safety Initiative was jointly funded and supported by the NSW Premier's Department, South Sydney Council, the Attorney General's Department, the Department of Housing, the Department of Juvenile Justice, the Department of Community Services, the Department of Education and Training, South Eastern Sydney Area Health Service and NSW Police Service. The aim of this initiative was to develop innovative ways of responding to local issues and concerns in order to address current crime and safety problems being experienced by people who live, work and visit Woolloomoolloo. A number of steps were taken to develop the Crime and Prevention and Safety Coordinators Plan including: the formation of a Safety Committee consisting of community representatives and government and non-government agencies; the formation of partnerships with government and non-government agencies; joint funding and a commitment by government departments and local council for the initiative; establishment of a referral group of government representatives and South Sydney Council; employment of a Crime Prevention

Coordinator; consultation with Stakeholders and regular community meetings; needs analysis of the community; collection and compilation of crime data an the development of the Crime Prevention Coordinators Program. The formal evaluation results were not reported however there had been a decrease in all crime in the area, an increase in youth and children's activities, improved community development and a safer environment since the implementation of the program (Nicoll, 1999).

2.9 Interagency Collaboration

Collaboration in human service delivery involves complementary organisations in the same or different sectors committing to a common goal or a set of goals and jointly making decisions as to manner in which these goals are to be achieved. Collaboration incorporates joint decision making and ownership. Ideally all parties would face the same amount of risk from collaboration. The degree of formalisation varies across collaborative arrangements. There are generally four phases of collaboration that are identified in the literature. After the general agreement that the status quo is inadequate, key stakeholders are identified and assembled in most cases by a lead organisation. The first phase of collaboration involves these stakeholders agreeing upon definitions of concepts and outlining their issues of concern. Secondly, stakeholders articulate their values and intentions and in the process formulate a common goal/s to be achieved and through which means. Thirdly, the agreed upon initiatives are implemented. Finally the fourth phase involves the institution of a long term structure that nurtures and sustains the relationships, whilst simultaneously encouraging evaluation (Graham and Barter 1999). Evaluations of collaborative agreements can be at any of these four stages.

Example 1: Inter-Agency Collaboration - Housing, Health and Social Care Services in the UK

The collaborative arrangements between housing, health, and social care was intended to encourage people needing social care needs to reside in ordinary housing. This account is based on an evaluation of three way inter-agency collaboration of housing, health, and social care by Arblaster, et al., (1996). Prior to this initiative, it was extremely rare for a three way link (between three organisations) to be in operation, with the majority of the relationships being two-way.

It was found that formal inter-agency collaboration often occurred at a strategic level, but was not reflected through other levels of the organisation. Links at the service delivery level tended to be based on an ad hoc basis. It was found that collaboration was unable to fill the gaps in services for vulnerable people living in ordinary housing. Poor inter-agency collaboration was also revealed at specific points where users gain access to services. For example housing agencies expressed frustration at getting community care workers to formally assess service users.

This study differentiated external factors affecting collaboration from internal factors. External factors are identified as local and national factors, outside the control of agencies, that influence collaborative efforts.
Some of the recommendations to responding to these internal and external impediments to collaboration include:

- The Central government setting out an interdepartmental policy for the social care and well being of vulnerable people in the community. In so doing, it is hoped that the roles, responsibilities, and boundaries of the different service providers will be clarified;

- Decent housing and a supportive environment, as identified by the World Health Organisation, is suggested should be promoted by health service providers;
- An integrated funding framework, which incorporates health and social care, is recommended be considered.
- Funding should also be flexible allowing change and adaptability when circumstances change,
- Project and service funding to non government voluntary organisations should provide more long-term security.

This would include effective administrative arrangements which encourages inter-agency cooperation with the effective use of resources to meet local needs;

- Agencies at the local should devise joint agreements defining their boundaries; and
- Staffing initiatives, including joint and professional training (providing an understanding of other professions), creation of joint posts dedicated to networking between agencies.

NSW Example 1: The Joint Investigation Program

The aim of this program was to promote the protection of children through a joint DoCS and Police investigation into all allegations of child abuse in cases which might constitute a criminal offence. Two initial Joint Investigation Team (JIT) pilots were located at Bankstown and the Entrance in NSW. There is now a statewide Joint Investigation program which comprises JIT services where DoCS and Police staff are co-located at nine locations in metropolitan Sydney, the Hunter and the Illawarra, and a Joint Investigative Response (JIR), from DoCS and Police where staff are located separately at local DoCS and Police offices and an after hours service available statewide. The Program is jointly funded by DoCS, the Police and NSW Health. The model is based on a teamwork response among participating agencies and comprises the key principles of joint investigation, agreed client focussed outcomes reflecting the needs of both service users and the government agencies involved and an integrated structure and articulated processes for decision making and service delivery. There are formal committees from the local to the statewide levels (Cabinet Office, NSW, 1999).

There are clearly defined roles and responsibilities for agencies and staff at all levels. There are also processes for joint decision making and the delegation of tasks that are backed by tools for identifying suitable referrals to JIT/JIR services and for intake, investigation and assessment, record keeping, supervision, referrals and case closure. A clear joint manual includes information on all of the procedures (Cabinet Office, NSW, 1999).

Despite the integrated processes, the program operates with a dual management structure for both DoCS and the Police. The dual management structure comprises locally based Joint Investigation Coordination Committees, a Statewide Joint Investigation Management and Monitoring Committee, the Joint Investigation Evaluation and Monitoring Steering Committee and the Child Protection Chief Executive Officers. Local committees coordinate the Joint Investigation program's operation at the local level through a regular interagency meeting. The chair is rotated between or delegated from DoCS and the NSW Police. The management and monitoring of the Joint Investigation Program across the state is undertaken through an interdepartmental committee that meets monthly (Cabinet Office, NSW, 1999).

The evaluation of the pilots found that the model employed reduced the emotional trauma for child victims, resulted in a more effective investigations process, generated

improved levels of cooperation between the Police Service and DoCS and produced a better quality of evidence, resulting in increased criminal charges (Cabinet Office, NSW, 1999).

NSW Example 2: Regional Coordination Program

The Regional Coordination Program (RCP) operates statewide in NSW and aims to achieve sustainable social, economic and environmental benefits for regional NSW by facilitating collaboration between government and communities. It also aims to enhance Government services by coordinating service delivery in a way that meets the needs of regional communities and makes the best use of government resources. The RCP is project-based and responds to regional issues that require a coordinated, whole Government approach (Cabinet Office, NSW, 1999).

A Regional Coordinator aims to achieve positive outcomes for the community through collaboration and coordination between agencies. Regional Coordinators are responsible to the Directors of the Regional Strategic Projects. Regional Coordination Management Groups (RCMGs) provide regional strategic management for projects and strategies. RCMGs also provide structure for the dissemination and exchange of information and consultation between regional level agencies and central metropolitan agencies. The RCMG members are responsible for seeking the appropriate level of authority for the participation in initiatives from their agency line management. While State Government agencies form the operational core of the RCP, the participation of Local and Commonwealth Government agencies, non-government organisations and business and other community stakeholders are essential to the effectiveness of RCP issues and project management (Cabinet Office, NSW, 1999).

In 1996 a major evaluation program resulted in the extension of the program to cover all of rural and regional NSW. An evaluation framework for the Program has been developed and is currently being updated. The Program has enhanced the Government's capacity to respond to regional issues in a timely and coordinated manner (Cabinet Office, NSW, 1999).

NSW Example 3: The NSW Strategy to Reduce Violence Against Women

The objective of this strategy was to develop and promote effective preventive strategies/programs; to develop awareness and skills of those in the service delivery system; and to improve access to services to women who are experiencing violence across NSW. The strategy was centrally driven but regionally based. The strategy draws on Action Plans of locally-based initiatives that operate in each region. Issues are managed at the local level by a Regional Reference Group. Initiatives draw on existing services such as crisis support, information and referral, accommodation, health counselling and sexual assault services to create a service system. An ongoing Regional Specialist is employed by the Attorney Generals Department. The Regional Specialist links government and non-government service providers, implements community education campaigns with government and non-government agencies and develops local prevention programs (Cabinet Office, NSW, 1999).

The strategy's development and implementation plan for agency involvement is formulated and driven by the Premier's Department. Other agencies involve include: the Department for Women, Attorney General's Department, Department of Health, and Community Services and NSW Police. Funding from existing resources is drawn from the four agencies and is pooled and provided to the Attorney General's Department for administration. A community development approach was adopted under the strategy and includes a broad range of funded and non-funded non-government organisations (Cabinet Office, NSW, 1999).

The evaluation of the strategy is not complete, however it was felt that the memorandum of understanding in cross-agency responsibilities played a critical role in the operation of the strategy and in agencies meeting their responsibilities. The State Management Group has operated well dealing with cross-agency issues. This process was assisted by high level of support from the Attorney General's Department (Cabinet Office, NSW, 1999).

2.10 Merging of Departments

The Merging of Government Departments is a classic example top down integration. Here administrative, organisational and management initiatives are introduced to integrate complementary service delivery programs at a high level of policy development. Integration at this level is seen as the first and necessary step towards integrating service delivery downstream. The aim of these approaches is to minimise infrastructure costs that are associated with the numerous outlets that provide multiple services. This case study will draw from the United Kingdom's, South Australia's, Victoria's policy directives on integration.

Example 1: The United Kingdom – Modernising Government

'Joining up' of the UK's public sector to make it more responsive to the needs of citizens is a key element of the Blair Government's 'modernising government' program that has been operating since 1997. Three of the general aims of modernising government project are: making policy more 'joined up and strategic'; making sure that service users, rather than providers are the focus by tailoring services to more closely meet the needs of people; and delivering services that are of high quality in an efficient manner.

One of the first initiatives of the modernising government reforms was listening to people through a 'peoples panel', that comprised of 5,000 representative individuals who were asked what they thought of the UK's public service. Following six practical standards were set in 1997, focusing on responding more efficiently and effectively to the needs of customers.

Some of the concrete examples of 'joining up' service programs include:

National, citizen-focused programs: These are services that will be available to the whole country that are centrally managed by government departments or agencies. Examples of these types of programs include the NHS Direct and Employment Service Direct.;

Group focused programs: National or area based initiatives that target a particular cross section of the population. Examples of these include the Better Government for Older People Pilots, the New Deal for the Young Unemployed and the Service Families Task Force;

Area based programs: These are similar to place management programs that target areas where there is evidence of multiple deprivation. Some of these area based programs have large area boundaries such as Health Action Zones and the Local Government Association's (LGA's) New Commitment to Regeneration. Examples of more locally based programs include the Employment Zones, Education Action Zones, the new Deal for Communities and People in Communities.

The preferred way of delivering services in 'joined up' system is through one-stop shops. These can be places people visit to get advice and information about the different services that they have access to. Examples of these include the Public Record Office's Family Record Centre and the Lewisham and Camden one-stop shops

for benefits. One-stop shops can also be ‘virtual’, available through the telephone or Internet like the MODs Veterans Advice Unit.

These programs tend to be budgeted for through the pooling funds from the different departments. The Government’s ‘Invest to Save Budget’ initiative will support integration through an outlay of 230 million dollars over the next three years to fund projects that involve two or more organisations jointly delivering services.

Example 2: South Australia – Department of Human Services

The South Australian Department of Human Services was established in October 1997. The new portfolio is an amalgamation of the SA Health Commission, the Department of Family and Community Services, Department of Housing and Urban Development (housing activities), the SA Housing Trust, the SA Community Housing Authority, Homestart Finance and the Institute of Medical and Veterinary Science. In its new form, the Department is responsible for policy administration and for the operations of public health, hospitals, family and community services, disability services, aging, and housing. Its combined budget is estimated at 40 per cent of State’s annual expenditure employing close to 22, 000 people.

The rationale for this approach is the South Australian Government’s belief that the amalgamation of complementary services will provide an opportunity for greater integration at the service delivery level and a reduction in infrastructure costs.

It is important to keep in mind that the South Australian Department of Human Services approach to integration is restricted to central office responsibilities, including organisational and funding roles. As a result, there is no integration per se, in direct service delivery. It is hoped that amalgamation at the central office level will ultimately lead to integrated service delivery. Some of the aims of this new management structure that have been documented in the *Bulletin – Department of Human Services* by the Chief Executive’s Officer (1998) include:

- A clearer relationship between the service provider function and policy, planning, purchasing and program management;
- Forging closer ties between planning and policy development, coordination and funding of services and service delivery in order to achieve greater integration in the delivery of services;
- The importance of central office planning processes to complement regional and local area planning;
- Clearly specifying which of the service providers will liase with whom within the Department;
- A structure that specifies outcomes and outputs, although provides the necessary flexibility in achieving these; and
- A Senior Executive who emphasises service culture and who creates a management framework for the new Department that allows for greater integration of human services within the community. The structure has a regional and statewide focus at a very senior level.

It is important to keep in mind that the South Australian Department of Human Services approach to integration is restricted to central office responsibilities, including organisational and funding roles. As a result, there is no integration per se, in direct service delivery. It is hoped that amalgamation at the central office level will ultimately lead to integrated service delivery.

Since the establishment of the Department of Human Services in 1997, the Country Division has been engaging service providers from within the department in country areas what is referred to as 'an integrated service planning design process'. Its aim is to develop a blueprint for integrated services that cut across health, housing and family, and youth services. Integral to this scheme is the identification of key stakeholders and partners in service planning and service delivery in State and Local Government and non-government sectors (Withman, 1998).

On a practical level, the Integrated Area Planning approach involves Senior Managers at regional or area level working together with the community and other key service providers to identify and plan around service provision. The publication of a plan, that outlines goals, strategies and methods of evaluation is the most tangible output that has been generated. This process of planning was trialed in the Eyre region, the Far North and Far West region incorporating the regional centres of Whyalla, Port Augusta, Port Lincoln, Ceduna and Cooper Peddy. It is noted that those who were involved in the planning process were particularly mindful of improving the services to Aboriginal people and generally viewing service users as 'clients' (Withman, 1998).

Example 3: Victoria – The Department of Human Services

The Victorian Department of Human Services is also an amalgamation of separate government departments and a good example of top down integration. The Victorian Department of Human Services was formed in April 1996 incorporating the former Department of Health and Community Services, the Office of Housing, and the Office of Youth Affairs (Victorian Department of Human Services, 1999).

The ministerial portfolios that come under the banner of the Department of Human Services include: Health Care, Aged Care, Youth and Community Services, Housing, and Aboriginal Affairs. The Department purchases and provides services to its constituents within these areas. The Department is composed of seven divisions, including, the Acute Health Division, the Aged, Community and Mental Health Division, the Public Health Division, the Disability Services Division, the Youth and Family Services Division, the Housing Division, and the Aboriginal Affairs Australia. The six aims of the Department of Human Services, outlined in the 1998-99 Departmental Plan are to:

- Improve services for the most vulnerable sectors of the client population;
- Improve and maintain high quality services and facilities for clients;
- Strengthen population wide interventions and outcome measurement to underpin sectoral strategies;
- Strengthen service integration to better tailor services to clients needs;
- Achieve a more adequate mix and equitable distribution of human services; and
- Drive further performance improvement in purchased and directly delivered services.

The rest of the Victorian case focuses on the Aged, Community and Mental Health Division, (ACMHD) one of the seven Divisions of the Department of Human Services outlined above.

The ACMHD recently published a detailed set of policy guidelines to strengthen and better focus the Primary Health and Community Support (PHACS) system in Victoria. The policy directives are documented in *A Stronger Primary Health and Community Support System: Policy Directions (1998)* with an earlier discussion being published in

Towards a Stronger Primary Health and Community Support System – A Discussion Paper (1998). These policy initiatives aim to improve 'linkage' and 'functional integration' through making the service system responsive to the changing needs of the Victorian population and to ensure that Victorians receive an 'optimal' mix of care. The reforms contained in this policy directive will be trialed over the next three years through demonstration projects. The reforms intend to respect organisational and clinical autonomy of providers to ensure that funding to specialist services are not compromised. The four major aims of the ACMHD include to:

- Improve access, quality, and responsiveness of services to consumers, their carers, families, and referring providers;
- Increase service providers capacity to implement the social model of health;
- Make services more cohesive through a range of system integration mechanisms in order to improve the capacity of the system to coordinate and improve the continuity of care and support; and
- Create service coordination links between primary health, community support, and the broader health-care and support system (ACAMH, 1998c:iii).

The present move towards a more coordinated and integrated approach to delivering PHACS is seen as a part of the natural evolution of the sector. Historically, there have been a large number of narrowly focused providers operating independently with a complete lack of overreaching agencies performing a cross-agency/ coordinated roles to enhance service delivery (ACMHD, 1998a).

Central to the policy initiatives instigated by the ACMHD is the establishment of 'local service systems' in various catchment areas. Local service systems will integrate social health with the broader care and support systems, enabling service users ready access to an array of services quickly and easily. Practically this will involve a 24 hour telephone information service.

The policy documents recognises that success in this form of service delivery crucially hinges on the relationship between the Department of Human Services and the Private Sector, the Commonwealth, State, and Local Governments. The Department of Human Services is committed to working collaboratively with the different tiers of government, the private sector and the non-government voluntary organisations. Private for profit providers will be encouraged to provide services that are purchased by the ACMHD. These include services provided by private doctors, pharmacists working and the various private nursing homes. The Department perceives its central office role as developing policy and managing the selection process for demonstration projects, whilst the Department's regional offices will be responsible for implementing policy and demonstration projects. The Commonwealth Government is supportive of the PHACS initiatives 'in principle' and will work in tandem with the Victorian Government. The 78 local governments in Victoria are established to play an important role, alongside the Department's regional offices to improve its planning, funding purchasing functions for example in Home and Community Care (HACC), maternal and child health services (ACMHD, 1998a, ACMHD, 1998b, ACMHD, 1998c).

3 Conclusion. Learning from Experience

3.1 Introduction

A total of ten different case studies of current initiatives involving improvements in the integration of human services were identified and summarised: Service Hubs; Multi-Purpose Services; School Linked Services; 'One stop shops' for information and referral; Interagency Case Management Approaches; Social Partnerships; Formal Networks; Community Level Integration; Collaboration Approaches; and The Merging of Government Departments. The considerable overlap between different models is evidenced by the varying elements present in each of the twelve NSW Initiatives which were also considered. The models should not be understood as necessarily alternatives to each other, nor do they provide an exhaustive coverage of all possible approaches. The examples identified in the case studies should be regarded are just some of the more prominent examples of the search for improvements in the coordination and integration of service delivery. As a result, these examples serve to illustrate the sorts of initiatives that are currently 'leading edge' practice in other comparable jurisdictions today.

Integration is often seen as a way to increase efficiency and hence to save money. But efforts to improve the integration of services need to be understood as having a cost The financial and human costs associated with integration should be taken into account when deciding on a whether to pursue a particular integration approach. The important fact to focus on is that the cost-benefit ratio of integration is not fixed, but will vary with the type and number of clients and the complexity of their needs, the extent and character of integration, and other factors that will enter into the planning decision.

3.2 Lessons from the Case Studies

A number of lessons for policy makers and service providers in NSW can be drawn from the approaches outlined in Section 2. Thirteen of the most important of these are listed below. These deal first with a number of specific models and types of activity, gradually moving towards more general principles that might inform the development of government policy and administration in the human services field.

i. The Advantages of Co-location

As the Service-Hub model demonstrates, co-locating existing services provides a simple mechanism for increasing customer convenience and reducing access costs. Most local communities in NSW already have a basic set of community services. In only a few instances, however, has accommodation arrangements been such that co-location of like service agencies has been a central feature of their operation. With the exception of recent initiatives such as the Claymore Integration Project, Schools as Community Centres Program and Community Service Centres in Broken Hill, Tamworth and Orange, most non-government agencies in NSW are currently responsible for their own accommodation. In consequence, the agencies are spread on a fairly ad hoc basis across wide areas. The importance of providing appropriate accommodation, adequate resourcing for the co-location of services appears to have been a successful strategy emphasised in the Government Access Program, the Claymore Integration Project, as well as in the Joint Investigation Program, where it has assisted with bridging cultural differences between agencies.

ii. Building on the MPS success - Advantages of Combining Services.

The MPS model, as developed in Australia, is currently concerned only with health and extended care services in small and remote communities in which larger, more specialised facilities are not economically viable. The approach appears to be viable for other settings and for other client groups. A similar development in the United States, the Multi-service Centre for Chinese American Immigrants discussed in a recent article by Julian Chow (1999), demonstrates that the general approach is flexible and capable of considerable adaptation to a range of different circumstances.

The demonstrated success of the approach to date, also points to opportunities to establish similar initiatives in other fields of human service - for example in child welfare and in services for the mentally ill and homeless. MPS-like initiatives to these sorts of specialised client groups could be trialed both in isolated areas, and in regional and metropolitan areas, where they would provide opportunities for decentralisation of existing provision, and for improving conditions of access and regional equity whilst maintaining financial viability of service provisions and facilities.

iii. Linking services through assessment and client assignment processes

There would also appear to be considerable scope for improving the match between clients and services and promoting functional links between services by close attention to the processes of client assessment, (which should include provisions for continual or ongoing reassessments) and by improving the referral processes between agencies, as outlined in the case study of service hubs. Some NSW examples of this sort of initiatives were taken in the recent Demonstration Projects in Integrated Community Care (Fine, Thomson and Graham, 1998). The Community Care Assessment Framework, including the introduction of the CIARR form, builds on this by providing elements of a common data collection and referral system. To date, relatively little use has been made of Information Technology (IT) outside of the health system. While not dependent on computerisation, this form of linkage has the capacity to build on the potential of modern IT to improve service productivity, harnessing the electronic sharing of records and the speed of information transfer to link geographically dispersed agencies and to free staff time from tedious manual duplication of client records and the taking of client histories.

iv. Schools as a Venue for Delivering Human Services

For the NSW Government there are undoubtedly complications to arise from education remaining largely outside traditional early intervention measures. Schools are a useful venue from which human services to children and youth can be delivered. Targeting problem areas provides one useful approach, but more the approach to be adopted by Families First, focussing on at risk individuals, would appear to be the most efficient way of managing resources.

Crucial to the operation of a school linked services is a ‘feed back loop’, such as that referred to in the New Beginnings example. In a feed back loop information is continually changing hands between teachers and social workers administering the service. There are also a number of other lessons that can be learnt from the approach. One of the founders of the New Beginning project, Payzant (1994, cited in Cullen 1997) reflected that collaborative initiatives like these need the institutional support of all levels of government. This institutional support has to be expressed through policy, procedures and commitment of resources at all levels. It was also highlighted that integration did not simply involve better coordination. Even though at the beginning there are advantages to having a smaller number of agencies working together.

Through time a concerted effort has to be made to develop an integrated system. This is necessary, he argues, to prevent integration from simply being an 'add on' to the list of duties already undertaken by teaching staff or the changes being simply of symbolic value. The importance of those who were involved at the initial stages of the program bringing on board new partners to ensure the long term viability of the project was also stressed.

v. The Value of Community Consultation

The evaluation of the NSW Schools as Community Centres Program also highlighted the importance of community consultation prior to the decision to locate a community centre in an area and of building trust with the community by creating opportunities for families to participate in community projects and events that are non-threatening. Also generic program indicators are required rather than departmental specific indicators. In addition ongoing monitoring and evaluation of the program of the local indicators in also necessary. Other factors that contributed to the success of the program included: a local approach so that the community centres are tailored to meet the needs of the community, the appointment of a facilitator with appropriate skills and abilities; commitment at a senior level, support for the school principal and the school community and appropriate accommodation and resourcing for the community centre.

A number of other NSW Initiatives including Woolloomooloo Crime Prevention and Safety Initiative, The NSW Strategy to Reduce Violence Against Women and the Regional Coordination Program also stressed the importance of community consultation in order gain accurate information from which to formulate programs that meet the needs of local communities. In the Community Participation and Development Project the process of community consultation motivated people to work together and promoted the ownership of the program by the local people.

vi. Integration Initiatives Need Time to Develop

An important lesson from a number of the case studies is that integration initiatives need time to develop and mature. Longer term funding of the project is necessary to allow sufficient time for development of collaborative processes, establishment of processes and protocols, as well as to monitor progress. The importance of allowing sufficient time for planning and training to develop the skills necessary for participating agencies to engage in joint activities was also emphasised in the Joint Investigation Program. The Woolloomooloo Crime Prevention and Safety Initiative also highlighted the need allow enough time for interventions to be developed and owned by the services. Time is also important to allow for some reflection and to conduct ongoing evaluation of the process to inform future policy directions.

vii. Preference for Personal Delivery of Services

The Government Access Program in NSW showed that there was a strong preference among rural communities and elderly people for personal delivery of services. This program has shown that it is important to secure a range of services before establishing a Government Access Centre (GAC) and locations should be determined according to the level of existing services, distance and isolation from services, relative disadvantage and financial viability of the Centre. It is also evident that in the short term setting up appropriate systems will initially mean additional costs for service agencies to provide their services through GACs. The question is whether there is cheaper alternative to providing the same level of service – without compromising service expediency and the family friendly environment. Should one stop shops be centres for integrated service delivery, or is it sufficient to be yet another information

and referral point which clients must pass through on their quest to finding someone who can actually assist them deal with the problems they are experiencing?

viii. Drawing Appropriately on Case Management

Service providers have been drawn to Case Management for a number of reasons. These include the fact that in the absence of systemic change, it enables them to better meet the needs of their clients. On a more general level, the popularity of Case Management has been attributed to the quest for a more efficient method of service delivery and as a means of improving resource allocation to clients with complex needs. However, difficulties arise in using case management approaches too extensively, due to the high transaction costs incurred. These are estimated at 20-30 per cent of service costs in established programs involving specialised case managers (Fine and Thomson, 1995). Further, the approach appears to be 'time limited' as personnel engaged by social service agencies are seldom appointed for long periods, say 20 years, that may be necessary to integrate services for foster children. It is important to bear these limitations in mind when designing further interventions based on the principles and approach of Case Management. For these reasons it is important to warn against uncritical adoption of Case Management as a sort of universal panacea for problems of fragmented service provision. Nonetheless, Case Management does present a useful and flexible approach that can be of value to service providers and policy makers in NSW for carefully selected individual cases in which the complexity of problems or service provision over a short or medium time frame is likely to be an issue. Its greatest contribution would appear to be as one option in the development of more integrated patterns of service delivery in particular types of innovative services, such as that outlined above for 'vulnerable children' presenting in medical or educational settings, that can be used not instead of other approaches, but as an adjunct to them for use with individual clients.

ix. Locally Based Social Partnerships

The success of the Premier's Forum and The Regional Coordination Program, both of which contain elements of the Social Partnership approach, in enabling a large number of agency to collaborate and initiate community driven projects within short timeframes highlights the potential of locally based Social Partnerships for further development in rural NSW and regional urban areas.

The Social Partnership Approach, as developed in Ireland, is similar in certain respects to community development approaches to the fostering of decentralised human services in local communities with which NSW has much experience. There are a number of reasons why the approach is deserving of further application and development in the NSW context. First, the approach is decentralised at the point of service delivery and in important details of planning, but that also maintains many of the strengths and advantages of centralised, state wide, administration of funding and expertise. Second, there are attractive elements of social justice and renewal in the approach which could well serve as political pluses in regional areas and in many suburban localities. By drawing together at the local level a potentially powerful coalition of informed and committed local community members with representatives of existing state government and perhaps non-government service providing organisations. Third, the social partnership approach builds on the sorts of experience that Australians have already endorsed and found attractive. By promoting a serious, business-like approach at the local level, with ongoing funding dependent on the quality of plans, the implementation process and the results of reviews, the approach is likely to be readily understood and to have considerable credibility. Because it draws

existing providers and local community figures into a collaborative process, many of the negative and divisive side-effects of alternative approaches, such as competitive tendering, can be avoided. At the same time, there appear to be a number of elements promoting economic efficiencies in the way support is provided at the local level.

x. The Importance of Commitment and Support from Senior Levels of Government

A key question for New South Wales in fostering improved linkages between services is how might support and encouragement be best provided to non-government service providers to develop formal networks, without the government being seen as too interfering, managerial, directive or threatening?

The success of service networks seems to depend on supporting coordination in the field (the meso or local level of provision) with parallel coordination within government and planning bodies, (the macro level). There appears little to be gained from each separate department going out and commencing its own integration initiative. In the Schools as Community Centres Program, the Government Access Program and the NSW Wales Strategy to Reduce Violence Against Women a high level of central support and coordination were key elements in the success of the programs. Building on these successes requires high level inter-departmental linkages of equal vision.

xi. Clear Objectives and Achievable Goals

Several of the case studies presented earlier pointed to the problems that arise when policy objectives are vague or there are too many goals to be reached in a short time. 'By enumerating so many goals and expanding the arenas to be influenced through collaborative actions, it would appear an already difficult and highly complex effort is made even more complex and challenging'. (Harbert. et. al 1997:101) Evidence from research undertaken by the Annie E. Casey Foundation was presented, revealing that having even three goals to be achieved through collaboration is extremely difficult, complex, time consuming, and fraught with many obstacles. The importance of strong vision with clear objectives and achievable goals was also clearly demonstrated in a number of the NSW initiatives, such as the Premier's Forum, the Regional Coordination Program and the Kings Cross Place Management Project.

xii. Building Trust and Promoting Communication Between Agencies

Fundamental to the current thinking about successful integration initiatives is the importance of developing trust between collaborating agencies. On the positive side, this has been well demonstrated in recent projects New South Wales, where the Schools as Community Centres Program, the Government Access Program and The Claymore Integration Project showed that it was necessary to build and sustain trust within the community and between agencies before any types of coordination or integration could be implemented.

On the other hand, the three way collaborative relationship in the UK (see section 2.9) reveals the conflict that can be created by competing government policies. On the one hand collaboration was encouraged amongst Housing, Health and Social Care Services, whilst on the other hand compulsory competitive tendering and contracting was promoted. The short-term nature of competitively tendered contracts, increased the uncertainty to non government organisations, that would otherwise be interested in collaboration. Administrative complexities were also created by these conflicting policies. It was evident in the Government Access Program that the problems associated with securing service agency support and the incompatibility of individual agencies were alleviated by consistent administration and operational processes.

The need to overcome problems associated with the lack of mutual trust and agreements between organisations was also commented upon in a number of the other accounts analysed for this report. Gray (1989), for example, argues that there is a risk involved with entering collaborative relationships because the process is unfamiliar and outcomes uncertain and threatening to the autonomy and accountability of the participating organisations. The degree of risk faced by each agency is said to increase when competitive models (such as competitive tendering) set one agency against another, and as the aggregate number of agencies in the service network or integration rises. As the number of organisations involved increases, the greater the complexity of the linkage system and the amount of time that needs to be invested in maintaining these linkages.

xiii. The Importance of Funding and Administrative Arrangements

The importance of developing administrative arrangements to support the integrative initiatives between services at the local cannot be overestimated. Administrative arrangements effectively make or break the integrated approach and hence much thought has to be given to how best to administer the approach, with each case likely to be different. For instance in some instances creating a 'coordinator' position in a local area who liases with the different service providing agencies – who's position is jointly funded by the relevant government departments – may suffice. A number of the NSW Initiatives, including the Regional Coordination Program, the Claymore Integration Project and the NSW Strategy to Reduce Violence against Women stressed the pivotal role of a coordinator in bringing agencies together and acting as a catalyst for change. A dedicated coordinator has the ability to focus on the project and achieving the objectives and outcomes.

In other instances it may be necessary to involve senior staff in the different departments/divisions to formulate a protocol, that frontline staff can follow. Service or memorandums of agreements were a feature in some of the NSW Initiative including Community Participation and Development Project, The NSW Strategy to Reduce Violence Against Women and the Joint Investigation Program and have the potential to ensure that agencies meet their responsibilities. Funding arrangements is the other important area, which may be contentious, especially when the Commonwealth government is involved.

3.3 Future Directions

As discussed earlier in the report, moves towards improving the integration of human services in New South Wales may be introduced at any of three levels: the macro level of legislation, planning, funding and administration; the meso level involving working relations between service providing organisations; and the micro-level, at the point of service delivery to the consumer. Whether a particular approach or level of integration is required, or a combination of both, depends very much on specific circumstances.

It is unlikely that any of the approaches outlined can provide all the answers and options for the State government. The most advisable approach would be not to attempt to copy all the details of any of the particular models outlined, but to draw elements from a number of different approaches to develop solutions which are tailor made to the actual problems and difficulties being tackled.

A preliminary review process

Before actions are undertaken, a review of the major issues and options for action needs to be undertaken. An approach commonly used for this is through the creation of a Planning or Steering Group/Committee, composed of senior staff from the

different divisions. This appears to be favoured for evaluating administrative arrangements and financing arrangements as these individuals are likely to have a detailed knowledge of the existing system. Having an individual well versed in integration can enhance the output generated by these Committees. Apart from considering the administrative and financing arrangements, the Committee should aim to codify objectives through consulting stakeholders including users, prospective users and their families. The committee should also consider how the integration of services could be enhanced by emphasising on local or regional administrative arrangements, involving the use of existing or new forms of local authority. A time frame for implementing any processes of integration considered could also be decided and the lead agency that would steer the process be nominated. Thought would also need to be given as to how information technology, particularly databases and administrative records, could be best utilised and consider any privacy issues that may arise. The criteria on which performance is to evaluated should also be decided by the Steering Committee.

Sharing ideas and developing a common vision.
A subsequent step, but one that could be carried out with some overlap with the first stage, is to help develop a consensus amongst those most likely to be affected about the possible gains from integration initiatives, and about the sorts of moves that this might take. Interested parties for whom participation should be considered include government officials, all relevant service providers (including service level staff), and consumers - both the recipients of service and relevant others, such as family carers, consumer representatives, and community representatives.

Involving service providers, consumers and others likely to be immediately involved in any integration initiatives appears to be a widespread practice in those projects which were most successful in achieving their aims. This is because the ultimate success of any venture of this kind depends very much on the commitment and good will of those directly affected. If integration is to depend on the imposition of rigid rules or strict financial control measures, the transaction costs are likely to be high in relation to any benefits obtained. Those who need to be involved at some stage include both management and service staff of organisations, and, where appropriate their representative organisations such as trade unions and service associations.

Clearly, care is needed in developing consultative processes which are sufficiently inclusive to be successful, without being unwieldy, chaotic, open-ended or too expensive. Mechanisms such as conferences and seminars provide useful and well recognised means of establishing open forums for debate of ideas. Other processes, such as working parties and committees can be established as a second stage to work up specific proposals. Publications, especially in magazine format, as was used with the *Community Solutions* publication in the recent NSW Demonstration Projects in Integrated Community Care, also provide an effective way of disseminating information and ideas of interest to service managers and personnel.

Using a pilot or demonstration projects approach
Because the area of service integration is such an uncertain one at present, the experimental and demonstration project approaches to developing and implementing any potential system-wide innovations are particularly suitable. In turn, introducing reforms which have not been tested remains, at best, a risky enterprise. This does not mean that there is no need for ongoing improvements in the integration of service provisions. Opportunities for innovation should be encouraged, and assistance provided in linking service managers and administrators with experts and advisers who have the skills and experience to assist them where necessary.

Appendix A: Methodology

A total of 147 separate articles were identified and collected during the search process. These varied considerably in quality. The majority of the source material was from academic journals. This is indicative of the difficulty we experienced in acquiring primary evaluation reports or other primary documentation. Other source material included chapters from books, policy documents, conference papers, evaluation reports, government reports, Internet sites.

Over one quarter of the material compiled was used in this report and is listed in the Consolidated Reference List. It is important to note that the review undertaken was not intended to provide a comprehensive or encyclopedic coverage of the models of coordination and integration that are currently operating in Australia, the United Kingdom, and the United States. However, in the short time available, it was possible to obtained sufficient material to review and illustrate the nature and type of integrative programs currently being undertaken by government and service providers in a number of comparable countries.

In the inventory assembled, community level integration was by far the most popular model reported in the literature, accounting for over 20 per cent of all the material collected. The popularity for this approach is possibly as much a reflection of liberal democratic governments in the US and UK encouraging decentralised local initiatives and funding from private donors as it is a reaction to the fragmenting tendencies of competitive tendering which received so much emphasis only a few years before. This is also a less involved approach to integration – not requiring a significant reorganisation from government in restructuring existing administrative, organisational and funding arrangements.

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