

Coordinating health care for people with serious mental illness

Michael 2025; 22: 54–59.

doi: 10.56175/Michael.12584

Healthcare systems often struggle to meet the care and treatment needs of individuals with serious mental illness. My Harkness project investigated how services are coordinated for people with serious mental illness, the factors influencing coordination, and the role of peer support in facilitating integrated health care. The project is structured in three parts:

First, it outlines the key challenges in coordinating transitions from hospital to home.

Second, it describes how medical, mental health, and social services are coordinated in two northeast states in the United States and identifies ongoing coordination challenges. This is followed by an exploration of care coordination practices in Norwegian healthcare services.

Third, it examines the role of peer support in care coordination for individuals with serious mental illness with examples of digital peer support initiatives both in the United States and Norway.

Serious mental illness (SMI) encompasses conditions such as schizophrenia, schizoaffective disorder, psychotic disorders, major depressive disorders, and bipolar disorder (1). Many individuals with serious mental illness also experience chronic medical health conditions, requiring coordinated cross-sectoral care. These co-occurring chronic health conditions are associated with a shorter life expectancy of approximately 10–20 years compared to the general population (2). Coordinated mental and medical healthcare is a critical policy priority.

Care coordination is a person-centered approach that ensures individuals' multiple and evolving health needs are met through appropriate care delivered by the right professionals at the right time (3). Integration involves coordinating healthcare across various professionals, multidisciplinary teams,

services, and support systems. Integrating mental health into primary care and co-locating services aims to improve coordination and outcomes for individuals with SMI. My Harkness project aimed to investigate how services are coordinated for people with SMI and chronic medical conditions. It also aimed at identifying influencing factors and assessing the role of peer support in coordinating health care.

First, we carried out a scoping review of the research literature (4) to provide an overview of the key challenges in coordinating transitions from hospital to home and to identify approaches that can improve coordination and the ability of people with SMI to manage their lives in the community. Second, we investigated how medical, mental, and social services for people with SMI were coordinated by service providers in two Northern New England states (5). Third, we explored the potential of peer support to improve the coordination of physical and mental health services for people with SMI (6).

The scoping review (4) included a broad systematic literature search, screening 2413 titles, reading 285 abstracts and 55 research articles in full text, and including 16 articles in the final review. The interview studies (6,7) were conducted with service providers and peers in healthcare organizations (e.g., community mental health centers, welfare service offices, and primary care). Data sources included 35 interviews with administrative leaders and healthcare professionals (psychiatrists, psychologists, social workers, nurses) in the selected organizations and five interviews with peer support workers.

Findings

The scoping review (4) identified two primary challenges in coordinating hospital-to-home transitions for individuals with SMI. First, personal challenges influencing the individual's community adjustment and ability to manage life at home due to symptoms, worries, and lack of daily activities. Second, systematic challenges influencing continuity of care, difficulties with accessing and receiving consistent mental health treatment and medications post-discharge. The approaches to improving care coordination were multifaceted programs or interventions that commonly addressed knowledge about illness and resources, decision-making involvement, and family and peer support. Several interventions targeted many of the identified challenges to care coordination.

In the interview study with service providers (5), we described coordination and related challenges at three levels: (1) Provider-level coordination, describing how service providers bridge services and manage inter-professional communications, and their contrasting perspectives on

the locus of responsibility for coordination for people with SMI and medical comorbidities. (2) Individual-level coordination describes how service providers support the person's self-management and assist with care navigation, emphasizing trusting and continuous relationships. Providers describe how the right to individual choice and autonomy can hamper information sharing and challenges due to patients being unaware of physical problems, not seeking adequate physical care, and avoiding recommended treatment. (3) System-level coordination describes how providers link service users with appropriate residential and care provision services. However, there are significant difficulties with ensuring adequate service funding, access to psychiatric inpatient care, housing for service users, and recruiting and retaining staff. Primary care team huddles and shared medical record systems were examples of care integration and coordination solutions attempted across the two states.

Our paper on peer support in coordinating health services for individuals with SMI (6) demonstrates that peer support workers have the capacity for physical and mental health coordination. They use their experiences to help service users prepare for upcoming health visits and connect them with community services. Peers are also aware that their role is non-clinical as their relationship with the service users is based on mutuality. However, challenges remain in funding peer support services, and peers experience often struggle with managing boundaries as well as their own health issues.

Impact

Upon returning to Norway, I continued my research on coordinating mental health services for people with SMI to explore how it was evolving in the Norwegian context and to assess potential challenges. Norway has made notable progress in integrating mental and medical healthcare for people with SMI. A key goal is to ensure that inpatient capacity in mental health care meets the needs of individuals requiring inpatient treatment (7). There is also a strong emphasis on improving the quality of life and life expectancy for these patients. The government has funded multidisciplinary teams, such as Flexible or Assertive Community treatment teams, to ensure continuous service and early intervention for people at home. A patient pathway for mental health has been introduced to ensure timely follow-up of mental, medical, and social needs, guidelines for treatment, and agreements between specialist and municipal services on hospital-to-home transitions (7).

We interviewed 27 municipal healthcare professionals (medical doctors, nurses, social workers, and social educators) in one rural and one urban

municipality in western Norway to gather their perspectives on care coordination for individuals with SMI (8). The interviewees emphasized that ensuring a stable and meaningful home life is crucial for recovery and maintaining good health. Care coordination involves ensuring proper housing, supporting daily activities, and timely health care access. Coordinating preventive measures to support the person at home, including symptom monitoring, emergency psychiatric care plans, general practitioner involvement, and medication adjustments, is crucial.

Individuals with SMI often visit the emergency room during acute episodes, especially at night or on weekends. Coordinating care in these situations is particularly challenging due to the complex health needs and difficulties accessing medical records. Inpatient care is limited to stabilizing acute and severe symptoms. The interviewees described hospital discharge coordination as challenging particularly concerning information exchange and disagreement over who is responsible for assessing and responding to the person's physical health needs. Although patient pathways are in place to enhance system-level care coordination by clarifying responsibilities and improving cooperation between the primary and specialist health services for individuals with SMI, little change was perceived for this population post-implementation.

Reflections on career impact

There has been a growing focus in Norway on peer support in mental health, including formalized training and employment of peer support workers in mental health services. During my Harkness fellowship, I was involved in a pilot study carried out by Karen Fortuna on digital peer support. This study involved a peer-delivered self-management intervention for people with SMI using a mobile application (app), PeerTECH, to support recovery and illness management and resulted in three published papers (9–11). Analysis of text-message exchange in the PeerTECH app along with interviews with peers and service users highlighted the value of human support from peers in delivering the intervention and illustrated how the peers integrate peer support through personalized text messages and sharing their lived experiences. They also identified and helped address the person's unmet health needs (10,11).

Peer support is a form of social support relying on the peer's own experience of having a mental illness and having progressed in recovery to be able to manage his/her illness and live a fulfilling life in the community (9). It is an alternative to conventional treatment and care supporting self-determination, personal empowerment, and choice. The development of

peer support services for people with SMI in the United States can be viewed as a response to inadequate access to affordable and effective community-based mental health services (9).

Upon returning to Norway, I received a seed grant from HelseCampus, a research cluster funded by the University of Stavanger, Stavanger University Hospital, and Stavanger municipality, to continue research on digital peer support and to assess the usability of PeerTECH in Norway. Together with service users, peer support workers, and service providers in municipal mental health services, we have co-created and culturally adapted PeerTECH into a Norwegian DigiPer app (DigitalLikeperson app). We are preparing a pilot study with DigiPer with Norwegian service users and peer support workers to assess its feasibility and preliminary effectiveness.

Reflections on future research

In 2024, we received funding from the Norwegian Research Council for a project to implement and evaluate an interprofessional Health Needs Assessment for older adults living at home in two Norwegian municipalities. This project aims to systematically identify unmet health and care needs, support independent living, and enhance quality of life. It addresses early detection of health needs through interprofessional and coordinated preventive approaches.

The project involves co-designing interprofessional health needs assessment with stakeholders, training healthcare professionals, and conducting a randomized controlled trial (RCT) to evaluate its effectiveness. Outcomes measured will include quality of life, survival, health service use, and cost-effectiveness. It will explore how interprofessional health needs assessment influences interprofessional collaboration, care coordination, decision-making, and implementation at various levels. Ultimately, the project aims to reduce service delivery inequalities, support healthy aging, and promote a consistent and fair allocation of health services for older adults.

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