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ORIGINAL RESEARCH

Perspectives on Coordinating Health Services for Individuals with Serious Mental Illness – A Qualitative Study

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Purpose: Individuals with serious mental illness (SMI) might require coordinated health services to meet their healthcare needs. The overall aim of this study was to describe the perspectives of professionals (registered nurses, medical doctors, social educators, and social workers) on care coordination and measures to ensure proper and coordinated follow-up of the healthcare needs of individuals with SMI. More specifically, we investigated which measures are taken by employees in municipal health and care services to prevent the deterioration of health conditions and which measures are taken in cases where deterioration occurs despite preventive efforts.

Method: The study comprised individual qualitative interviews with professionals employed in municipal health and care services in two Norwegian municipalities. The interview material was analyzed using systematic text condensation.

Results: Three categories and seven subcategories were created in the data analysis: 1) Maintain a stable and meaningful home life, including *ensuring proper housing* and *access to services and assistance in receiving healthcare*; 2) Measures to prevent deterioration of the health condition, including *close monitoring of symptoms*, *emergency psychiatric care plans* and *emergency room calls and visits*; and 3) Inpatient care to stabilize acute and severe symptoms, including *municipal inpatient care*, *returning home after inpatient care* and *a need for shared responsibility for treatment and care*.

Conclusion: Professionals employed in municipal health and care services coordinate health services to ensure proper and coordinated follow-up of the healthcare needs of individuals with SMI by ensuring housing services and access to the required healthcare. Measures taken when deterioration occurs include monitoring symptoms, use of emergency psychiatric care plans, emergency room contacts, or inpatient care.

Keywords: care coordination, service integration, qualitative interviews, chronic medical condition, physical health

Introduction

Individuals with serious mental illness (SMI), such as schizophrenia, schizoaffective disorder, major depressive disorders, and bipolar disorders,[1] have a reduced life expectancy of approximately 10–30 years compared to the general population.[2–6] One possible reason for premature deaths is the inadequate treatment of chronic medical conditions such as cardiovascular disease, chronic obstructive pulmonary disease, and diabetes mellitus.[2–5,7]

Coordinated health services are essential to meet the oftentimes complex treatment and care needs of individuals with SMI.[6,8,9] Care coordination can be defined as

> The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of healthcare services.[10]

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Multiple care coordination frameworks have been developed.[10–13] These frameworks can help assess coordination activities, identify coordination gaps, and determine whether there is a need to improve care coordination.[10] One framework, the "Care Coordination Measures Atlas" from the US Agency for Healthcare Research and Quality (AHRQ),[10] considers care coordination to include several bridging activities focusing on professionals' roles in meeting individuals' healthcare needs. The coordination activities can be categorized at the provider-, individual-, and system-level of care.[8,14,15] Provider-level activities include (a) clarifying responsibility areas; (b) communication between stakeholders (eg, team members, service users, and families); and (c) facilitating transitions across services. Individual-level activities include (d) clinical assessment of the individual's healthcare needs and goals; (e) creating care plans; (f) planning and monitoring care and responding to change; and (g) supporting self-management. System-level activities include (h) linkage to community resources and (i) alignment of resources to individuals' needs.

Coordinated care is continuous over time, for example, between healthcare visits, and includes professionals who are familiar with the individuals' illness history and who are responsive to their needs and requests.[16] Such care includes proactive outreach such as phone calls and home visits to ensure appropriate follow-up and to identify unmet healthcare needs.[16] Coordinated care can be established within multidisciplinary care teams, including general practitioners (GPs), nurses, other clinicians, and administrative personnel.[8,15–17] Care coordination can be complex when the individuals have multiple healthcare needs, but such coordination is nonetheless imperative in these situations in order to avoid care fragmentation, which can jeopardize the quality of health service delivery.[10,11,13,18,19]

There are various possible measures to facilitate and improve care coordination that focus on the provider-, individual-, and system-level of care. Care coordinators are provider-level professionals who are responsible for coordinating individuals' care across multiple services.[17,20,21] System-level measures can include co-located services brought together for practical ease of access to healthcare[17,18,22] and ensuring proper housing if needed.[8,23] At the individual-level, continuous relationships between individuals with SMI and professionals are essential.[8] Efforts to improve care coordination should make it clear who is responsible for individuals' treatment and care.[17,18] Coordination tools such as shared care plans,[8,18] shared information technology,[8,17,18,20] shared documentation, and record-keeping across services[18] are measures that can clarify responsibilities within and between levels of care.

Literature reviews show that mental and physical healthcare for individuals with SMI is not always sufficiently coordinated,[17,18] and individuals with SMI often report a lack of communication between professionals focusing on their chronic medical conditions and those focusing on SMI.[24,25] SMI symptoms could also overshadow chronic medical conditions, and mental health professionals are often not sufficiently familiar with these medical conditions to provide proper care.[23] Municipal professionals have experienced that individuals living in supported housing with round-the-clock healthcare receive the most appropriate healthcare.[23] Research shows that there are unmet healthcare needs among individuals with SMI due to a lack of treatment motivation and to obstacles to accessing services.[25] Some individuals also avoid recommended healthcare,[8,26] and a gap exists between available services and the individuals' need for coordinated care.[8,9,20,26] Consequences for the individual with SMI can be deterioration of the health condition. Deterioration is anything that changes an individual's mental health condition, and general health, for the worse and indicates the need for clinical assessments, close monitoring of the health condition, interventions, and often increased demands for coordination.[27] Early recognition of deterioration and response to changes could prevent symptom exacerbation, need for inpatient care, and relapse.[27]

Study Aim

The overall aim was to describe the perspectives of professionals (registered nurses, medical doctors, social educators, and social workers) on care coordination and measures to ensure proper and coordinated follow-up of the healthcare needs of individuals with SMI. More specifically, we investigated which measures are taken by employees in municipal health and care services to prevent the deterioration of health conditions and which measures are taken in cases where deterioration occurs despite preventive efforts.

Method

The Norwegian Healthcare System

The Norwegian healthcare system is publicly funded and is divided into municipal health and care services and specialist health services. Municipal health and care services are organized outside hospital facilities to ensure that the residents are offered necessary healthcare.[28] The municipalities focus on preventive measures, mental and physical treatment and care, and supporting individuals living at home.[28] It is mandatory that the municipality have a coordinating unit with overall responsibility to ensure coordinated care for individuals who need multiple services.[28] In addition to the coordination units, all professionals involved in an individual's care must continuously assess healthcare needs and coordinate needed services to ensure proper care.[28]

Municipal health and care services include GPs, who usually provide the first consultation when individuals are seeking healthcare. For individuals with SMI, relevant services can be home care nursing or any other home-based healthcare, mental healthcare services, and inpatient mental healthcare institutions.[28] Some municipalities also have a multidisciplinary primary healthcare team consisting of GPs, nurses, and administrative staff. If case of acute need outside office hours, the emergency room can be contacted. The municipality must also offer acute inpatient care to individuals who require immediate physical or mental health assistance. However, this duty only applies to the individuals to whom professionals employed in the municipalities have sufficient competency to assess, treat, and provide proper care. If the municipalities do not have sufficient competency, treatment is a task for specialist health services.[28] In addition to the healthcare services, municipalities must ensure adapted housing with support from professionals for those who require such support, for example, supported housing with round-the-clock healthcare.[28]

Specialist health services provide inpatient treatment and care in hospitals as well as outpatient treatment and care.[29] Municipal health and care services and specialist health services are both responsible for providing mental healthcare for citizens, and individuals with SMI will often receive specialist health services. In the case of short-term SMI and when milder mental illness persists over time, the specialist health service can be involved in the diagnosis and assessment of the individual's healthcare needs. Involving specialist health services is essential to ensure that treatment needs in individuals with SMI are not overlooked and to prevent deterioration and prolonged treatment.[30] Individuals needing specialist health services can be referred to the patient pathway for SMI by medical doctors.[31] The pathways were implemented in 2019 to improve care coordination and to provide timelines for assessment, treatment guidelines, procedures for care transitions, and an increased focus on physical health. The patient pathway is intended to give a holistic, predictable, and individually adapted follow-up course without unnecessary waiting times.

The Municipal Health and Care Services Act[28] obliges municipal health and care services and specialist health services to enter into legally-binding cooperative agreements covering accountability and responsibility for individuals who require coordinated services. The agreements must include a protocol for care transitions between specialist health services and health and care services in the municipality, including routines for the follow-up of individuals in need of healthcare services. The agreements must also cover guidelines for the information exchange between municipal health and care services and specialist health services.

Study Design and Setting

This study comprised qualitative individual interviews[32] with professionals involved in service provision to individuals with SMI in two Norwegian municipalities. The two municipalities included one urban municipality with approximately 145,000 inhabitants and one rural municipality with approximately 20,000 inhabitants. The urban municipality has an organizational structure consisting of four health and welfare offices functioning as coordination units with dedicated care coordinators who allocate health services upon application from service users or referral from GPs. The rural municipality organizes mental healthcare services in one unit that is responsible for allocating and coordinating mental healthcare services upon application from service users or referral from GPs.

Interview Participants and Recruitment

We used purposive sampling to select interview participants who were explicitly knowledgeable regarding the study's aim.[32] Interviews were conducted with multidisciplinary professionals with similar roles and functions in the two municipalities in order to obtain multiple perspectives on coordinated care. The inclusion criteria were 1) being involved in service provision to individuals with SMI, 2) qualified as registered nurse, medical doctor, social educator, or social worker, and 3) being employed in supported housing with round-the-clock healthcare, municipal inpatient acute care, mental healthcare institution, mental health home care, emergency room, GP office, or health and welfare office.

Leaders were contacted via email with information about the study, and the leaders provided a list of names of potential interview participants. The first author contacted potential interview participants via email. The potential interview participants were included if they were interested and willing to participate in the study. We recruited 27 participants, including nine leaders. Table 1 presents information about the interview participants.

Table 1 Information About the Interview Participants (N = 27)

Variables		**N**
Gender	Female	22
	Male	5
Age (in years)	29–39	6
	40–49	15
	50–69	6
Municipality	Rural	13
	Urban	14
Education	Social educator	4
	Registered nurse	13
	Social worker	5
	Medical doctor	5
Employed in	Supported housing with round-the-clock healthcare	6
	Municipal inpatient acute care	2
	Mental healthcare institution	2
	Mental health home care	7
	Emergency room	4
	GP office	4
	Health and welfare office	2
Work experience in mental healthcare (in years)	1–10	8
	11–20	14
	21–44	5

Table 2 Interview Guide

Clarify responsibility areas
• How is the cooperation between professionals in and between levels of care formalized?
Communication
• How does communication occur between professionals or between professionals and service users? (for example, meetings, phone calls, oral, written, and electronic communication and information exchange)
• How is information adapted to each individual's healthcare needs and capacity for involvement?
Facilitating transitions
• How are transitions in and between levels of care facilitated?
Assessment of healthcare needs
• How are the individuals' healthcare needs mapped?
Monitoring care and response to change
• How are the individuals' health conditions and healthcare needs to be monitored and followed up? (for example, practices for referrals, care planning, treatment, and services)
• How do the Professionals prevent deterioration of health condition?
• How do the Professionals handle deterioration of health condition?
Align resources to the individual needs and linking appropriate services
• How is the service provision tailored to the individuals' healthcare needs and capability for involvement?
• How are the individuals involved in decision-making regarding services, treatment, care, and follow-up?
Self-management
• How do professionals support service users with strategies for self-care and self-management?
Care plans
• Do the individuals have a care plan? (for example, covering needs, goals, assigned services, and care coordination measures).

Data Collection

An interview guide[32] (Table 2) was developed with questions inspired by the framework presented in the AHRQ's[10] "Care Coordination Measures Atlas."

The first author conducted the interviews from May to October 2020 at the participants' workplaces or at the university. Interviews were conducted until data saturation was reached, meaning that including more interview participants would probably not result in new information.[33] We assumed that we had collected enough data to shed light on our study aim and that further data collection would not yield more new information.[33] A digital audio recorder was used during the interviews, which lasted between 30 minutes and 2 hours, with a mean duration of 55 minutes. The audiotaped interviews were transcribed verbatim into 500 pages of written text. All the interviews were recorded and transcribed in Norwegian and then translated into English by the researchers.

Data Analysis

The transcribed interview material was analyzed using systematic text condensation (SCT).[34] SCT is a suitable strategy for qualitative analysis because it emphasizes the interview participants' perspectives. SCT consists of the following four steps. 1) The interview material was read initially to obtain an overall impression and identify preliminary themes relevant to the study's aim. 2) Units of meaning, such as words, sentences, and paragraphs related to the interview participant's perspectives on care coordination were identified and coded using the NVivo software tool. The codes were organized into subgroups. 3) The content of each subgroup was condensed and synthesized. 4) Three categories and seven subcategories were created. In the results section, we present these categories in detail. Table 3 illustrates an example of the analysis process.

Research Ethics

The study was approved by the Data Protection Official for Research at the Norwegian Centre for Research Data (NSD), Project Number 132714. The participants signed an informed consent form before the interviews, from which they could

Table 3 Example of the Analysis Process

Preliminary Theme	Meaning Units	Code Group	Subgroups	Category
Proactive health services	Having a safe and stable place to live is fundamental to recovery and maintaining good health. We do not have a housing shortage in our municipality. We have vacant housing due to an excellent employee who is responsible for coordinating housing, which furthermore helps the individual to buy a home and enter the private market. We have resource-intensive individuals who have relocated from supported housing with round-he-clock healthcare and purchased their own homes later. Multidisciplinary meetings are vital, not only when things are severe, but also for creating plans and talking in peacetime to figure out what we can do for the individuals when their health deteriorates. The main issue is that numerous available healthcare services exist, but some individuals do not use them. It seems difficult for many individuals to receive care, especially when combined with drug use and alcohol dependency. Coordinating care and helping individuals to receive healthcare, including establishing contact with services, scheduling and helping prepare for appointments, and transporting to GPs, hospitals, emergency rooms, dentists, or other relevant services, are the most common work tasks for professionals in housing services.	Access to services and proactive care	Ensuring proper housing Access to services and assistance in receiving healthcare	Maintain a stable and meaningful home life

withdraw without explanation. A signature indicated that the participant understood the nature of participation and the allowed interviews to be audio recorded.

Results

Below we present our results in three categories and seven subcategories describing the perspectives of professionals on care coordination and measures to ensure proper and coordinated follow-up of the healthcare needs of individuals with SMI.

Maintain a Stable and Meaningful Home Life

Coordinated follow-up of individuals with SMI depends on access to proper housing and coordinated services that cover their healthcare needs and make it possible to maintain a stable and meaningful life at home.

Ensuring Proper Housing

Interview participants from both municipalities emphasized that having a safe and stable place to live is fundamental to achieving recovery and maintaining good health. The consequences of not having a safe place to live were illustrated by one interviewee who said:

> Living poorly, losing your home, or moving a lot is bad for your mental health. It is bad for everything – their state of health could deteriorate quickly if a person is forced to live such a rootless life. (Nurse, mental health home care)

According to professionals in the urban municipality, there is a waiting list for supported housing with round-the-clock healthcare. Therefore, accessing proper housing for all individuals who apply can be difficult, particularly for some individuals with several issues related to SMI, chronic medical conditions, drug addiction, aggression, and cognitive impairment. However, the housing situation differs between the two municipalities. Professionals in the rural municipality stated that they usually have access to housing for everyone who applies. A nurse said:

> We do not have a housing shortage in our municipality. We have vacant housing due to an excellent employee who is responsible for coordinating municipal housing, which furthermore helps some individuals buy a home and enter the private market. We have resource-intensive individuals who have relocated from supported housing with round-the-clock healthcare and purchased their own home later . We have housing with extra support for individuals with SMI and drug issues, and temporary housing – we do not use shelters. That, I believe, is also critical. A shelter is not a place to recover. (Nurse, mental health home care)

The interview participants employed in housing services, including supported housing with round-the-clock healthcare and mental health home care, focus on the individuals' resources, coping skills and goals and on the facilitation of a good life despite their illness. They also closely monitor the individual's health condition and respond to any change in order to ensure that assigned services are adapted to the individual's healthcare needs. These interview participants also share a common focus on stabilizing and enabling the individual to live as independently as possible at home, to prevent deterioration, and hozpitalization. One social worker said:

> We spend a lot of time with the individuals and stabilizing SMI symptoms. Calm, safe, and secure. That is what it is all about. (Social worker, supported housing with round-the-clock healthcare)

Interviewees experienced that the co-occurrence of SMI and chronic medical conditions frequently affects the individuals' ability for self-management. Several interviewees from housing services said that they support self-management skills by making individuals aware of their symptoms so as to better manage their illness at home and seek the required healthcare. They also support self-management skills through teaching activities related to daily living such as buying groceries, cooking, and doing housework. Many interviewees observed that individuals often have an unhealthy diet with nutrient-poor food, which affects their physical health. One measure is that at supported housing with round-the-clock healthcare in both municipalities' dinner is served daily to ensure nutritious food at least once a day, which is vital for maintaining good health.

Access to Services and Assistance in Receiving Healthcare

After an application for or referral to municipal health and care services, it is common practice for care coordinators from health and welfare offices or mental health units to map the individual's healthcare needs. Furthermore, the coordinators provide information about available health services so the individual can choose their home-based follow-up. A nurse said:

> The healthcare needs of the individual determine which services are provided and which professionals are involved. The challenge is to identify and cover those needs. (Nurse, municipal inpatient acute care)

Interviewees valued multidisciplinary meetings with professionals involved in an individual's care as the basis for communication and care planning to ensure the individual's access to the needed healthcare and to facilitate appropriate services. The meetings could also include professionals from specialist health services. Such meetings are particularly beneficial for improving the service provision at home for individuals with frequent admissions in order to prevent deterioration and the need for inpatient care. Service user attendance at the meetings is desirable so as to clarify their needs, wishes, goals, and expectations for treatment and care. One social worker expressed a desire for more meetings and stated:

> Regular multidisciplinary meetings with professionals within and between levels of care should be the first commandment for successful care coordination. Multidisciplinary meetings are vital not only when things are severe, but also for creating plans

> and talking in peacetime to figure out what we can do for the individuals when their health condition deteriorates. (Social worker, supported housing with round-the-clock healthcare)

According to GPs and interview participants from housing services, the municipalities have several health services accessible to individuals with SMI. However, interviewees from both municipalities had experienced difficulties with some individuals taking advantage of standardized municipal health and care services. In addition, some choose not to seek or receive the recommended healthcare. The interview participants were particularly concerned about the individuals' physical health. Employees in supported housing with round-the-clock healthcare experienced that potential physical healthcare needs related to symptoms of underlying chronic medical conditions, chest pain, and stomach aches could be misinterpreted as symptoms of anxiety and SMI. As a result, these symptoms could be overlooked, not assessed, or not appropriately examined at hospitals. GPs reported that individuals suffering from SMI often receive less healthcare for chronic medical conditions than the general population. Moreover, there is no structure to invite them to medical appointments so as to ensure coordinated follow-up by assessing the individuals' health condition and responding to eventual changes. A GP said:

> The main issue is that numerous available health services exist, but some individuals do not use them. It seems difficult for many individuals to receive healthcare, especially when combined with drug use and alcohol dependency. Their unhealthy habits are so entrenched. It frequently comes down to the environment, their belonging in society, and difficult habits to get rid of. (Medical doctor, GP office)

Several interview participants were concerned that some individuals have difficulties navigating healthcare, choosing the right services, and using the services over time. It can be difficult for them to, for example, arrange transportation to the hospital and stay long enough to receive the recommended care. A common view expressed by the interviewees is that they consider themselves to be care navigators helping to guide and connect the individuals to the healthcare they need. A nurse said:

> Coordinating care and helping individuals to receive healthcare, including establishing contact with services, scheduling and helping prepare for appointments, and transporting them to GPs, hospitals, emergency rooms, dentists, or other relevant services, are the most common work tasks for professionals in housing services. (Nurse, mental health home care)

Some professionals from the rural municipality explained that their primary healthcare team had increased access to services and provided coordinated mental and physical healthcare for individuals with SMI. This team was also beneficial for identifying unmet healthcare needs. GPs and nurses from the team visit the individuals at home for consultations, to treat and monitor health conditions, for blood tests, wound care, other care procedures, and they can follow-up with phone calls.

Measures to Prevent Deterioration of the Health Condition

The professionals coordinate care to prevent deterioration of health conditions by closely monitoring the individuals' symptoms at home, using emergency psychiatric care plans, and emergency room calls and visits. These measures are described below.

Close Monitoring of Symptoms and Emergency Psychiatric Care Plans

If an individual's health condition deteriorates, it is customary for professionals employed in housing services to coordinate the situation with the GP. Furthermore, they usually agree to closely monitor the individual's health condition at home in order to prevent further deterioration. Some also receive help from the acute team at the community mental health center. A common view among the interviewees is that inpatient care is often unnecessary, because they often have the resources to prevent deterioration at home. However, sometimes professionals cannot prevent deterioration sufficiently at home, even if they try to. A nurse said:

> When someone is admitted, they are in a terrible state. We deal with a lot in the housing services, but sometimes we cannot cope with the deterioration and preventing further deterioration at home. Furthermore, the individuals themselves are also concerned

> that we will not be able to provide sufficient follow-up when they feel awful. They find it too unsafe to be in their home. (Nurse, supported housing with round-The-clock healthcare)

According to interviewees employed in housing services, it is customary to have an emergency psychiatric care plan that includes an overview of signs of a deteriorating health condition and the coordination of appropriate measures. This plan is considered valuable. The interviewees emphasized the need to develop the strategies covered by the plan together with the individuals when they are stable and feeling well so that they can explain what symptoms to be aware of and how to address these to prevent relapse in the best possible way. The first preventive step in the care plan is often to contact the GP. One GP said:

> If the individual comes to the GP early in the event of deterioration, we can avoid further escalation and reverse the health condition mildly and positively. Medication adjustments, for example, could be one approach to accomplish this. (Medical doctor, GP office)

Emergency Room Calls and Visits

Deterioration of an illness can occur acutely and without the individual's GP being involved. In such cases, emergency room nurses and medical doctors handle and coordinate the individual's healthcare needs. Emergency room interviewees might experience frequent contact with individuals with SMI. Consultations usually concern the deterioration of an already diagnosed SMI, injuries due to self-harm, suicide issues, or poor physical health. These individuals may have various needs for coordinated care. An interview participant said:

> It does not necessarily have to be an emergency room appointment or inpatient care that is the solution, but simply having a phone call with us and being heard. To have someone to talk to and to be followed up with a subsequent phone session to hear how everything is going. Someone cares, and I believe the staff here handle it well. (Nurse, emergency room)

However, some individuals have more complex healthcare needs that require clinical assessments, more resources, and more comprehensive interventions than phone calls alone. Individuals often have intense symptoms of mental illness and poor physical health when they contact the emergency room. When clinical assessments are required in the individual's home or outdoors, the urban municipality has an emergency car that is used by a medical doctor and nurse in over half of all cases involving mental illness. A nurse described how difficult it could be to care for individuals suffering from SMI and how they try to facilitate appropriate healthcare, saying:

> A lot is going on, and not everyone wants help. They are welcome to come to the emergency room if they are open to talking. Furthermore, we frequently schedule double appointments. We strive to keep them shielded, and they do not have to enter the waiting room. We can try to speed up the appointment if they already have a therapist. If they do not, we have to start over. (Nurse, emergency room)

Emergency room interviewees believed that these individuals could have had a better course of treatment if the deterioration had been detected and responded to earlier and measures had been implemented at home. These interviewees also expressed that having cooperating professionals who already knew the individual's medical history would facilitate information exchange and the assessment of healthcare needs. In most cases, these professionals are the GPs and mental health home care professionals. The main challenge is that these professionals are only available during certain office hours, even though individuals with SMI might need help 24 hours a day. Another challenge described by the interviewees is that municipal health and care services and specialist health services use electronic medical record systems that generally cannot communicate, which hampers the flow of key information. A medical doctor in the emergency room gave an example:

> Without a shared medical record system, we often do not have enough medical information to make necessary assessments regarding the individual's healthcare needs because we do not have an overview of the entire situation. For example, consider a situation where there might, or might not, be a need for admission to specialist health services. (Medical doctor, emergency room)

Inpatient Care – to Stabilize Acute and Severe Symptoms

If measures implemented at home or in the emergency room fail to stabilize the individual's health condition, transitions to inpatient care might be necessary.

Municipal Inpatient Care

Emergency room interviewees were concerned that admission to specialist health services is usually the only alternative for treatment or care in the evening, at night, and on weekends. If for various reasons, hospital admission is not possible, individuals with severe symptoms could be sent home without treatment and care, due to a lack of accessible municipal health and care services. However, interview participants from both municipalities emphasized that inpatient care is not necessarily in the individual's best interests. A medical doctor said:

> Psychiatric inpatient care is not necessarily in the individual's best interests over time, as coping with symptoms at home would be preferable. My upbringing is that people are self-counseling and want to be in their own environment. (Medical doctor, emergency room)

Usually, inpatient care takes place in specialist health services. In the rural municipality, medical doctors have the opportunity to refer individuals with already diagnosed SMI and chronic medical conditions to municipal inpatient acute care 24 hours a day. Mental health home care professionals stated that their partnership with municipal inpatient acute care had expanded because more individuals needed instant care. One nurse talked about how they try to meet all individuals in need:

> Our department is never full. We run double rooms and corridors as needed. We bring in extra staff and align the resources to take care of the individuals, to provide a service offering. (Nurse, municipal inpatient acute care)

Nurses stated that individuals admitted to municipal inpatient acute care were often in poor physical health and struggled with self-care, including alcohol and substance use issues. The individuals receive coordinated multidisciplinary healthcare and support from GPs, nurses, and physiotherapists during admission and recovery. GPs experienced municipal inpatient acute care as an important 24-hour service and a necessary supplement to specialist health services. They stated that those admitted did not have any previous alternative service offerings.

GPs in the rural municipality could also refer individuals who needed close follow-up of their mental health to a municipal mental healthcare institution. Nurses at this institution explained that individuals who were admitted received multidisciplinary follow-up 24 hours a day. In addition, one day a week there was a GP who focused on physical health, and once a month a psychiatrist from a community mental health center focused on mental health.

Returning Home After Inpatient Care

The interviewees perceived that coordinating discharge from specialist health services could be challenging. Several interviewees experienced that inpatient care stabilized symptoms; however, the individual's mental health condition often changes when the individual comes home. One said:

> Specialist health services receive individuals on a ward with complete control of meals, bedtimes, and doors. Individuals frequently stabilize when they enter inpatient care. As a result, they are thought to be in a stable state of mental health during the inpatient stay, and there is thus no basis for admission. (Nurse, mental health home care)

Several interview participants experienced that discharge often took place quickly, without any opportunity for them to be prepared. The individual's mental illness symptoms were also often exacerbated shortly after discharge. One participant stated:

> The biggest challenge is when the eagerness for discharge becomes so dominant that the specialist health services do not do a good enough job during the inpatient stay – a problem that has become worse. (Nurse, mental health home care)

The interviewees highlighted electronic messages with treatment and care information as a beneficial communication tool during transitions. A nurse said:

> Electronic messages have been an addition in recent years. We get a message from the specialist health services regarding discharges. Furthermore, we receive information about admissions – because the individuals may have been admitted without our knowledge. (Nurse, mental health home care)

However, several interview participants experienced a gap between the information needed and the information received from specialist health services, for example, not receiving information regarding inpatient treatment and healthcare needs after discharge. It is preferable to supplement written information with phone calls and meetings between stakeholders involved in an individual's care in order to clarify further healthcare needs and follow-up after discharge. Professionals from the municipalities are often invited to a meeting during the inpatient stay in order to coordinate further follow-up of the individual's needs. Professionals from housing services were concerned that their services should be continuous even if the individual was admitted, and they reported being happy to attend such meetings. A social educator said:

> If we become involved before discharge, we can provide better follow-up afterwards. We clarify what we are responsible for and the specialist health services' areas of responsibility. If we are not included, there is less continuity of care at home. (Social educator, mental health home care)

Discharge letters from specialist health services usually provide a direction for further follow-up measures. Measures could include scheduling a GP appointment for assessment, testing of serum medication levels, and adapting medication. However, it is often unclear which medical doctor holds the medical responsibility for the individuals at home. It can either be one in the specialist health service or the GP. GPs stated that they are not always involved in discharges and follow-ups at home, even if they wanted to be involved. One of them said:

> GPs are used to dealing with SMI, and I think they are good at it. Many individuals know their GP much better now than they did 20 years ago, and the GPs often know their families. This is a good position from which to contribute. (Medical doctor, GP office)

Some individuals need outpatient treatment in the specialist health service after discharge, but there are challenges related to waiting times for this treatment and rejection of referrals. Furthermore, when individuals need supported housing with round-the-clock healthcare immediately after discharge, this might be challenging to access, and the professionals must coordinate the arrangement of temporary housing.

A Need for Shared Responsibility for Treatment and Care

The interviewees underlined the importance of statutory cooperation agreements with specialist health services, covering areas of responsibility to achieve coordinated services as vital aspects of care coordination. It is a reassurance for these interviewees that they can get advice and guidance from specialists even after the individuals are discharged. One said:

> Knowing that even after the specialist health service has completed its treatment, their job is not finished because we share the duty and ownership of the individuals. We often do well and can accomplish a lot independently, but knowing that we have someone sharing the responsibility with us is beneficial. (Social educator, mental health home care)

An example of well-functioning coordinated care is agreements whereby psychologists and psychiatrists from the community mental health center provide home treatment to individuals who have problems with attending the clinic. However, the coordination with specialist health services may not always function as desired, despite the agreements. Disagreements regarding areas of responsibility and assessing the individual's healthcare needs are coordination challenges. Nurses from municipal inpatient acute care, which mainly focuses on physical healthcare, have experienced individuals being admitted with severe psychotic symptoms hampering physical healthcare. In such cases, the nurses think that specialist mental healthcare services are responsible for providing care. However, specialist mental health professionals encounter individuals whose physical health is too poor for them to receive mental healthcare.

Several interviewees stated that they had expected patient pathways to improve care coordination and to clarify who has the main responsibility to follow up on the healthcare needs of individuals with SMI. However, they had not noticed much change. One nurse stated:

If I concentrate on noticing a difference, it is in the newly ill. It is true that they are entering a new process, but in the context of the people we are discussing, individuals with SMI, this is a transition in and out of specialist health services. It is the same procedure as before. (Nurse, mental health home care)

Discussion

We interviewed professionals from municipal health and care services involved in coordinating health services for individuals with SMI. Our study describes the perspectives of professionals on care coordination and the measures taken to ensure proper and coordinated follow-up of the healthcare needs of these individuals. Ensuring housing and access to the required healthcare services are key issues. Measures taken to prevent the individual's health condition from deteriorating and in cases where deterioration has occurred include close monitoring of symptoms, using emergency psychiatric care plans, emergency room calls and visits, or inpatient care to stabilize symptoms.

The interview participants in our study emphasized that access to needed services is essential for individuals with SMI to maintain a stable and meaningful life in their homes. Professionals provide individuals with information about available services and help them navigate and receive healthcare by connecting them to the services. A recent study by Storm et al[8] showed similar results, reporting that individuals with SMI often need help navigating within healthcare and might lack information about available services. These findings indicate that addressing the multiple needs of individuals with SMI could require individual-level coordination activities, such as professionals' support and navigation, to ensure access to healthcare.[8] Further, our results show that there are employees in housing services working to support the individual's self-management skills by teaching them to recognize and manage symptoms at home and when to seek healthcare. The literature shows that individuals with SMI can experience challenges in interpreting symptoms.[35] Supporting the individual's illness self-management skills are individual-level coordination activities that can promote health[8] and increase the individual's ability to carry out self-care tasks and navigate healthcare.[10]

Research[8,26] argues that some individuals avoid recommended healthcare even if they have opportunities to access healthcare services. The duration of SMI correlates with treatment motivation.[25] However, Haussleiter et al[25] reported that individuals with SMI could have poorer access to health services – including preventive measures, treatment, and care – compared to the general population. Our findings indicate that some individuals have difficulty taking advantage of available healthcare services and therefore receive poor follow-up of chronic medical conditions. Research also shows that several Norwegian municipalities do not have adequate service provisions for individuals with SMI,[23,26] and national and international research shows a gap between available services and the healthcare needs of individuals with SMI.[8,9,20,26] One possible explanation could be that SMI symptoms are so severe that the individual cannot manage to take advantage of available services at home and also does not follow up on recommended treatment and care.[9,23,26]

Our study reports that the primary healthcare team in the rural municipality has successfully provided coordinated mental and physical healthcare for some individuals with SMI and has been able to identify unmet healthcare needs. Similarly, a study by Abelsen et al[36] reports that individuals followed up by primary healthcare teams reported better access to relevant services, coordinated care, and increased self-management skills. The team's expertise in both SMI and physical health and their knowledge of other relevant services were reported to be important factors in more holistic care.[36] Overall, multidisciplinary teamwork has proven that system-level coordination increases the quality of care,[37–39] leading to positive health behavior changes and improvement of symptoms.[38]

Interview participants from housing services were concerned with recognizing and monitoring symptoms to prevent the deterioration of health conditions and the need for inpatient care. A Norwegian study by Ose et al[23] also reports that individuals living in supported housing with round-the-clock healthcare often are closely followed-up and receive sufficient healthcare.[23] In our study, interviewees in the emergency room reported frequent contact with individuals with SMI who were in a state of deterioration of their mental health condition. They described assessing and safe-guarding the individual's healthcare needs as challenging because they did not know the individual's medical history. A shared medical record system between the services within the municipality level and between the specialist and municipal level of care could improve access to necessary medical information. Such a system could help assess

healthcare needs and coordinate needed services. These findings are aligned with research emphasizing the importance of adequate health record systems for proper provider-level coordination.[8,39,40] Our results also highlighted electronic messages as a beneficial communication tool in care coordination, but the system does not always work as desired. Hence, information technologies that facilitate information exchange among professionals and across services are potential solutions for improving care coordination.[15,41] Prioritizing shared medical record systems and electronic messages is also in line with the political focus on strengthening and implementing eHealth platforms.[14]

Multidisciplinary meetings were described as a vital provider-level coordination activity that could facilitate communication between professionals, assessment of healthcare needs, care planning, and proper follow-up. Similar, another study documents that communication and information exchange are essential coordination enablers.[40] Regular meetings can facilitate care coordination by ensuring that service provision matches the individual's resources, needs, and goals.[18,21,26,37,38,40,42,43] Meeting points where professionals can communicate, share essential information, and learn about each other's roles and responsibilities can improve care coordination.[20,22,26,44] Interview participants in our study say they value cooperating with professionals employed in specialist health services to meet individuals with SMI`s healthcare needs. Including professionals from specialist health services at multidisciplinary meetings can be beneficial. Several studies[37,38,42–44] support the importance of meeting points, and they stress that well-functioning care coordination builds on respect between involved professionals and knowledge about each other's responsibilities, competencies, and available services.

Interviewees in our study reported that if measures implemented in the municipality cannot stabilize symptoms, admissions to specialist health services might be necessary. Kim et al[40] emphasize that cooperative agreements between municipal health and care services and specialist health services that specify the roles and responsibilities of each side can facilitate effective care coordination. Skjærpe et al[26] argue that shared responsibility for the individual's care strengthens coordination across levels of care. A lack of consensus about who should take responsibility for the general healthcare needs of individuals with SMI could hamper proper and coordinated care.[25] Thus, efforts to improve care coordination should clarify areas of responsibility for treatment and care.[10,17,18]

We found that several professionals had expected patient pathways to improve system-level care coordination by helping clarify responsibility and by strengthening the cooperation with specialist health services in order to follow up on the healthcare needs of individuals with SMI. Still, the professionals did not notice much change after implementing the pathways. This view seems consistent with another study that documents how patient pathways have increased the burden of administrative work and reduced the professionals' time dedicated to treatment and care.[45] In addition, there is a lack of clarity regarding the overall goals and contents of the pathways.

Strengths and Limitations

There were limitations in our study due to the Covid-19 pandemic, including challenges with recruitment and conducting the interviews within the time scheduled. Another study limitation is that we did not conduct interviews with individuals with SMI or with professionals from the specialist health service, which would have given a larger sample with more perspectives. Our study shows some variation in the services offered in the two municipalities. These variations could be seen in connection with another Norwegian study,[46] which reported differences in the organization of coordinating units between rural and urban municipalities. Even though we believe the study results have relevance and can be transferable to similar settings,[32] our results may not be transferable to other municipalities due to, for example, financial and organizational differences.

A strength of our study that could enhance its transferability[47] is that the included multidisciplinary professionals who had experience in coordinating care for individuals with SMI were employed in several municipal health and care services. In addition, we included two municipalities that varied in size and organization. Another strength is that our data material was linked to the bridging activities in the AHRQ's[10] coordination framework. This provided valuable theoretical inspiration for the data analysis,[34] as well as documented the relevance of the framework for research to describe coordination measures for individuals with SMI.

Conclusion

Professionals employed in municipal health and care services coordinate health services to ensure proper and coordinated follow-up of the healthcare needs of individuals with SMI by ensuring housing services and access to the required healthcare. Measures taken when deterioration occurs include monitoring symptoms, use of emergency psychiatric care plans, emergency room contacts, or inpatient care. Our study implies that regular multidisciplinary meetings where the involved discuss care coordination challenges, clarify areas of responsibility, and determine which measures to implement can improve care coordination. Future coordination activities may also benefit from multidisciplinary teamwork, efforts for the prevention and early detection of exacerbated symptoms, and shared medical record systems within and between levels of care.

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Abbreviation

SMI, serious mental illness.

Consent for Publication

Interview participants have been shown the article content to be published. The authors are prepared to provide copies of signed consent forms to the journal editorial office if requested.

Data Sharing Statement

The interview material reported in this study is available from the corresponding author on reasonable request.

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Author Contributions

All authors contributed significantly to this study, in its conception, study design, execution, data collection, or analysis and interpretation, or in all these areas. The authors took part in drafting, revising, or critically reviewing the article and gave final approval for this version to be published. The authors have agreed to submit the article to this journal and take responsibility for the content of the article.

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