Appendices to

An Evaluation of the Nimbin Integrated Service Project (NIS)

Final Report

25 July 2012
Appendix 1 – Full Literature Review

A Review of the Literature on Rural Integrated Mental Health Services

Background
In Australia mental health care is delivered by a range of providers. These include the public sector funded by state or territory health departments, general practitioners (GPs) and private psychiatrists who are funded federally, through rebates and 'gap' fees made by clients. Non-government organisations also provide services which may be funded from either source. The conflicting sources of funding as well as the contradictory approaches to treatment by each provider has created difficulties and a fragmented service that is often complex for consumers and carers to negotiate (Eagar, Pirkis et al. 2005). A number of studies have highlighted the fragmentation of services and lack of integration in the provision of mental health services in the primary health care setting, particularly in rural areas (Buchan and Boldy 2004; Veysey 2004; Bambling, Kavanagh et al. 2007; Hodgins, Judd et al. 2007; Cleary, Hunt et al. 2009; Allan 2010).

Primary care is the part of Australia’s health system that people use most. It is the first point of health care delivered in, and to people living in their communities – outside of hospitals (Australian Government Department of Health and Ageing, 2011, Para. 2). Often discussions of primary care refer only to the supply of and access to general practitioners as well as clinicians who have a health related background such as practice nurses, psychologists, and community health workers. The rural primary care setting defined in this way provides support for a large proportion of people with mental health and drug and alcohol related problems (Hodgins, Judd et al. 2007; Allan 2010). For the purposes of this literature review the term primary health care will be used as it encompasses a much broader and more comprehensive approach to health care. The Australian Primary Health Care Research Institute (APHCRI) describes primary health care as being: evidence based care provided by appropriately trained clinicians from public health and other sectors who work collaboratively in multidisciplinary teams, with common referral processes to promote public health.

‘Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation’.
(Commonwealth of Australia, 2009, p. 22)

General Practitioners are the first point of contact for many people in primary care settings and GPs constitute the majority of the mental health workforce in the Australian community, particularly in rural areas that experience a shortage of both specialist mental health practitioners and other professional primary care clinicians(Perkins and Lyle 2005; Bambling, Kavanagh et al. 2007; Hodgins, Judd et al. 2007). Often GPs lack training in the speciality of mental health (Perkins and Lyle 2005) and referral to a specialist mental health professional rarely occurs in rural areas (Bambling, Kavanagh et al. 2007; Hodgins, Judd et al. 2007). Often this is due to a lack of trained and skilled clinicians, to whom they can refer. This in turn has led to an overburdening of GPs.

In addition, the treatment and management of mental health disorders in rural areas can be complicated by physical isolation, distance, time, cost, lack of transport, lack of privacy and fear of stigma, lack of culturally appropriate services, and the availability of adequate services (Veysey 2004; Cheyne-Macpherson 2007) (Meyer and Morrissey, 2007). Problems with service delivery are further compounded by staff shortages and the uneven geographic distribution of mental health professionals and facilities (Cheyne-Macpherson 2007) (Meyer and Morrissey, 2007).

This paper reviews the literature on integrated mental health services in rural areas.

Aim
To understand existing models of integrated mental health services in rural Australia, and elsewhere, through a critical analysis of recently published academic and grey literature.
Objectives

- To define what is meant by an integrated service
- To briefly outline the policy context for the development of integrated mental health services
- To identify existing models that aim to integrate services for mental health in rural Australia and elsewhere, with a particular focus on services which provide for dual-diagnosis patients
- To determine the range of models in use and what frameworks these models are based on
- To explore the role of the Nurse Practitioner within these models of mental health service provision
- To appraise how successful these models have been.

Definition of an Integrated Service

The literature on the integration of services in mental health suffers from poor definition and uses a range of terms. These include multidisciplinary, interdisciplinary, integrated, shared care and collaborative care. In this review, the integrated services described have been specifically derived from literature on rural primary health care settings. A broad reading of the literature has produced a composite definition of integrated mental health services in rural areas. It is defined in this paper as a coordinated and collaborative approach to person centred care for people with mental health illness. The responsibility for care is seen within this definition as not residing with a single person or service provider, rather a combination of providers who utilise a person centred approach to patient care. This involves a number of clinicians both general and specialised who collaborate to share care, share health care records, and referrals between services.

Key features of integrated services include community consultation and engaging non-government agencies to establish shared aims, objectives and values of a program that are unique to each rural community. This assumes the implementation of standardised training, education, documentation and referral processes to ensure that all clinicians and services have a working knowledge of each other’s roles and responsibilities. Senior management support in these models includes shared governance and understanding of the model across services and or organisations and is required for integration to work. The implementation of shared policies, procedures and funding is also imperative to support integration within services.

The literature review will broaden the reader’s understanding of integrated mental health services and facilitate further insight regarding these services. It also includes suggestions for future policy making as well as identifies areas that need further exploration through research and more generation of evidence.

Review Method

Review Question

The literature was examined to answer the following questions:

- What models of integrated mental health services exist in rural areas of Australia and elsewhere?
- How effective are these models?

Search Strategy

The review brought together studies and reports that focussed on integrated service models of health care in rural areas with a particular emphasis on mental health and/or drug and alcohol. The initial search was carried out in October 2011 when the following databases were systematically searched: MEDLINE, Informit, Psych info and EBM. These databases were selected as their content relates to clinical medicine, Australian scholarly research, has a multidisciplinary, public affairs and rural and remote health focus as well as a broad range of publications on health topics. The search terms and process are outlined in Table 1.

Over 700 papers were identified from the initial search strategy. Limits applied included English language only, and papers published in the last 10 years. Literature more than ten years old was not
included to account for the significant changes to health service structure, management, policy, regulatory and legislative frameworks prior to this. The majority of these 700 articles were excluded after removing duplicates and reviewing the title and abstract of each. For all studies that met the inclusion criteria or in cases where the title and abstract were inconclusive, full texts were retrieved and assessed for applicability to the review objectives. A total of 26 papers remained for detailed scrutiny. This search was limited to refereed journals.

A further search was conducted in February 2012 of Australian Government reports sourced from the Australian Department of Health and Ageing website using mental health as a subject heading. A summary of the reports and programs identified that relate to the purpose of this review is provided in Table A.
Table 1 – Literature Review Process Published Studies

Flow Chart of Stages of Searching

Potential relevant papers identified by literature search 786
- Informit 84
- Medline 459
- Psych Info 185
- EBM 58

Papers excluded after limits applied and duplicates removed
- Informit 59
- Medline 329
- Psych Info 180
- EBM 35

540 papers excluded after initial evaluation of titles (63)

34 papers excluded after evaluation of abstracts

26 papers included in review

Literature Review

MeSH Terms (Medical subject headings)

- alcohol*
- area*
- Australia
- care*
- country
- deliver*
- delivery of health care, integrated
- drug*
- framework*
- health
- health services accessibility
- healthcare
- hospitals, rural
- integrat*
- mental
- mental disorders
- mental health
- mental health services
- mental*
- model*
- outback
- regional
- remote*
- rural
- rural health
- rural health services
- rural population
- service*
- system

Limits applied
- Humans only
- English Language
- All Adult
- Last 10 years
Policy context for the development of integrated mental health services

As early as 1992 national health plans and legislation identified the need to implement multidisciplinary service delivery for people with chronic mental health conditions in Australia. These plans also discussed the need for information systems to support continuity and integration of services (Perkins, Roberts et al. 2006). The development of national outcome standards for mental health services, quality assurance programs for mental health services and support of an independent system of assessing whether services are meeting standards has been endorsed and supported by Commonwealth, State and Territory Health Ministers in the National Mental Health Plan (1992) and the National Mental Health Policy (1992). These policy documents describe integration in a mental health system as being comprehensive, coordinated and individualised care provided through intersectoral links between mental health services and other organisations which allows for community participation in mental health service development.

The Australian Department of Health and Ageing established a list of National Standards for Mental Health Services (MHS) in 2010 and integration features as one of these standards. These are situated within programs and plans described in the previous pages. According to this standard each defined community should provide integrated services both with other sectors and within the health system. Key features of the integrated mental health services were described as:

- A balanced approach to services in order to ensure continuity of care for the client (Commonwealth of Australia 2010).
- A case manager to maintain contact with the client between inpatient and community settings and between acute and rehabilitation programs (Commonwealth of Australia 2010).
- Frequent meetings held for the stakeholders of each of the MHS programs and sites including management meetings with all service providers (Commonwealth of Australia 2010).
- Access to the individual client care plan (Commonwealth of Australia 2010).
- All staff have an understanding of the roles and responsibility of each service (Commonwealth of Australia 2010).
- Consistent policies and procedures implemented across all services including referral processes (Commonwealth of Australia 2010).
- Services are evaluated using criteria consistent criteria (Commonwealth of Australia 2010).
- All mental health staff are aware of the full range of services and information available for clients including non government services, welfare services, disability support, school counsellors and aged care assessment teams (Commonwealth of Australia 2010).
- Links with other sectors at local, state and national levels to ensure specialised coordinated care and promote community integration (Commonwealth of Australia 2010).

In an integrated model, all of the separate programs and services such as inpatient care, crisis intervention, case management & rehabilitation, disability support, health promotion, developmental programs are described as one mental health service with separately funded programs working collaboratively to achieve a single integrated mental health care system for the defined community.

Since 1992 four mental health plans have been implemented to guide mental health reform in Australia. The second National Mental Health Plan published in 1998 found widespread failings in integration. The third plan published in 2003 focused on people in need of mental health care and stated they should have access to timely and effective services irrespective to where they live (Perkins, Roberts et al. 2006). This has relevance to rural and remote populations who are faced with geographical isolation, low resource availability and a high proportion of relatively inexperienced or skilled staff (Tobin 1996).

The ‘Better Outcomes in Mental Health Care’ initiative in Australia (2001 – 2005) represented a major development in attempting to integrate mental health care in Australia. It recognised the central role of primary care, promoted integrated medical and psychological care, and attempted to better link GPs, non-medical mental health specialists and psychiatrists to meet population-based mental health needs. Central to its development was a commitment by GPs to develop progressively better mental health skills and measure both individual consumer and system-related outcomes.
Another government initiative implementing Multi-purpose Services (MPS) was introduced in rural Australia in 1991 as a solution to poor health outcomes in rural Australia compared to metropolitan populations. This report highlighted difficulty in attracting health care staff and lack of viability and range of health services in rural areas(Australian Government Department of Health and Ageing, 2010, Para. 3). MPS are integrated health and aged care services that provide flexible and sustainable service options for small rural and remote communities. This model provides small communities who are having difficulty supporting a range of independently run services the opportunity to develop a more coordinated and cost-effective approach to service delivery. (Australian Government Department of Health and Ageing, 2010, Para. 3)

“Multi-purpose Services (MPS) are integrated health and aged care services that provide flexible and sustainable service options for small rural and remote communities”. (Australian Government Department of Health and Ageing, 2010, Para. 2)

Integration was described as being most beneficial in an MPS when stakeholders trusted each other and long term relationships were formed (Anderson, Bonner et al. 2011).

A very recent national primary health care strategy will be implemented on 1 July 2012 known as Medicare Locals. Medicare Locals will focus on improving on primary health care and ensuring that services are better tailored to meet the needs of communities.

Medicare Locals will have a number of key roles including:

- Linking GPs, nursing and other health professionals, hospitals and aged care, Aboriginal and Torres Strait Islander health organisations, and maintaining up to date local service directories (Australian Government Department of Health and Ageing 2011a).
- Working with Local Hospital Networks to make sure that primary health care services and hospitals collaborate (Australian Government Department of Health and Ageing 2011a).
- Implement after hours face-to-face GP services (Australian Government Department of Health and Ageing 2011a).
- Identify where local communities are missing out on services they might need and coordinate services to address those gaps (Australian Government Department of Health and Ageing 2011a).
- They will be accountable to local communities to make sure the services are effective and of high quality (Australian Government Department of Health and Ageing 2011a).

Another Commonwealth health initiative that is currently out in draft for consultation is the ten year roadmap for national mental health reform. (February 2012). Some of the recommendations from this report are consistent with the findings from this literature review. These include:

- Improving the quality, accessibility, coordination and integration of services (Australian Department of Health and Ageing 2012).
- Strengthening approaches to planning integrated services (Australian Department of Health and Ageing 2012).
- Changing the way governments, non government organisations, providers and the private sector do business with each other and the community to remove service access barriers, improve effectiveness, remove duplication, and drive integrated, coordinated and flexible local solutions and the governance of services and support (Australian Department of Health and Ageing 2012).

**Findings**

**What models of integration exist in mental health services?**

A significant number of qualitative studies and government reports have been conducted or reported around a range of integrated services in mental health. Models of services described in the publications include:
- Local generalist staff supported by community mental health staff from hubs with visiting psychiatrists from metropolitan centres (Perkins and Lyle, 2005, Perkins et al., 2006)
- Visiting specialist workers providing drug and alcohol and mental health services to remote Aboriginal communities alongside and with Aboriginal Health workers (Allan, 2010, Haswell-Elkins et al 2009)
- The implementation of multipurpose centres in rural areas (Anderson et al, 2011)
- Referral and shared care arrangements for rural GPs, health and non government service providers (Perkins et al., 2006, Bambling et al, 2011, Harvey and Fielding, 2003)
- Service outreach programs (Perkins et al., 2006, Harvey and Fielding, 2003)
- The use of an emergency triage liaison 24hr telephone service with specialist psychiatry back-up that health professionals, consumers and carers in rural and remote areas can access to receive advice, information and support. As well as a distance consultation and liaison service for consumers and health professionals using Telemed. (Taylor et al, 2009)

Each of these studies or reports contributes to understanding the effectiveness of these models and how they have worked or not worked. It is noteworthy that there is no one model proposed and that variation between these reflects the services available.

Integration has been described as occurring when pre-existing services became part of an integrated service model which now functioned as a single coordinated service. (Anderson, Bonner et al. 2011). Features of integration reported in the literature included shared staff among pre-existing services, more engaged multi skilled staff who embraced the change and coexistence, coordinated meetings to discuss service provision and case review, and participants identified themselves as being part of a new service model. Integrating services when they work can enhance communication between staff members and services that would have not otherwise had a great deal of contact (Anderson, Bonner et al. 2011).

**What frameworks are these models are based on and how successful are they?**

The majority of written reports or studies described various models of integrated mental health services that have developed in the last decade under the National Mental Health Strategy. These studies also identify gaps in how service are delivered or the effectiveness/non effectiveness of these models from the author’s perspective. Concerns has been expressed by GPs, community mental health teams as well as non-government sector organisations, on the effectiveness or otherwise of integration (Allan 2010, Bambling et al 2007, Barnes et al 2003, Buchan et al 2004, Cleary et al 2009, Crosbie 2009, Hodgins et al 2007, Judd et al 2004). GPs showed a lack of understanding of the integrated models and lacked knowledge re treating people with mental health problems in the community (Bambling et al, 2011, Buchan and Boldy, 2004). GPs also resisted working with allied health and non-government agencies. They did not see a role for multidisciplinary teams or non-government organisations (Bambling et al, 2011, Buchan and Boldy, 2004). Community teams also appeared unresponsive to general practice needs. Overall the clinicians lacked an in depth knowledge and understanding of their integrated service mode (Allan 2010, Bambling et al 2007, Barnes et al 2003, Buchan et al 2004, Cleary et al 2009, Crosbie 2009, Hodgins et al 2007, Judd et al 2004). This is despite the number of in depth government policies and reports that highlight the need to integrate services in mental health and provide detailed descriptions of what these services should deliver and how.

The literature also lacked detailed information about the consumers’ evaluation of integrated health care models. Only a small number of papers discussed this perspective. Tzeng et al 2007, reported patients in the redesigned care network having a better quality of life, lower family burden, decreased days in hospital and less admissions to hospital. Bartels et al, suggested locating integrated mental health facilities physically alongside primary care clinics or GP practices to enhance access to treatment. Culturally tailored mental health services need to be developed and evaluated with indigenous consumers, carers and communities. Haswell-Elkins et al 2009 highlighted the importance of community empowerment and partnership approach to mental health and well being in indigenous communities. Culturally tailored mental health services need to be developed and evaluated with indigenous consumers, carers and communities.
Was there a role for the Nurse Practitioner within these models?

None of the papers or reports sourced and searched either investigated or reported on the role of a Nurse Practitioner (NP) in rural integrated mental health services. This is perhaps surprising given there is research evidence of high levels of consumer satisfaction with NP roles in other settings (Elsom, Happell & Manias 2005). The vast majority of the available research suggests that consumer satisfaction with NPs is generally higher than with GPs (Horrocks et al. 2002; Kinnersley et al. 2000; Mundinger et al. 2000; Shum et al. 2000; Venning et al. 2000). Longer time spent in consultation, more frequent follow-up visits, the provision of information and health teaching, and a superior quality of care, were specific characteristics in which NPs were considered to perform favourably compared with GPs. These factors all relate to the interpersonal relationship, considered to be the cornerstone of mental health nursing practice (Elsom, Happell & Manias 2005).

Other research investigating the effectiveness of the nurse practitioner role (Horrocks et al. 2002) found that nurse practitioners in a variety of health care settings provided an equivalent standard of health care in treating specified health conditions to that of their medical colleagues. Horrocks et al. (2002) undertook a systematic review of randomized controlled trials and observational studies comparing nurse practitioners and doctors in a primary care setting and found that, on average, clients were more satisfied with care by a nurse practitioner. In a randomized controlled trial by Kinnersley et al. (2000), comparing nurse practitioners with general practitioners in the UK, again, clients reported significantly greater levels of satisfaction with nurse practitioner consultations and they reported receiving more education regarding their health condition from nurse practitioner consultations. In another randomized trial comparing nurse practitioners with junior doctors in an accident and emergency unit in the UK, patients seen by nurse practitioners were found to be better informed about their injury (Sakr et al. 1999). A randomized trial comparing nurse practitioners with medical practitioners in a major rural emergency department in Australia, found patients were equally satisfied with the care provided by nurse practitioners and medical practitioners (Chang et al. 1999). These findings suggest that clients were at least as satisfied with nurse practitioner care as with the care provided by medical staff (Chang et al. 1999, Kinnersley et al. 2000; Horrocks et al. 2002). Further, the findings suggest that clients were better informed about their health conditions following nurse practitioner consultations (Sakr et al. 1999, Kinnersley et al. 2000).

The increased support for the GP working in collaboration with the highly specialised nurse practitioner is reported to have the potential to reduce heavy workloads (Bagg, 2004). A research paper by Fisher in 2005 demonstrated that the mental health NP role in Australia has the potential to help resolve the crisis in mental health nursing. The mental health NP role has assisted in retaining expert mental health nurse clinicians through better pay, career structure and job satisfaction. Mental health NPs will help improve access to mental health services by providing quality, cost-effective mental health care for clients who are not currently serviced adequately (Fisher 2005).

The literature is replete with successful collaborative stories where mental health NPs provide cost-effective quality care for consumers of mental health services, while at the same time provide effective collaborative partnerships with the physicians. The mental health NP can ease workloads for GPs and psychiatrists, as well as increase profitability and efficiencies in GP practices (Fisher 2005).

The gatekeepers of a client’s healthcare under a primary health care model needs to be responsible for coordination and case management; this needs to be broadened from the current model to encompass other providers such as remote area nurses, nurse practitioners and midwives.

The NP does not work in isolation (even if geography isolated) but works as part of a health care team including other health care professionals to deliver safe and efficient Primary Health Care. Registered nurses and NPs are ideally placed to deliver primary health care in Australia. A recent major ongoing investigation of the NP role in Australia led by Professor Glenn Gardner from the Queensland University of Technology. This investigation known as The Australian NP Project AUSPRAC study has over the past 3 years been studying NP and is producing comprehensive findings about all aspects of NP work. AUSPRAC conducted a national census of all Australian NPs who were authorised to practice in Australia in July 2007. The results showed that the majority of NPs authorised in Australia at the time were employed in New South Wales, particularly in metropolitan areas and further the Emergency Department was the most commonly reported clinical field. (Gardner et al, 2009)
The role of the NP in primary health care settings will be further explored in a separate literature review as part of a PhD.

Quality of research or reports
The methodological quality of the papers studied varied considerably. Few papers were published in A or A* journals. The studies were carried out in a variety of settings, mostly in rural settings within Australia although there were a few international studies and one Cochrane review.

How successful these models have been?
The descriptions, findings and recommendations and limitations for each of the papers studied in this review are described in Table B.

Implications for Practice
From the review several recommendations to improve integration of mental health in primary health care settings emerged.

1. To ensure integration in mental health service delivery there needs to be combined training and education programs that offer a consistent approach by all primary care providers delivering mental health care as part of this model. This training should include education that emphasises service integration and interagency referrals and communication. A sustainable, skilled and appropriate workforce is required in order for service access to be improved. (Bambling et al 2007, Barnes et al 2003, Cleary et al 2009, Hodgins et al 2007, Judd et al 2004, Perkins et al 2006)

2. The education program provided for teams who are building an integrated service will then utilise a system wide language, system wide tools and a system wide approach regarding common mental health problems, and provide up skilling and support opportunities for primary care clinicians. (Judd, Davis et al. 2004; Hodgins, Judd et al. 2007). However these systems must be designed and be implemented by the services involved and run collaboratively with joint governance models.

‘Creating clinical integration requires that all participating clinicians broaden their professional paradigms. In practice, this requires cross training, a mechanism for cross agency discussion and collaboration and shared assessment and treatment planning’. (Veysey 2004) p35.

3. More specifically the review suggests that:
- Education programs targeting GPs must include:
  - Information about the local community mental health service and what they provide including the types of services provided, target population, cost and referral protocols (Bambling et al, 2007)
  - Establishing relationships with community mental health services staff and having a clear understanding of each other’s roles (Bambling et al, 2007)
  - Training in counseling (Bambling et al, 2007)
  - Better preparation in their undergraduate training in more common disorders such as anxiety and depression. (Bambling et al, 2007)

4. Education programs targeting Mental Health services must include:
- An emphasis on how to work in multidisciplinary teams in the community as opposed to working in a hospital setting
- Communication processes to notify GPs re client management plans, admission and discharge processes and discharge planning that includes all of the team. (Anderson et al, 2011)
- Specific education and information about the local area
- Support for and inclusion of Aboriginal Health Care workers. (Allan 2010).
5. High level management support is required to:
   - Implement a memorandum of understanding between the GPs and the mental health services to define the different roles and responsibilities of the team and local variations.
   - Provide well-resourced and coordinated clinical and community services to form part of the integrated team.
   - Drive integration, facilitate change management, ensure performance and accountability and to manage and report on program funding and outcomes.
   - Develop record keeping systems, referral practices, accountability frameworks and reporting lines that work effectively.

6. Community engagement and collaboration in decision making around mental health services is important. Service integration requires detailed planning at the local level with leadership that encourages structural and cultural changes. This must include community as well as professional and health service leaders. (Eager et al 2005, Vesey et al 2005, Bartels et al 2004)

7. Involvement of Aboriginal Medical Services and Aboriginal health workers in delivering services to Aboriginal populations is also imperative as well as improving access to appropriately qualified Aboriginal and Torres Strait Islander mental health workers. (Allan 2010, Haswell-Elkins et al 2009, Phillips 2004, Toomey & Kluin 2007)

8. Consideration should be given to the location of integrated mental health facilities. If they are physically located alongside primary care clinics or GP practices this has been shown to enhance referrals and communication between providers, collaboration in treatment planning and access to treatment(Bartels, Coakley et al. 2004).

9. Develop local systems to enable governments, non-government organisations, providers and the private sector do business with each other and the community to remove service access barriers, improve effectiveness, remove duplication, and drive integrated, coordinated and flexible local solutions. This will require improving coordination and integration between mental health and health drug and alcohol, housing, justice/corrections, employment, disability community, and immigration services. (Anderson et al 2011, Eager et al 2005)

10. The division of roles and responsibilities for service provision across health, housing, education, training employment and welfare, the different levels of government and different sectors, combined with a lack of integrated planning and shared governance has created barriers to fully meeting consumer needs for these services. More than 90 per cent of people with profound mental illness, including psychoses, are accessing some mental health services, but without holistic and coordinated support, recovery and independence can be difficult to achieve. This often places the burden on carers and families or with repeat presentation to emergency departments or readmission to acute care services. (Eager et al 2005)

11. A rapid expansion of primary care services specifically targeting youth is required. (Hickie et al, 2005)

**Implications for research**
Further areas for research have been identified in the literature to inform integration of mental health services, particularly in a primary health care setting. This research should focus on

1. The scarcity of evidence around qualified Nurse Practitioners coordinating care within this model.
2. Further studies are recommended that focus on a more holistic approach to the evaluation of the impact crisis assessment teams in rural/remote areas using a broader range of outcomes. (Adesanya 2005)
3. Further research is required on the need for gender specific programs.(Veysey et al, 2005).
### Table A - Summary of Relevant Government Reports and Programs

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<thead>
<tr>
<th>Report/Program</th>
<th>Year</th>
<th>Initiative</th>
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<tr>
<td>National Mental Health</td>
<td>1st plan 1992-1997</td>
<td>These strategies outline major policy reforms in Australia’s mental health system.</td>
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<tr>
<td>Strategy</td>
<td>2nd plan 1998-2003</td>
<td>1st plan focused on reforms to the specialist public mental health sector. For example, increases in community-based care, decreases in standalone psychiatric hospitals, mainstreaming of acute beds into general hospitals.</td>
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<td></td>
<td>3rd plan 2003-2008</td>
<td>Under the 2nd plan, greater emphasis was given to the private mental health sector and how this role complemented the public sector. However, data that could inform an evaluation of effectiveness against all the objectives of the Second Plan were not collected routinely by mental health services and other organisations involved more broadly in the mental health field.</td>
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<td>4th plan 2009</td>
<td>Under the 3rd plan, fostering partnerships between the two sectors was the priority.</td>
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<td>The 4th plan focused on the promotion as well as the prevention of mental health issues.</td>
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<td>The aim of these reports was to reduce the impact of mental disorders on individuals, families and the community and guarantee the rights of people with mental illness.</td>
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<td></td>
<td>One of the weaknesses of these plans was the strong focus on public and private health facilities and services to provide mental health care.</td>
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<td>The role of nongovernmental organizations in the provision of mental health interventions requires more definition and clarity in these plans.</td>
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<tr>
<td>Initiative/Program</td>
<td>Period</td>
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<tr>
<td>Australian Integrated Mental Health Initiative</td>
<td>2003-2009</td>
<td>This initiative was conducted over 5 years in the Northern Territory and engaged managers, service providers, Aboriginal Mental Health Workers and communities to explore mental health in remote communities and to find new ways to deliver services. This was a major mental health research project to date in the NT. It established base line measures, explored understandings of mental health from the community perspective, developed service based strategies for improved cross cultural assessment, conducted the first Indigenous mental health clinical trial of a new brief psychotherapy, and developed a range of resources for service providers and the community linked with a training program.</td>
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<tr>
<td>Department of Health and Ageing (2010) National Mental Health Report 2010: Summary of 15 Years of reform in Australia’s Mental Health Services under the National Mental Health Strategy 1993</td>
<td></td>
<td>This report is the eleventh in the National Mental Health Report series released by the Australian Government. It summarises the progress of mental health reform undertaken over the fifteen years of the National Mental Health Strategy, and provides a view of trends and performance at the national and state and territory levels over the period spanning the First, Second and Third Mental Health Plans from 1993 to 2008.</td>
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<td>Council of Australian Governments (COAG) national action plan on mental health The Mental Health Services in Rural and Remote Areas program</td>
<td>2006 - 2011</td>
<td>Provided opportunities for allied and nursing clinicians to provide mental health services, including, Aboriginal health workers, and Aboriginal mental health workers in rural and remote communities throughout Australia. The program increased access to mental health services in rural and remote areas where access to services was low. The program consists of two stages. Under stage one (implemented in June 2007), funding was provided for identified geographical areas-of-need through 15 selected non-government organisations that have capacity to deliver mental health services. Non-government organisations include divisions of general practice, Aboriginal medical services and the Royal Flying Doctor Service. Stage two builds on stage one and will increase mental health services in rural and remote areas of high need. Stage two was implemented in June 2008, with funding provided to 24 organisations in 25 rural and remote areas. The Australian Government describes the commitment of $73.9 million to build the capacity of drug and alcohol non-government organizations in this report.</td>
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<tr>
<td>National Mental Health Reform</td>
<td>2011</td>
<td>One of the strategies of this policy is to improve access to primary care</td>
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<td>The Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative</td>
<td>2011</td>
<td>Aims to improve outcomes for people with a clinically-diagnosed mental disorder through evidence-based treatment. Under this initiative, Medicare Benefits Schedule (MBS) rebates are available to patients for selected mental health services provided by GPs, psychiatrists, psychologists (clinical and registered), eligible social workers and occupational therapists.</td>
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<td>Ten Year Roadmap for National Mental Health Reform: draft for consultation</td>
<td>February 2012</td>
<td>The draft roadmap details a commitment by governments to a long-term national reform plan for mental health to guide future action and investment across Australia over the next ten years. Some of the recommendations from this report are consistent with the findings from this literature review. These include</td>
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<td>- Improving the quality, accessibility, coordination and integration of services.</td>
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<td>- Strengthening approaches to planning</td>
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<td>- Changing the way governments, non-government organisations, providers and the private sector do business with each other and the community to remove service access barriers, improve effectiveness, remove duplication, and drive integrated, coordinated and flexible local solutions and the governance of services and support</td>
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| Adesanya A. Australasian Psychiatry. 13 (2) 135 – 139, 2005 | Location – Regional Victoria | This research paper evaluated the use of a crisis assessment team and compared data findings across one service that uses this model of care. A crisis assessment team consisting of a psychiatrist and junior medical, nursing and allied health staff was established to perform a triage and gate-keeping role for all potential admissions into the adult inpatient unit. This 24 hour service managed psychiatric crisis presentations within the community. The team met twice a day to discuss new patient referrals, and to review current patients. The team also provided a 24 hour on call outreach emergency service to all age groups. The team was also actively involved in discharge planning for inpatients and worked collaboratively with relevant agencies to implement case management arrangements when patients were discharged. | The establishment of a crisis assessment service in a regional/rural integrated mental health setting did not appear to make a statistically significant reduction in duration of psychiatric hospitalisation. | Further studies focussing on a more holistic approach to the evaluation of the impact crisis assessment teams in rural/remote areas using a broader range of outcomes. | Strengths
Limitations to the study were identified. |
| Allan J. Australian Journal of Primary Health. 16(4):311-8, | Qualitative action research was used to gain an in-depth understanding of service delivery in drug and alcohol and mental health for Aboriginal people in Western | Most drug and alcohol workers (D&A) did not have knowledge or experience of the primary health care setting. They could not assist the Aboriginal health care workers to integrate drug and alcohol interventions into their practice. | The action research approach introduced an education and support plan for Aboriginal health care workers, this was delivered by the drug and alcohol workers and included | Strengths
Limitations to the study were identified. The project aims, methodology and data collection methods were clearly explained. | Weaknesses
Before and after models of evaluation are problematic – there may be significant changes in the population which explain the (non) difference. There was no mention of ethical approval for this study. The author did not completely discuss the data, tested hypotheses, and methodology. Data was compared across one service only. |
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<td>3.</td>
<td>Anderson, JK, Bonner A, Grootjans J. The International Electronic Journal of Rural and Remote Health Research 3 Dec 2011 Location – Rural NSW</td>
<td>A review of the Multi-Purpose Service (MPS) model in rural NSW. This program was implemented in rural Australia in 1991 as a solution to poor health outcomes in rural compared to metropolitan populations, difficulty in attracting health care staff and lack of viability and range of health services in rural areas. The aim of the study was to describe the main concerns of participants involved in the development of MPS in rural NSW. Participants involved in the study were from 13 MPS services in rural NSW. 30 in depth interviews were conducted overall and</td>
<td>Trust was the most significant risk identified when integrating services. In order to embrace the ideal of the MPS model stakeholders needed to trust each other sufficiently to integrate their organisational identity. Integration was described as being most beneficial when stakeholders trusted each other and long term relationships were formed. Effective integration in an MPS model can enhance communication between staff members and services who would have not otherwise had a great deal of contact</td>
<td>The need to improve strategies that lead to better understanding of processes for the management of change is required, this will improve trust and lead to greater integration between services. Stakeholders need to trust each other and form long term relationships as well as have a good understanding of the integrated service and how it works</td>
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<td>4. Bambling M. Kavanagh D. Lewis G. King R. King D. Sturk H. Turpin M. Gallois C. Bartlett H.</td>
<td>This study looked at the perceptions of referral and shared care arrangements for rural GPs, Queensland Health and non government service providers for mental health patients. 8 general practices from 8 rural Queensland towns were included in the study as well as 3 rural mental health services and 2 non government agencies. A sample of 37 GPs, 19 Queensland mental health staff and 18 participants from government organisations were interviewed.</td>
<td>There were significant problems identified with inter-service communication and liaison. Specific strategies were identified to promote better integrated services. GPs reported that the current system excessively emphasised crisis management and was not adequately focussed on continuum of care. GPs reported a lack of understanding of shared care arrangements and how it worked eg referral processes. GPs resisted working with allied health and non government agencies. GPs lacked knowledge of treating people with mental health problems in the community.</td>
<td>Better marketing strategies to GPs about the integrated mental health models and how and why they work. Focus on integrated mental health models in undergraduate training in medicine. Education programs for GPs which should take into consideration the local context, cover systems issues as well as skill development and aim to develop personal relationships between mental health clinicians and GPs to enhance outcomes.</td>
<td>Strengths Sample from a wide range of services, 8 towns and various practice settings. The sample was limited to one area of Queensland only and did not represent the views of the state.</td>
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<td>5. Barnes L. Rudge T.</td>
<td>Co-morbidity is identified as a key issue for MH and D&amp;A services in Australia. Services are often provided within different organisational structures and in two systems that have different treatments and processes. This small hypothetical study explored how the use of the label ‘dual diagnosis’ impacts on service delivery. Semi structured telephone interviews were conducted with one mental health nurse and one drug and alcohol nurse from each of the rural health regions in South Australia. The number of regions was not identified in</td>
<td>This study showed that individual needs of the clients set the way in which nurses combined their various skills, knowledge and resources. The responsibility of care is seen as not residing in ‘one’ nurse or service provider and the nurses from MH and D&amp;A position themselves so that they are co-responsible for the outcome of the client.</td>
<td>Educate rural nurses in both D&amp;A and MH so they understand both systems and can work across them.</td>
<td>Strengths Limitations of the study identified, eg small scale study, views of clients were not presented. Ethical approval was obtained for this study. Weakness Difficult to interpret the sample size.</td>
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<td>6. Bartels et al. AM J Psychiatry. 161:8. 2004</td>
<td>This multi site randomised trial included 10 sites with primary care patients 65 years or older. Initially 24, 930 patients were screened. The final study group consisted on 2,022 patients. The research demonstrated that these patients are more likely to accept collaborative mental health treatment within a primary care setting than in mental health or substance abuse speciality clinics.</td>
<td>Integrated care provided in the community has been advocated as a means to enhance communication between providers, reduce stigma and medical expenditures, and avoid artificial separation of medical and psychiatric problems that can result in substandard care. This model also enhances access to timely treatment. Integrated care may be effective in engaging older primary care patients who are at risk of suicide.</td>
<td>Locating integrated mental health facilities physically alongside primary care clinics or GP practices enhances referrals and communication between providers, collaboration in treatment planning and access to treatment.</td>
<td>Strengths: A very comprehensive paper where the authors completely discussed the data, tested hypotheses, presented the data in tables and explained how missing data was handled. Limitations and recommendations for further research were reported.</td>
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<td>7. Buchan T. Boldy DP. Australian Health Review. 28(3):292-300, 2004 Dec 13. Location – inner city area of Perth</td>
<td>This paper provides the views of a sample of GPs, psychiatrists and MH administrators regarding the key elements of a best practice, integrated, community-based mental health service that was focussed on integration with primary care. An exploratory qualitative study was used. 24 GPs from 14 practices were purposively selected as well as 15 psychiatrists, and 11 administrators. The site chosen for the study was an area of lower socioeconomic status and therefore had higher mental health risk factors compared to other areas. The site chosen also had a new mainstream mental health service delivery. Several GPs made a point that they rarely made referrals except in urgent situations. They did not see a role for multidisciplinary teams or non-government organisations. Community teams were unresponsive to general practice needs.</td>
<td>To improve integration in mental health service delivery there needs to be an agreed definition of the scope of primary care psychiatry, methods to improve GP access to mental health services as well as a focus on improving communication and education.</td>
<td>Strengths: A large sample size across 14 GP practices including perspectives from 11 health administrators and 15 psychiatrists. Provides a useful overview including recommendations on how to improve integration in mental health services Organised and objective writing styles</td>
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health service that had not achieved a high level of integration and had low level of cooperation with GPs according to the authors.

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<td>8. Cheyne-Macpherson, K. Department of Health and Ageing. Presentation at the 9th National Mental Health Conference Albury2007</td>
<td>Conference Paper presented at the 9th National Mental Health Conference Albury 2007</td>
<td>Council of Australian Governments National Action Plan on Mental Health 2006 – 2011 emphasised coordination and collaboration of government, private and non-government providers, in order to deliver a more seamless and connected care system. $4 billion dollars worth of funding was provided. Programs described in this paper included Beyond Blue targeting depression in men, National Suicide Prevention Strategy, Telephone counselling and self help web based program, Funding to support undergraduate and post graduate programs in MH designed to grow the mental health workforce.</td>
<td>Recognised the need for the Australian government to work collaboratively across jurisdictions and with health professionals and non-government sectors to facilitate better integration of mental health services Under the Better Access Initiative GPs are supported to co-ordinate the treatment of patients with mental health disorders in the primary care setting</td>
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<td>9. Cleary M, Hunt GE, Matheson S, Walter G. Drug &amp; Alcohol Review. 28(2):122-8, 2009 Mar Location – Australia wide</td>
<td>The aim of this study was to determine the views of a wide range of Australian mental health service providers on staff education and training, client contact and management, assessment, and treatment effectiveness and service delivery. A survey was sent to 171 mental health stakeholders in Australia identified through internet searches, state mental health departments and professional organisations. 66 responded (39% response rate)</td>
<td>Integrated service models was identified as the most preferable and effective model of care. However barriers were identified such as an absence of clear service models, deficiencies in organisational culture, absence of integrated education and an experienced skilled workforce.</td>
<td>Almost all participants indicated a need for further training in dual diagnosis, cross training of staff and supervision as well as institutional support for integrated treatment programs</td>
<td>Strengths Ethics approval was obtained for the study. Limitations to the study were identified including a limited response rate.</td>
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<td><strong>10.</strong> Crosbie D, MJA, volume 190, number 4, 2009</td>
<td>This opinion paper describes how over the past 15 years state governments have agreed to a series of national mental health plans where the overall aims of basically remained the same. There are at least ten national reports summarising information about levels of mental health services provision, shifts in funding allocation, and efforts to engage the community, carers and consumers. In practice the existing monitoring and reporting tells little about mental health services in Australia.</td>
<td>The concern described in this paper relates to lack of outcome data and effective evaluation. If measures are not in place to monitor outcomes, service systems have a tendency to continue providing the same services to the same patients. There is no national reporting system for mental health outcome data</td>
<td>Outcome data needs to be collected and reported by dedicated research bodies rather than relying on governments to collect and evaluate data.</td>
<td>Weaknesses: The description, data and findings were too generalized.</td>
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<td><strong>11.</strong> Eager K, Pirkis J, Owen A, Burgess P, Posner N, Perkins D, Australian Health Review; May 2005; 29.2 Location – NSW, Inner Urban and Far West</td>
<td>This paper described outcomes the national mental health integration program that was funded by the Commonwealth Department of Health and Aged Care in 1999. 29 projects were initially proposed but only 3 went on to implementation phase. The aim of the program was to establish and document linkages between private psychiatric services and the public health mental health service and to create a more flexible integrated framework between services. A national reference group was established to advise and support the project and to develop a national evaluation.</td>
<td>For providers the program improved in working relationships, created learning opportunities and increases referral and shared care opportunities. For consumers and carers, the programs resulted in a greater range of options and increased continuity of care. For the wider system, the program achieved significant structural and cultural change. Cost wise there was no increase in expenditure. Practical challenges in achieving integration of services are significant and should not be underestimated. It takes more than large amounts of money to achieve integration of services</td>
<td>Service integration requires detailed planning at the local level with leadership that encourages structural and cultural changes. Integration needs to be planned at the local area level. System level integration is required within the specialist mental health sector and beyond to include GPs and non government organisations. No one model fits all. Ways to improve integration differs between areas and depend on the size, level and mix of existing resources, availability of local leaders and existing</td>
<td>Strengths: Very senior qualified authors wrote this paper using data findings from across the 3 sites. The authors discussed the data and presented the data in tables and graphs. The writing style was organised and objective. Very good discussion outlining key points.</td>
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framework. The 3 areas that implemented the program included Inner Urban East Melbourne, Illawarra, and Far West NSW.

Consumers play a vital role in driving the process for cultural change. There is an ongoing need for initiatives and incentives to achieve better integration amongst services. It is important to consider broader innovations occurring elsewhere and to consider international literature.

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<td>12.</td>
<td>Cochrane Review, 2009 Specialist outreach clinics in primary care and rural hospital settings</td>
<td>An extensive review of specialist outreach clinics in primary care and rural hospital settings. Includes national and international settings. Published in 2009. 73 outreach interventions were identified covering many specialities, countries and settings. 9 studies met the inclusion criteria and were randomised controlled trials.</td>
<td>This paper included four studies that were specifically related to mental health. Two were conducted in the UK and two in the USA.</td>
<td>Implications for practice - Interaction is greatest when outreach is part of a complex multifaceted intervention which involves case conferences, joint consultations, seminars and education sessions, other health professionals or other care enhancements.</td>
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<td>13.</td>
<td>Harvey CA, Fielding JM. Medical Journal of Australia. 178 Suppl:S49-52, 2003 May</td>
<td>A summary of mental health services used to facilitate care for people with schizophrenia. A description of services available in Australia. Community based services include mobile crisis teams, providing home-based acute treatment, and case management services for ongoing treatment.</td>
<td>In Australia the configuration of public mental health services varies between states, but overall, community based services are increasingly integrated and responsive to people with schizophrenia. Home based acute treatment by mobile crisis teams is more acceptable to patients and families and is less disruptive and burdensome for families than standard in patient care. Case management has well resourced and coordinated clinical and community services including community based psychosocial interventions are important to support people with schizophrenia in the community. There needs to be more community based psychosocial rehabilitation programs. It is important to educate families and carers.</td>
<td>Weaknesses There was no explanation of the method used for data collection. Findings were not compared to those of others in the literature. The description, data and findings were too generalized. This was an informed opinion piece.</td>
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Other services include management by GPs, shared care between the GP and private psychiatrist, and case management via community mental health. It has been shown to reduce symptoms, improve social functioning and minimise drop-out from services. The case manager has a central role in coordinating, integrating and allocating the care of individual patients.

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<td>14.</td>
<td>Haswell-Elkins et al 2009 <strong>Location – Far North Queensland</strong></td>
<td>This paper highlights a community empowerment and partnership approach to mental health and well being in indigenous communities. It described a program that emerged from a literature review and consultation and provides an example of a mental health research partnership.</td>
<td>Mental health often focuses on crisis management rather than proactive health promotion</td>
<td>Culturally tailored mental health services need to be developed and evaluated with indigenous consumers, carers and communities.</td>
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<td>15.</td>
<td>Hickie IB. Groom GL. McGorry PD. Davenport TA. Luscombe GM. Medical Journal of Australia. 182(8):401-6, 2005 Apr 18</td>
<td>This paper reports on the service gaps in Mental Health reform and highlights youth health and integrated primary care programs as a priority</td>
<td>Develop and evaluate youth friendly models to complement primary health care. GPs responses to young people with MH problems underestimate their need for psychological assessment and intervention</td>
<td>Rapid expansion of youth-health and primary care services</td>
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<td>16.</td>
<td>Hodgins G. Judd F. Davis J. Fahey A. Australasian Psychiatry. 15(1):52-7, 2007 Feb <strong>Location - Southern Mallee region</strong></td>
<td>A description of how a locally developed and delivered training program was offered to GPs to improve integration of mental health services. 49 GPs completed the training The training was provided through 6 one hour workshops. Emphasis on training GPs in primary care</td>
<td>The training was evaluated through pre and 6 week post questionnaires assessing attitudes and practice with respect to treatment of patients with mental health problems.</td>
<td>GP MH education should take into consideration the local context, cover systems issues as well as skill development, and aim to develop personal relationships between MH clinicians and GPs to enhance outcomes Increase use of CBT therapy</td>
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<td>17. Judd F. Davis J. Hodgins G. Scopelliti J. Agin B. Hulbert C. Australasian Psychiatry. 12(1):42-7,2004</td>
<td>The Rural Integrated Primary Care Psychiatry program is based on strong education and training to support primary health care clinicians and requires collaboration and shared care between primary health care clinicians and specialist services.</td>
<td>The overall aim of the program was to improve service integration and to extend the availability of evidence based mental health interventions to a larger proportion of individuals in rural areas. The program was evaluated using pre and post training data on participants knowledge, attitudes, practice and work satisfaction.</td>
<td>Highlights the importance of having an integrated training and education program that offers a consistent approach to all primary care providers delivering mental health care as part of this model. The education program provides a system wide language and approach regarding common mental health problems, and provides up skilling and support opportunities for primary care clinicians. Ongoing supervision is provided to clinicians after the training in a case based learning environment</td>
<td>Strengths: Very senior qualified authors wrote this paper. The program could be replicated in other areas.</td>
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<td>18. Meyer P, and Morrissey J. 2007 Location – International study comparing models</td>
<td>This descriptive paper reviewed evidence for the effectiveness of community based services for rural areas by way of a literature review. 10 papers were studied overall.</td>
<td>Identified and compared two community based models for management of patients in rural areas with mental health problems. 1. Assertive community treatment model which uses large multidisciplinary staffed teams with shared case loads to provide a full range of services.(6 studies) 2. Intensive case management encompasses a range of services that are less intensive and includes assertive outreach, assessment of consumer need and negotiation and coordination of</td>
<td>The evidence suggests that intensive case management programs are effective only in community settings where there are adequate support services.</td>
<td>This research did not provide adequate guidelines about minimum staffing requirements or essential program requirements or evidence to support either of these models.</td>
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<td>19.</td>
<td>Perkins D &amp; Lyle D. 2005 &lt;br&gt;&lt;i&gt;Location – Far West Area Health Service, remote NSW&lt;/i&gt;</td>
<td>This paper reports on the evaluation of an Australian government and NSW state funded mental health integration project. To improve access to MH services in remote NSW, the FWAHS adopted a model where they regularly fly in psychiatrists from metropolitan areas. Access to psychiatrists was achieved in remote communities in FWAHS</td>
<td>The evaluation included observation, case studies and focus groups with consumers and other key stakeholders as well as provider interviews and surveys. The arrangements for the visiting psychiatrists were reported to be satisfactory by all respondents.</td>
<td>Visiting specialists can be deployed in a primary care settings and can be recognised for their support of local providers.</td>
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<td>20.</td>
<td>Perkins DA, Roberts R, Sanders T, Rosen A. &lt;br&gt;&lt;i&gt;Australian Journal of Rural Health. 14(3):105-10, 2006 Jun.&lt;/i&gt; &lt;br&gt;&lt;i&gt;Location – Far West Area Health Service, remote NSW&lt;/i&gt;</td>
<td>To improve access to MH services in remote NSW, the FWAHS adopted a model where they regularly fly in psychiatrists from metropolitan areas. Access to psychiatrists was achieved in remote communities in FWAHS. This model was reviewed by examining data and evidence from occasions of service, audits as well as interviewing relevant provider groups.</td>
<td>Community Mental Health Teams, hospital staff and Aboriginal Medical service staff as well as GPs were provided with clinical and broader support services. The visits from the psychiatrists not only included direct patient consultations but also preplanned secondary activities such as case load review, mentorship and education of local MH and primary health care staff. Resident staff continues planned care between visits and are able to consult by phone if necessary. Also monthly tele-education sessions occur. Remote patients are able to remain in their community for treatment. Collaboration with GPs was not highly successful as GP turnover was significant and it was difficult to maintain relationships with visiting psychiatrists. GPs were also in short supply and had little time for non-core</td>
<td>If visiting psychiatrists are used to support integrated models of service delivery they need to not only provide direct patient care but to work alongside clinicians providing them with education and ongoing support. This is particularly relevant in remote communities.</td>
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| 21. Phillips M, Aboriginal and Islander Health Worker Journal, 26 (2) 2004, 30-31 | This paper describes the experiences of an indigenous researcher in working on a project to evaluate an integrated mental health service at Mount Isa. Semi-structured interviews were conducted with carers and committee members and indigenous workers who had dealings with the Integrated Mental Health Service in Mount Isa. No specific details were provided about the participant size. | The findings identified gaps in how the integrated mental health service is delivered and other areas of concern. Lack of - financial support - indigenous support programs - professional resources - Aboriginal Mental Health workers - training for staff - communication between service providers - support facilities - Little or no understanding of indigenous needs | Establish a critical reference group with indigenous community members to encourage ownership and provide direction for the model and to ensure an indigenous perspective | **Strengths**
Easy to read short paper with good recommendations
**Weaknesses**
No references listed
No specific details provided re the how the research was conducted and the methodology |
| 22. Smith SM, Allright, S, O'Dowd T, Cochrane Collaboration Review | This review examined the effectiveness of shared care across the interface between primary and specialty care in chronic disease management. 20 studies were included 19 of which were randomised controlled trials. Eight studies presented data on mental health outcomes. | Shared care was defined as the joint participation of primary care physicians and specialist care physicians in the planned delivery of care for patients with a chronic condition. Benefits to shared care for mental health clients included improved quality of life. | **Strengths**
Sample from a wide range of services and practice settings. Including national and international
Very extensive discussion around methodology
**Weaknesses**
The review was not specifically related to mental health |
| 23. Taylor J. Edwards J. Kelly F. Fielke K. Health & Social Care in the Community. 17(2):216-24, 2009 Mar. | This paper described a model of integrated mental health care known as the Rural and Remote Mental Health Service. This service is the specialist provider of acute mental health services, directly and in directly, to people living in rural and remote areas of South Australia. An emergency triage liaison 24hr | The study found that consumers saw transfer to the city for mental health care as beneficial in spite of the challenges of being transferred over long distances, while being very unwell and separated from family and friends. Maintain the 24 hr telephone service and extend it out to further regions. Include information that promotes the service Use Telemed to conduct case conferences prior to discharge from tertiary hospitals, including the case manager and mental health team outside of the tertiary hospital. | **Strengths**
The study looked at six primary mental health care settings in South Australia
Selection bias may have occurred with the consumer reps
Carers perspectives were not obtained in this study, resulting in a gap in information. Only one consumer participant was Aboriginal which was limiting in terms of reflecting on | **Weaknesses**
No references listed
No specific details provided re the how the research was conducted and the methodology |
telephone service with specialist psychiatry back-up that health professionals, consumers and carers in rural and remote areas can access to receive advice, information and support. The model also provides a distance consultation and liaison service for consumers and health professionals using Telemed, which is the use of telephone and videoconferencing for clinical services, consultation, review and discharge planning. A memorandum of understanding was put in place to ensure that key agencies and services worked together.

The paper also documented the experience of mental health consumers travelling from the country to the city for acute care. Six purposively sampled cases were conducted collecting data through semi structured interviews with consumers, country professionals and tertiary mental health care providers.

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<td>24. Toomey T, and Kluin M, 2007 Mid Western NSW</td>
<td>This research paper explored co morbidity as it relates to indigenous persons in rural and remote areas of NSW. Co morbidity was defined as the co-occurrence of a mental health disorder</td>
<td>The paper was published by the Centre for Rural and Remote Mental Health, NSW. There was an overwhelming number of 'gap' issues identified from all groups relating to cultural differences and</td>
<td>Several recommendations were made for service providers to ensure culturally appropriate care is provided. Some of these recommendations included - Increase formal and informal</td>
<td>Experiences due to different cultural backgrounds.</td>
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health and drug/alcohol problem. A qualitative methodology was used with focus groups. The project was conducted in one area health service in NSW that consisted of 13 local government areas. Participants included 30 service providers from government and non-government agencies, 30 Aboriginal participants from rural locations and 30 Aboriginal participants from more remote locations. These included professionals, consumers, and community members.

issues, and clinical practice issues related to sharing of information and coordination between services. There was also a lack of access to trained Aboriginal and or mainstream clinicians.

links between service providers, Aboriginal services users and the community (Toomey & Kluin, 2007)
- Develop initiatives that explore and maintain ongoing relationships with the Aboriginal community (Toomey & Kluin, 2007)
- Reduce the Aboriginal community’s fear of the health service (Toomey & Kluin, 2007)

The project was conducted in one area health service in NSW that consisted of 13 local government areas. Participants included 30 service providers from government and non-government agencies, 30 Aboriginal participants from rural locations and 30 Aboriginal participants from more remote locations. These included professionals, consumers, and community members.

issues, and clinical practice issues related to sharing of information and coordination between services. There was also a lack of access to trained Aboriginal and or mainstream clinicians.

links between service providers, Aboriginal services users and the community (Toomey & Kluin, 2007)
- Develop initiatives that explore and maintain ongoing relationships with the Aboriginal community (Toomey & Kluin, 2007)
- Reduce the Aboriginal community’s fear of the health service (Toomey & Kluin, 2007)

A steering committee was established to oversee the development of the research and included key indigenous community members and health workers.

<table>
<thead>
<tr>
<th>Reference</th>
<th>Description</th>
<th>Findings</th>
<th>Recommendations</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Tzeng DS, Lian LC, Chang, CH, Yang, CY, Lee GT, Pan P, and Wey Lung F. 2007, Location – Southern Taiwan</td>
<td>The aim of this comparative research study was to compare the effectiveness of an integrated treatment model consisting of a teaching hospital, psychiatric rehabilitation institutions, a day hospital, community rehabilitation centres, day care farms, home based care, and outpatient clinics with those of the traditional treatment model provided by psychiatric hospitals. 257 patients were randomly selected from the above settings and compared to 247 patients in other more traditional health care models.</td>
<td>Patients in the redesigned care network had a better quality of life, lower family burden, decreased days in hospital, less admissions to hospital. Although the costs were higher the continued care network was more helpful in providing comprehensive mental illness services.</td>
<td>The promotion of community based treatment models tailored to individual needs</td>
<td>the use of nominal group technique which was used in the focus groups to ensure a culturally appropriate way of exploring the issues pertaining to Aboriginal co morbidity A steering committee was established to oversee the development of the research and included key indigenous community members and health workers.</td>
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</tr>
</thead>
<tbody>
<tr>
<td>26. Veysey BM, Anderson R, Lewis L.</td>
<td>This paper described a community based program in the USA that is targeted</td>
<td>Highlighted the need to have a gender specific program that is sensitive to women’s needs.</td>
<td>This paper highlighted that primary health care based services in the community to be</td>
<td>Strengths Easy to read thoroughly presented descriptive paper with</td>
</tr>
</tbody>
</table>

*Location – Rural town in the USA*

especially for women with drug and alcohol and mental health problems as well as histories of trauma and domestic violence. The program model integrates services at the person as well as the systems level. For example the Women’s resource centre is the focal point of service that offers peer support from other women, trauma recovery groups, body awareness programs, and formal treatment systems focussed on AOD and MH

Identified issues around community programs and their inadequacy to address clients who have suffered from trauma

Exclusionary practices within AOD and MH lead to fragmented care and narrowly defined service specific symptoms rather than addressing the holistic needs of the female clients. The women benefited from a treatment philosophy based on competency building and empowerment, services and support provided in a safe, accessible community based locations, mutual relationships built on trust, understanding and respect, the establishment and maintenance of safety and trauma specific treatment. The women in the study revealed that they needed jobs, friends, things to do and therapists who treat them with respect.

effective the interventions must be able develop networks of care to respond to the variety of personal, sociocultural, environmental, and interpersonal issues based on wholeness, complexity and self-described needs.

Creating clinical integration requires that all participating clinicians broaden their professional paradigms. In practice, this requires cross training, a mechanism for cross agency discussion and collaboration and shared assessment and treatment planning

Further research on gender specific programs. For example women who are often disadvantaged due to family violence, caring responsibilities for children, partners or parents, housing stress, poor health, disability, and substance misuse can contribute to and further entrench disadvantage and social isolation

good discussion and recommendations

*Weakness*

Only looked at one service
References (search strategy)


Government Reports


Other Sources


Appen dx 2 - A summary of individuals who participated in the evaluation

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Work Role</th>
<th>Type of contact</th>
<th>Helped with:</th>
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<tbody>
<tr>
<td>Dept of Premier and Cabinet</td>
<td>Manager</td>
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<td>Evaluation</td>
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<tr>
<td>Dept of Premier and Cabinet</td>
<td>Manager</td>
<td>Telephone interview</td>
<td>Evaluation</td>
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<tr>
<td>NIS</td>
<td>NP</td>
<td>Face to face interview x 2 plus</td>
<td>Evaluation</td>
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<td></td>
<td></td>
<td>telephone and email contact re. data</td>
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<tr>
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<td>GP</td>
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<td>Evaluation</td>
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<tr>
<td>Community based organisation</td>
<td>Welfare staff</td>
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<td>Evaluation</td>
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<td>Evaluation</td>
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<td>Evaluation</td>
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<td>Evaluation</td>
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<td>Lismore City Council</td>
<td>Manager</td>
<td>Email correspondence</td>
<td>Support with locally available data</td>
</tr>
<tr>
<td>NSW Ministry of Health</td>
<td>Health service staff</td>
<td>Telephone meeting and email</td>
<td>Advice about data from HOST and SC1-MHOAT</td>
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<tr>
<td>Queensland University of Technology</td>
<td>Academic</td>
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<td>Possible client feedback</td>
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<td>Evaluation</td>
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<td>Senior health service manager</td>
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<td>Senior health service manager</td>
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<td>Health service staff</td>
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<td>Evaluation</td>
</tr>
</tbody>
</table>
Appendix 3 - Unpublished documents accessed for the evaluation

2004
- NSW Premiers Department, Regional Coordination Program, North Coast. Review of Jungle Patrol Community Safety Street Beat Program. December 2004

2005
- Briefing note to Department of Health to secure funding for Jungle Patrol Street Beat Service written by Julie Byers Julie Byers Regional Co-ordinator North Coast 11 January 2005
- Government Agencies Meeting /Richmond Local Area command office (9 May 2005)
- Nimbin Strategy Discussion Paper Jul 2005
- Nimbin Neighbourhood and Information Centre Inc. (NNIC) Letter to stakeholders (24 August 2005)
- Discussion paper circulated for discussion and consultation with members of the Nimbin community. (July 2005)
- Nimbin community issues working group meeting (22 August 2005)
- Community patrol workshop notes, Nimbin Bowling Club (7 November 2005)
- Nimbin Brief for Tweed Cabinet meeting (from DP&C) – 2005
- Letter to stakeholders from Natalie Meyer (Neighbourhood Centre) on NNIC profile and integrated service delivery in Nimbin (2005)

2006
- Partnership Agreement 2006
- Nimbin working group (6 March 2006)
- Nimbin Strategy: Integrated Health care Worker (May 2006)
- Nimbin Interagency meeting (25 May 2006)
- Response to Premier’s Department – Nimbin Brief for Tweed Cabinet meeting prepared by Julie Byers Regional Co-ordinator Premiers Department – North Coast June 2006

2007

2009
- Nimbin Integrated Community Care NP Scope of Practice document (March 2009)
- PBS/MBS Issues Brief 2009

Nimbin Integrated Services Annual Progress Reports
- First Annual Progress report August 2008
- Second Annual Progress report December 2009
- Third Annual Progress report December 2010
- Extract from 2011 Annual report
- Annual Stats report July 2008 – June 2009 from Genevieve Beggs
The development and implementation of the Nimbin Integrated Services Project 2000-2012

- **Jungle Patrol Community Safety Street Beat Program** funded by State Govt – for community development and crime prevention
- **Nimbin Strategy discussion paper** produced for discussion across community
- **Partnership Agreement signed**
- **January: Nurse Practitioner working full time at Neighbourhood Centre**
- **Street Beat Program begins with volunteers**
- **Nurse Practitioner starts work** (initially located at Nimbin Hospital)
- **Clinical Guidelines (Scope of Practice and Formulary) signed off**
- **Formal evaluation of the Project**
- **5 June – Nurse Practitioner starts work** (initially located at Nimbin Hospital)
- **Funds Identified**
- **Several public meetings held this year. Community concerned about lack of Jungle Patrol, levels of violence, and MH and D&A-related incidents. Agencies at meetings included: health, police, school, NNIC, DoCS, DP&C. + senior executive staff in RGO meetings**

**Clients seen:**
- 120 clients seen Jul 07 - June 08
- 112 clients seen Jul 08 - June 09
- 122 clients seen Jul 09 - June 10
- 119 clients seen Jul 10 - June 11
- 46 clients seen Jul 11 - Feb 12

- **Community-driven request for help**
- **Public meeting called for permanent activation of the vol group to tackle law and order issues**
Appendix 5 – Logic Model

Logic model for the evaluation of the Nimbin Integrated Services project (following Porteous, N. et al 1997 (Porteous, Sheldrick et al. 1997))

**Resources**
- Administration
- Reception
- Venue

**Nurse Practitioner**
- Authorised
- Experienced

**Collaborators**
- NNIC
- Nimbin Hospital
- NNSWLHD
- Police
- Department of Premier and Cabinet
- DoCS
- D&A services
- MH and ACS
- Probation and Parole
- Nimbin School/DET
- Nimbin Health

**Clients**
- People requiring health and welfare assistance Nimbin Community
  - Mental Health Clients
  - Dual Diagnosis Clients
  - Transient population

**Inputs/Components**
- Clinical Services
- Education
- Case Management
- Client Advocacy
- Community Development

**Activities**
- Flexile, immediate, short and long term support to clients
  - 419 new (not returning) clients seen since the NIS was established
  - 102 returning clients seen since the NIS established
  - One third self-referred clients
  - 20% of clients were in emergency or crisis situations
  - NP sees 4-5 clients per day

**Target Groups**
- Flexible, immediate, short and long term support to clients
  - 419 new (not returning) clients seen since the NIS was established
  - 102 returning clients seen since the NIS established
  - One third self-referred clients
  - 20% of clients were in emergency or crisis situations
  - NP sees 4-5 clients per day

**Outcomes**
- Continuity of care for clients in the Nimbin Community
- A well-used and accessible service
- Taken the pressure off other services
- Provided professional development and support for other staff
- Evidence of collaboration between services
- Contribution to reduction in violence in Nimbin
- Contribution to reduction in MH presentations at Nimbin ED