

Rural mental health service delivery models – a literature review

Prepared for Mid North Coast Local Health District



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We acknowledge this country as belonging to the Aboriginal and Torres Strait Islander peoples of Australia. Australia is the only place in the world where Aboriginal and Torres Strait Islander Australians belong. There is no place in Australia where this is not true.



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Introduction

Australian mental health services have matured significantly over the last 30 years following the initial ructions of the processes of de-institutionalisation. Services have evolved and matured, seeking to obtain both comprehensiveness and balance between institutional and community care. In some aspects of service delivery (particularly prevention and promotion) the Australian mental health system has obtained wide recognition from other countries (Parham, 2005).

Australia's journey in the development of its mental health services can be somewhat 'tracked' through study of the evolving National Mental Health Strategy and successive National Mental Health Plans, the fourth and last of which provides a view of current thinking (Gallagher, 2009). In the latest Plan eight principles have been agreed that underlie the thinking of the Plan and provide direction to actions:

- Respect for the rights and needs of consumers, carers and families;
- Services delivered with a commitment to a recovery approach;
- Social inclusion;
- Recognition of social, cultural and geographic diversity and experience;
- Recognition that the focus of care may be different across the life span;
- Services delivered to support continuity and coordination of care;
- Service equity across areas, communities and age groups; and,
- Consideration of the spectrum of mental health, mental health problems and mental illness.

While the progress forged through national planning and increased funding has been impressive, the mental health system in Australia remains fragmented and as a consequence presents problems to consumers and carers in continuity of care and gaining access to services actually needed and promotes system inefficiency through inappropriate funding allocation — resulting in service duplication and / or service gaps. The Fourth National Mental Health Plan summed it up as follows (Gallagher, 2009, p41):

"... despite increased funding to primary and specialist services, treatment rates for people with mental illness remain low compared with the prevalence of illness. For access to the right service to be improved, there needs to be an agreed range of service options, across both health and community support sectors. This should be informed by population based planning frameworks that specify the required mix and level of services required, along with resourcing targets to guide future planning and service development that are based on best practice evidence."

The continued existence of problems in mental health services delivery needs to be placed in the context of an overall willingness in the system to change, generally fostered at the national, state and territory and local jurisdictional levels. And while some parts of the system at an operational level may resist change (Fuller et al, 2004) there is ample evidence to suggest significant evolution of services is occurring.

The potential for change in service delivery thinking in the Mid North Coast Local Health District (LHD) is particularly fertile. Following the split of North Coast LHD and Mid North Coast (MNC) LHDs, MNC finds itself facing the challenge of having to be self-sufficient with a shortage of staff and beds. Providing further impetus, the NSW Mental Health Commission is developing a plan to refocus mental health services to better meet the needs of consumers and carers. This may provide opportunities for MNC to trial new service models and provide evidence about their feasibility and effectiveness.

The population projections for MNC suggest that the impact of current staff and bed shortages will exacerbate, particularly in relation to the aged and aging population and that new models of service

delivery will be required. Some changes can be examined such as the possible redesignation of hospital beds but this may require capital investment and/or changes in legislation with respect to the designation of mental health beds.

MNC would like to base its new mental health service models on the best available evidence. Examples of evidence based service delivery systems include hospital alternatives such as crisis intervention, and acute home treatment teams, police and mental health liaison teams, early intervention teams, primary health liaison, community based residential respite facilities, assertive community treatment teams, care coordination and support systems, vocational and longer term supported housing systems, systems to address comorbid conditions, and peer worker models.

A recent literature review by Harte and Bowers (2011) summarises some of the evidence from studies of service delivery models in both rural Australia and overseas. There are a number of Australian rural mental health plans that also provide innovative service models and useful detail. This report builds on those efforts to try to identify mental health service models that might be appropriate for consideration in the MNC LHD.

Methodology

The service models and discussions in this report are derived from searches within both academic databases and grey literature. After initial discussion with the research team a list of key words was searched for within *Medline*, *CINHAL* (Cumulative Index to Nursing and Allied Health Literature), *Cochrane Reviews* and *PsychInfo*. These keywords included *community mental health, service model, integrated mental health care, life course model, peer services, peer worker models, rural, mental health, service delivery, organisation, equity and mental health care, primary health care, governance, client-centred, care plans, models of collaboration, review*. These key words were searched individually and in combination with accompanying keywords. Only literature that was published in the English language and related to humans was searched.

In searching for mental health care models appropriate for the Aboriginal community the Centre for Rural and Remote Mental Health's Aboriginal Social and Emotional Wellbeing Senior Advisor, Len Kanowski was approached. Kanowski provided the research team with key articles, models and researchers to follow up. This was particularly necessary given some of the models and case studies of mental health service delivery can only be found in the grey literature, although some articles had been published in academic journals. The tacit knowledge shared by Kanowski added a holistic and culturally appropriate dimension to this methodology and final report.

Other information in this report was found outside of academic databases, in the grey literature. Key organisations and think-tank web sites were searched including the *Sax Institute*, *The Kings Fund*, *Sainsbury Centre* and the *Milbank Memorial Fund* as well as Commonwealth and State / Territory health authority websites. Citations in relevant articles were also pursued.

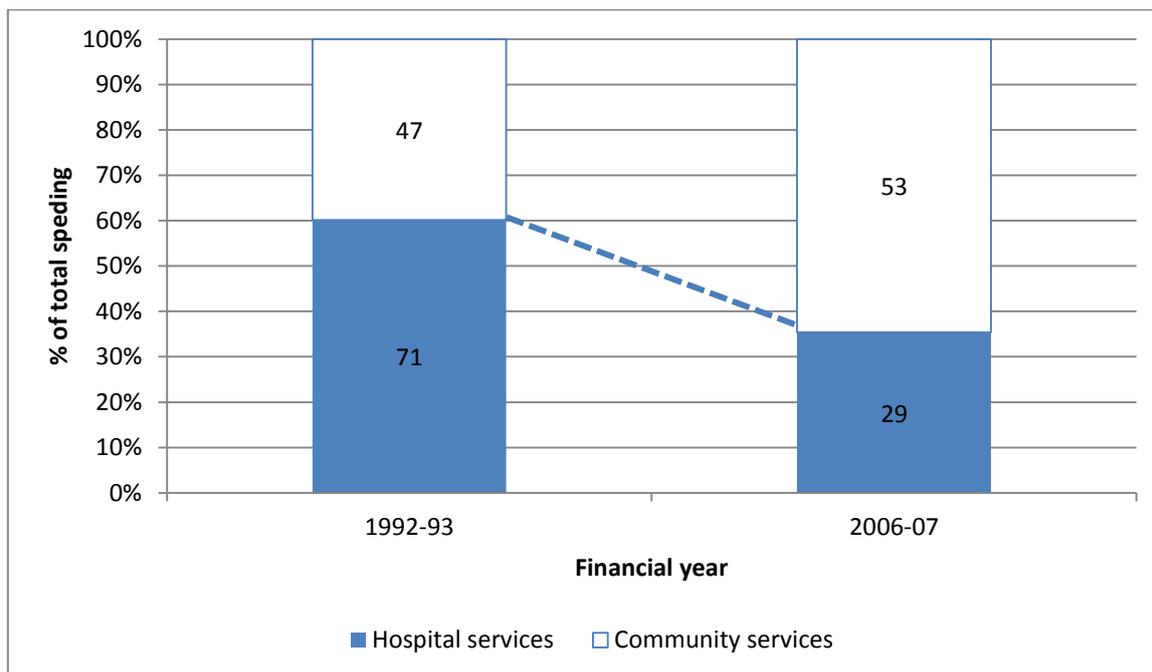
All literature found relevant to this report was managed in an EndNoteX7 library.

Service model thinking

Service components

Since the mid 1980's there has been a significant 'dis-institutionalisation' movement in Australia that has inexorably shifted specialist mental health services from an emphasis on acute inpatient care services to community based care. This shift is illustrated in Figure 1 taken from the Fourth National Mental Health Plan (Gallagher, 2009).

Figure 1: Allocation of total state and territory spending on hospital and community based specialist mental health services, 1992–93 and 2006–07



This has fuelled some debate about an ideal mental health services mix and appropriate levels of funding, more particularly the ideal relative service utilisation of different types of mental health services. Flannery et al (2011) in a review of the literature have concluded that there is insufficient evidence to support a single ‘formula’ to define an ideal mental health service, although Thornicroft and Tansella (2004, p 288) at least concluded that:

“... there is no compelling argument and no scientific evidence favouring the use of hospital services alone. On the other hand, there is also no evidence that community services alone can provide satisfactory and comprehensive care. Both the evidence available so far, and accumulated clinical experience, therefore support a balanced approach, incorporating elements of both hospital and community care.”

The bare bones of a ‘balanced’ approach to service delivery can be found in the World Health Organisation’s suggested optimal mix of mental health services which includes specialist mental health services (long stay inpatient facilities, community mental health and specialist psychiatric services), mental health services provided through primary health care services, what they call ‘informal’ community care¹, and self-care (World Health Organisation, 2003).

In Australia early attempts to systematically describe the components of a comprehensive mental health service are embodied in the modelling of the NSW public health system (NSW Department of Health, 2001). The model identifies a range of services that need to be delivered including²:

- Assessment (including physical exam and investigations, second opinions, tertiary service assessment (e.g. for early psychosis, , forensic, eating disorders, neuropsychiatric, affective disorders, post natal depression, personality disorders, dual diagnosis);

¹ These are services provided in the community but are not part of the ‘formal’ health and welfare system and might include peer support workers, police, teachers, etc.

² This 2001 work has formed the foundation for current work on the ‘National Mental Health Service Planning Framework’ (NMHSPF) fulfilling an initiative of the Fourth National Mental Health Plan. A Framework is due to be published in early 2014.

- Review (including for acute and stable / maintenance stages);
- Individual therapy (including medication, psychotherapies, living skills, social skills, rehabilitation);
- Group therapy;
- Tertiary service treatment;
- Consultation / liaison;
- Supported accommodation; and,
- Mental health prevention / promotion.

The model is somewhat agnostic on the settings in which these services can be delivered and allows for the following locations:

- Community based outpatient services;
- Extended hours / crisis services;
- Acute inpatient services including general acute beds, observation beds and Tertiary service acute beds;
- Non acute inpatient services (up to 90 days);
- Very long inpatient services (365 days);
- Forensic beds (long term); and,
- Supported community accommodation (“step down”³).

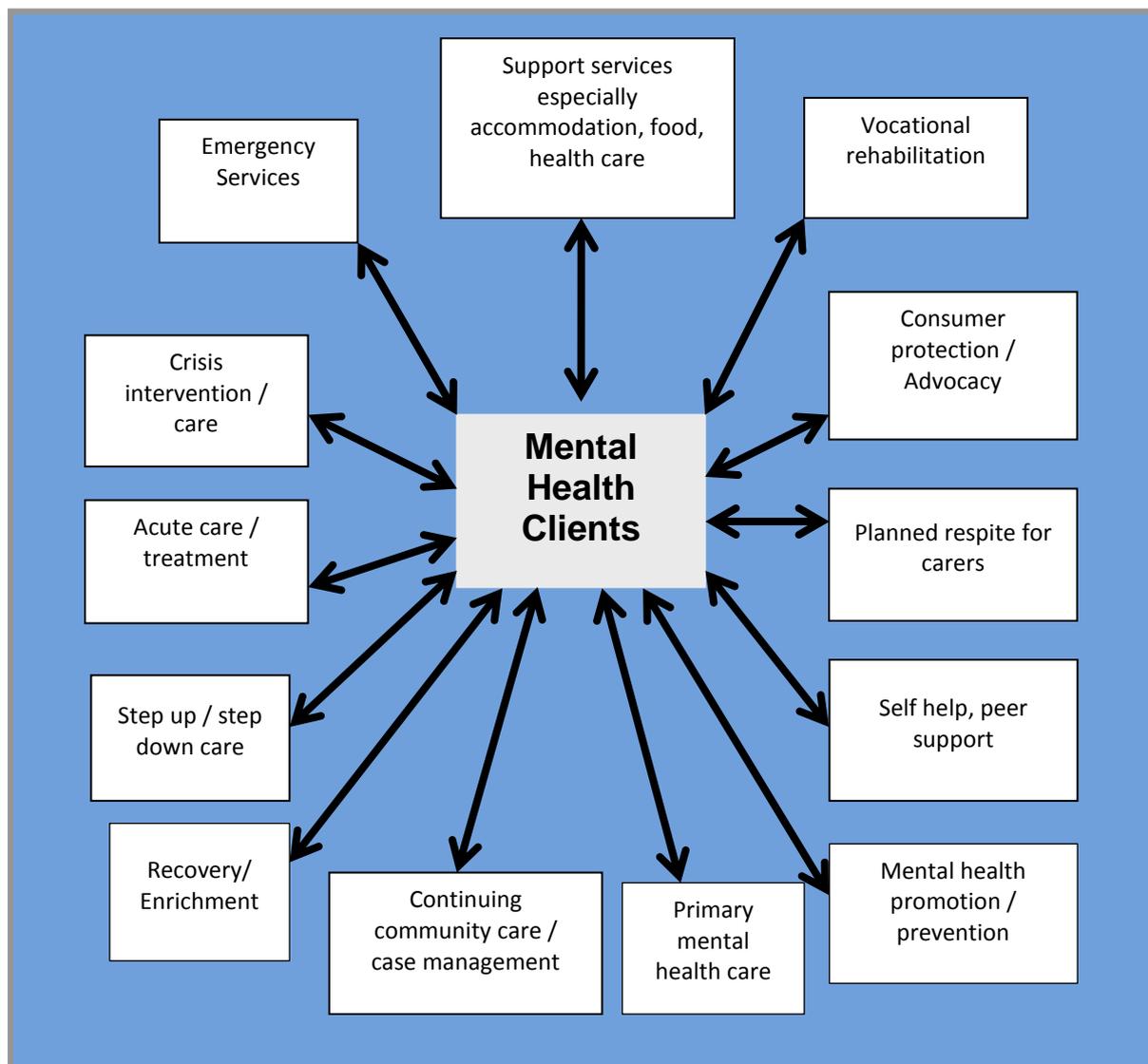
Note the services listed are confined to what might generally be considered as public sector ‘specialist’ mental health services, reflecting the target audience for the model. A broader approach to the key component requirements of a modern mental health service is offered by Flannery et al (2011) who include in their list acute and emergency response (in both the hospital and community settings), community continuing care services (including longer term care coordination), assertive rehabilitation teams, partnerships with general practitioners and with other human services agencies, supported accommodation and early intervention programs targeting young people experiencing their initial onset of mental illness.

There are many other similar such lists of services to those above attempting to establish a statement of what a comprehensive mental health service should provide (for example Thornicroft, 1999; Metropolitan Health and Aged Care Services Division, 2002; Healthcare Management Advisors, 2003; O’Kane and Tsey, 2004; Department of Health & Human Services, 2005; Sundararaman, 2009). Many authors also explicitly identify health promotion / prevention activities (e.g. Commonwealth Department of Health and Aged Care, 2000; Parham, 2005) as part of the required suite of services, but often this is done in isolation from ‘treatment’ services.

All of the thoughts of these documents are distilled into a simple summary of service components required developed by Santos and Ridoutt (2005) after extensive stakeholder interviews conducted in the Central Coast area of NSW (see Figure 2 below).

³ In 2001 when the NSW model was conceptualised ‘Step down’ services were more like older style ‘half-way house’ alternatives. In the intervening years the concept has evolved more to a ‘Step Up /Step Down’ service which provides an early intervention (to consumers in the community at risk of being hospitalised) or early discharge (for persons leaving acute care) option for people as an alternative to hospitalisation or after discharge from hospital. These services are normally considered to be a residential facility that will provide mental health care to those experiencing acute mental health symptoms and those who may not be ready to return to their homes. They can often be described as ‘community based beds’. Bower and Gilbody (2005) note two fundamental features of stepped care — (1) provision of the least restrictive treatment option available (2) in a ‘self-correcting’ mechanism (which focuses on whether health gains continue to be achieved).

Figure 2: Summary of components of comprehensive mental health service



Evidence for different components

As noted in the previous section there is limited evidence on the right approach to adopt in determining what combination of the above components is broadly appropriate, or even appropriate for a particular service setting, other than Thornicroft and Tansella's (2004) broad claim of support for a balance between acute hospital and community services. In truth much of the literature in this area is narrative in nature and when not arguing for comprehensiveness seeks to hedge recommendations in relation to specific circumstances.

Much more research is reported on evaluation of individual service components, in particular those services that represent growth outside of the more traditional elements of specialist mental health services. Thus the spotlight has shone most on the community based components of mental health services, especially the continuing community care, peer support, step up / step down, primary mental health care and recovery service components in Figure 2 above.

This level of scrutiny has arisen because many authors have claimed the dominant way of delivering community mental health care especially through one-to-one, in person visits to a mental health professional is not viable to cope with the true extent of demand on mental health services (e.g. Kazdin and Rabbitt, 2013), given that most estimate that currently up to 70% of people with a

mental health issue are not receiving professional mental health care (Boston Consulting Group, 2006; Gallagher, 2009; Australian Institute of Health and Welfare, 2012). Accordingly, a range of models for enhancing either the scope or efficiency of community care services have been mooted and tested both in Australia and overseas.

Arguably, especially in Australia, different ways of developing mental health services in the primary care sector has been most explored of new service component options. There is strong support for the role of primary care in the management of *any* chronic illness (Rothman and Wagner, 2003), based on the following logic:

- Chronic diseases have a broad spectrum of severity with most patients at the less severe end;
- For most patients with more prevalent chronic illness the pharmacologic regimens involve a limited number of non toxic drugs;
- Most adult patients have more than one chronic condition demanding therefore a more generalist approach to care coordination; and,
- Expertise in behavioural change and self-management support is critical to successful care.

These same authors and others from the same United States research persuasion (e.g. Wagner et al, 2001) identify six principles for successful management of chronic disease conditions in a primary care setting including:

- Population identification process;
- Evidence based practice guidelines;
- Collaborative practice models;
- Patient self-management;
- Process and outcomes measurement; and,
- Routine reporting and feedback loops, especially to the patient.

Some of these elements will be covered later in this report.

Most initiatives in the primary mental health care space have focused on general practitioner support or engagement (e.g. Foy et al, 2010; Fuller et al, 2011; Reid et al, 2011). Actions to more fully engage GPs has included building their competence (for instance developing a capacity to practice cognitive behavioural therapy), supporting them through consultation and liaison from psychiatrists or other mental health specialists, and / or co-locating specialist mental health professionals in general practices on a casual or routine basis. By and large this type of service model is widely supported (Fuller et al, 2011; Perkins et al, 2010) and has been shown to deliver services to a wider number of consumers, especially those with low prevalence mental health disorders (Clark et al, 2009). For instance Kates and Mach (2007, p 77) found through a meta-analysis of Canadian literature that management of depression in primary care was associated with ...

“... improved outcomes in terms of symptom reduction, relapse prevention, functioning in the community, adherence to treatment ... and satisfaction with care received.”

Since 2002, the Victorian Government has attempted to more formally and comprehensively engage general practitioners (and other primary health care workers) through Primary Mental Health and Early Intervention (PMHEI) Teams in each of their 21 Area mental health services. The key objectives of the PMHEI teams are to support and enhance the capacity of a range of primary care providers to recognise and treat mental health problems and disorders more effectively, via the provision of education, training and secondary consultation, promote shared care arrangements between

specialist mental health services and primary care providers, and provide early intervention services to young people who are experiencing the early signs and symptoms of first episode psychosis. The service model is intended to have a dual focus - approximately 50% training and secondary consultation type services and 50% direct services through shared care.

A 2005 review of PMHEI teams (Centre for Program Evaluation, 2005) found typical team activities have included conducting patient assessments; carrying out short-term treatment; discussing patients informally; telephone consultations; holding education sessions and running workshops. While most teams were judged to be effective, the establishment of the Youth Early Psychosis Program and new MBS funded services (Better Access) had confused the role somewhat of many teams. Moreover teams had encountered many barriers when attempting to engage GPs. These have included:

- Pressure of time for the GP, e.g. having limited time to sit in on assessments;
- Some GPs preference for the PMHT to take over responsibility for mental health patients (rather than share care or be supported in a primary care role);
- Difficulties engaging GPs in formal education and training;
- A lack of interest in mental health care by a proportion of GPs; and,
- Lack of interest from GPs who work in high socio-economic status areas, where patients can be referred to private providers (facilitated subsequently by Commonwealth Government programs like *Better Access*).

Efforts to involve general practitioners in mental health service delivery have always been subject to the willingness of GPs to engage with mental health patients, and their competence to provide effective services, both of which has been highly variable (Fuller et al, 2004). In rural areas the challenges to engaging GPs have been generally considered greater (though not insurmountable, Dunbar et al, 2007), requiring on the part of mental health workers according to Allan (2010, p 311):

“... a good understanding of the pragmatic and practical realities of their day to day practice and the philosophies that underpin these.”

While most research attention has been on primary care medical practitioners, other players in the primary care space have also been the focus of several studies. This includes maternal and child health nurses (Harvey et al, 2012), social workers (Thiel et al, 2013) and psychologists (Gunn and Blount, 2009). Kendall et al (2007) reporting on Victorian statistics, identified a number of primary care workers whose client case load involves a high proportion of people with mental health problems. The main four were:

Drug & alcohol workers	approximately 50% of total client presentations
Child protection workers	23% of parents plus high levels of morbidity in children
Housing support workers	at least 30% of homeless, at least 50% of public housing high-risk tenancies
Justice workers	at least 25% of youth and adult offenders

The Centre for Program Evaluation (2005) similarly found that PMHEI teams in Victoria were preoccupied with GPs but believed they could, resources permitting, increasingly turn their attention to working with other primary health and support services including:

- Local Community Health Centres;
- Psychiatric disability rehabilitation and support services;
- Drug and alcohol programs;

- Youth and family support agencies;
- Sexual assault centres;
- Home and community care workers;
- Maternal and child nurses; and,
- The Royal District Nursing Service.

Kendall et al (2007) have developed detailed suggestions for how to engage with these non medical, indeed non health in some cases, primary care workers and to develop their capacity to better meet the needs of persons with a mental health problem and deliver them better long term life outcomes.

Another service component that has been well studied has been case management, often otherwise termed as a 'brokerage', 'intensive', 'strengths' or 'clinical' approach (Flannery et al, 2011), a 'linkage' approach (Thiel et al, 2013) or a 'navigator' approach (Anderson et al, 2009). Thota et al (2012) describe the use of case managers to link primary care providers (including support and rehabilitation services), patients, and mental health specialists. In addition to case management support, Thota et al (2012) consider this model also includes primary care providers receiving consultation and decision support from mental health specialists (i.e., psychiatrists and psychologists) such as in the services described above. Case management is designed to (1) improve routine screening and diagnosis of mental health disorders; (2) increase provider use of evidence based protocols for the proactive management of diagnosed disorders; and (3) improve clinical and community support for consumer engagement in treatment goal-setting and self-management.

A particularly celebrated example of the case management service model implemented in the UK to significantly improve broader mental health service delivery reach and effectiveness is described by Thiel et al (2013). They evaluated a pilot scheme in Sandwell, at the heart of which was a team of 'link' workers who provide care coordination for complex patients (see Box 1).

This type of case coordination provided by a multi-disciplinary team Flannery et al (2011) might categorise as 'assertive outreach' services.

Broadly there is good support for the effectiveness of case management services but they can be resource demanding and therefore attract negative attention on the basis of cost effectiveness. Flannery et al (2011) has examined this debate and determined that an apparent poor cost effectiveness verdict could be more the consequence of difficulty in researching the issue. Where poor cost effectiveness has been decidedly proven, they argue that this can most often be the result of services not being directed at the right type of consumers (that is those with more complex problems).

The recently established and implemented Commonwealth Government initiative 'Partners in Recovery (PIR)' takes this latter

consideration into account, targeting its resource intensive services to only 24,000 Australians experiencing severe and persistent mental illness with complex needs that require services from

Box 1: The Sandwell Integrated Primary Care Mental Health & Wellness Service

The model funds a number of 'link' workers who act as navigators for clients with mental health problems as they attempt to access and negotiate the health and social care system. Link workers typically have a social worker background or could have personal experience with mental health problems (peer workers). Workers can refer patients to a wide variety of health or community sector services such as social services, financial advice agencies, substance abuse counselling, therapeutic services and peer support groups. Link workers form close relationships with their clients, building their confidence and self-esteem. They visit clients at home and accompany them to appointments if required. Link workers will also show clients simple wellbeing interventions such as relaxation techniques, but the main focus of their work is co-ordinating care services. Link workers stay with clients as long as necessary till recovery goals are achieved.

multiple providers, from multiple sectors, with more serious mental illness. The PIR initiative is a very similar approach to the service delivery model adopted by the Sandwell service but tries to build on ground level client specific efforts with more systemic and innovative collaboration outcomes. A total of 61 areas throughout Australia have been established roughly equivalent to Medicare Local boundaries in each of which a consortium of mostly non government organisations, whose primary or significant target group is persons with a mental health problem, led in most cases by a Medicare Local (although not exclusively), has been funded to provide PIR services. The PIR initiative for the North Coast consists of a consortium of nine non government organisations including drug and alcohol and Aboriginal health services and is unusually not led by a Medicare Local. The broad initiative is described briefly in Box 2.

Box 2: Partners in Recovery (PIR)

The PIR initiative targets the small proportion of the Australian population with severe and persistent mental illness that experience complex needs requiring high levels of inter-agency collaboration and individualised recovery pathways. The PIR is meant to work through

building stronger partnerships between sectors, services and supports, to ensure individuals are able to access the services and supports needed to sustain and support their optimal health and wellbeing.

In practice, this translates mostly to PIR consortium member organisations employing ‘support facilitators’ who undertake a comprehensive assessment of individual client support needs and develop a PIR Action Plan to guide engagement of partners and integrate service delivery.

Case management is most often provided by a mental health professional but can also be provided as noted in the quote above from Thiel et al (2013) by an allied health professional (for instance a social worker) or a non professional (for instance a peer worker).

The peer support worker, despite extensive use for many years in therapeutic group settings, is a more recent focus of attention in the mental health services context. Pitt et al (2013) have coined the term ‘consumer-provider’ and identified a range of roles including peer support, coaching, advocacy, case management or outreach, crisis worker or assertive community treatment worker, or providing social support programs.

Oades et al (2012) also note that peer support itself is not a single concept and that there are several schemes that have been used to describe the different forms that peer support initiatives can take. They first classify peer support groups according to purpose viz.:

- Remedial, focusing on the personal processes of recovery;
- Interactional, emphasising the interpersonal relationships and personal experience; and,
- Social- integrating the personal, interpersonal and political. The social classification involves social change and empowerment.

An alternative way to look at peer support they suggest is in terms of the role of the consumer in the service delivery as follows:

- Naturally occurring mutual support groups;
- Consumer-run services; and,
- The employment of consumers as providers within clinical and rehabilitative settings.

Because of this variety in the ways peer support services can present and operate, Pitt et al (2013, p23) found it difficult, in a review of 11 programs, to assess the effect of peer support programs. They concluded though that:

“...Involving consumer-providers in mental health teams results in psychosocial, mental health symptom and service use outcomes for clients that were no better or worse than those achieved by professionals employed in similar roles, particularly for case management services.”

Peer support service models are aligned with service models that embody the recovery approach, a conceptual framework which has become a major focus of national efforts (Gallagher, 2009; Brown, 2013) and consequently state and territory strategy (e.g. Department of Health & Human Services, 2005). The recovery approach forms the first priority of the Fourth National Mental Health Plan—2009–2014 (Gallagher, 2009, p13):

“Mental health service providers should work within a framework that supports recovery both as a process and as an outcome to promote hope, wellbeing and autonomy. They should recognise a person’s strengths including coping skills and resilience, and capacity for self determination. This may require a significant cultural and philosophical shift in mental health service delivery.”

Browne and Courtney (2006) lament that so far many efforts by service providers to animate a recovery approach are considered by consumers to be tokenistic.

Consumers themselves seemingly believe that the approach can be most practically expressed at the primary health care level where support of social and emotional wellbeing as well as more integrated mental health care can be achieved (Haswell-Elkins et al, 2009). Additionally, most of the attempts to introduce self-help have been made within the primary mental health care setting, such as guided self-help clinics (Farrand et al, 2009), self-help booklets and guided self-help interventions (Lucock et al, 2011) and personal planning and self-care management (Gillard et al, 2012). Most of these approaches have shown a degree of promise. A treatment approach developed for persons with a mental health problem in remote Indigenous communities that incorporated self-management principles and engaged family support was shown to deliver statistically significant positive changes in mental health outcomes (Nagel et al, 2009).

A summary of the assessed worth of these newer forms of models of care is provided in Table 1 below. The literature cited in Table 1 is by no means comprehensive, but begins to provide some support for the adoption of these different service components.

Table 1: Assessment of selected components of mental health service delivery

Mental health service component	Evidence support for effect	References
Primary mental health care	+ve	Kates and Mach, 2007
	+ve	Reid et al, 2011
	+ve	Foy et al, 2010
	+ve	Perkins et al, 2010
	+ve	Harvey et al, 2012
Case management / assertive outreach	+ve	Thota et al, 2012
	+ve	Thiel et al, 2013
	+ve	Clark et al, 2009
	Inconclusive	Flannery et al, 2011
Peer support	Inconclusive	Anderson et al, 2009
	+ve	Gillard et al, 2012
	+ve	Oades et al, 2012
	Inconclusive	Pitt et al, 2013

Mental health service component	Evidence support for effect	References
Recovery / self-help	+ve	Lucock et al, 2011
	+ve	Farrand et al, 2009
	+ve	Richards et al, 2003
	+ve	Hyde 2013
	+ve	Nagel et al, 2009

What components where? — Rural and remote application

Many authors argue on equity grounds the need for people living in rural and remote areas to have similar access to mental health services as those living in urban areas (Dunbar et al, 2007). Clearly though, in many sparsely populated areas of Australia achieving this ambition in terms of providing all of the services identified in Figure 2 is not feasible (Henderson et al, 1991; O’Kane and Tsey, 2004; Humphries et al, 2008), a point well-articulated by the Victorian Government Department of Human Services (2007, p 17):

“Rural public mental health services are delivered in a context of community expectations regarding quality, timeliness and effectiveness. Providing an adequate and sustainable level and mix of core services to small rural and remote communities continues to be a critical challenge ...”

Invariably then modellers of rural mental health services have attempted to design structures that deliver as much of Figure 2 as possible, as feasibly close to consumers as possible. The interesting question in these attempts is how, that is on what decision making criteria, are services determined to have achieved the greatest level of access whilst still maintaining acceptable service quality?

Thornicroft and Tansella (2004) offer a service distribution model based on **level of resources**. They identify three resource settings viz. ‘low’, ‘medium’ and ‘high’ (which they do not define) and describe the service components that could be sustained at each of these levels of resource availability. It is a ‘nested’ model, in so far as services available at the lower resource levels are also available at higher levels of resources.

At the lowest level of resource availability they suggest mental health services should be delivered exclusively within the primary care setting with specialist back-up. This includes:

- Screening and assessment by primary care staff;
- Talking treatments, including counselling and advice;
- Pharmacological treatment;
- Liaison and training with mental health specialist staff, when available; and,
- Limited specialist back-up available for:
 - training
 - consultation for complex cases
 - inpatient assessment and treatment for cases that cannot be managed in primary care.

Where a medium level of resources is available they argue for mainstream mental health care. This includes (as well as the services noted above):

- Outpatient/ambulatory clinics;
- Community mental health teams;
- Acute inpatient care;

- Long term community-based residential care; and,
- Employment and occupation services.

If a high level of resources is available then they advocate specialised/differentiated mental health services. This includes:

- Specialised clinics for specific disorders or patient groups, such as eating disorders, dual diagnosis, adolescent services;
- Specialised community mental health teams, including:
 - early intervention teams
 - assertive community treatment
- Alternatives to acute hospital admission, including:
 - home treatment/crisis resolution teams
 - crisis/respite houses
 - acute day hospital
- Alternative types of long stay community residential care; and,
- Alternative forms of occupation and vocational rehabilitation.

A second and alternative way of looking at the distribution of services is on the basis of **population size**. The Victorian framework to guide the enhancement of public rural mental health services (Victorian Government Department of Human Services, 2007) identifies four distinct population sizes (meaningful in the Victorian context but probably with more general Australian relevance) at which service planning can be targeted viz.:

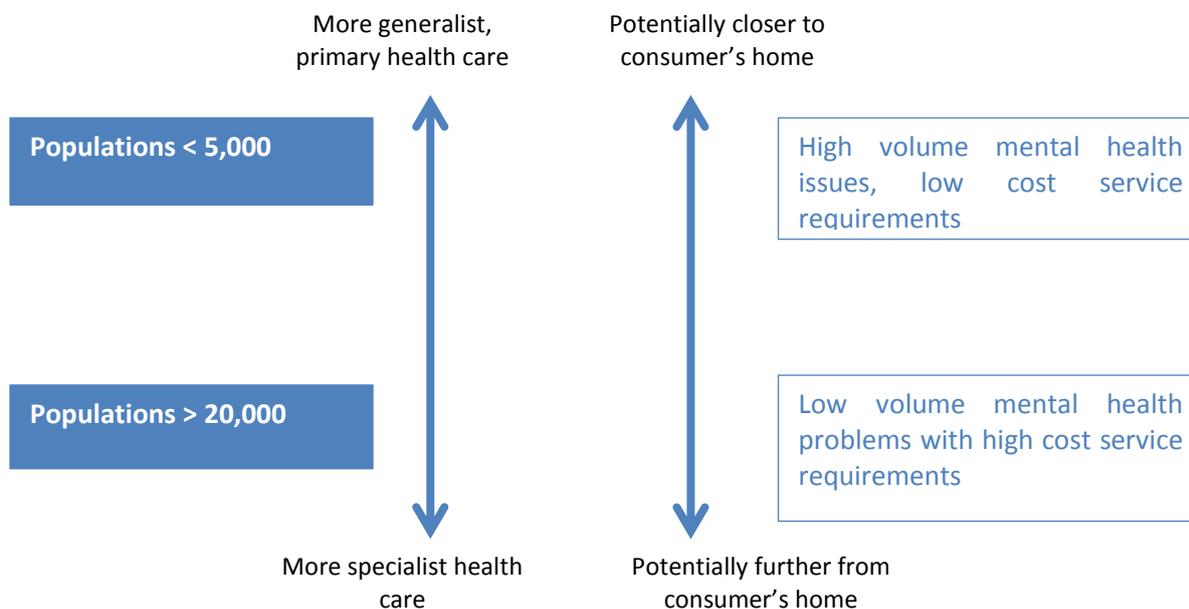
- Populations over 20,000 (regional centres);
- Populations between 5,000 and 20,000 (districts);
- Populations between 1,000 and 5,000 (towns); and,
- Populations of less than 1000 (small communities).

What specific services can or should be provided for each of these population sizes is not specified in the framework, the authors of the framework wishing to foster flexibility and innovation rather than provide prescriptions. By way of a broad guideline though the framework emphasises ‘sustainability’ and suggests that a perspective on what is sustainable might be found through (Victorian Government Department of Human Services, 2007, p17):

“Balancing the competing need for local access against the requirement to maintain appropriate standards of care and adequate levels of specialist care ...”

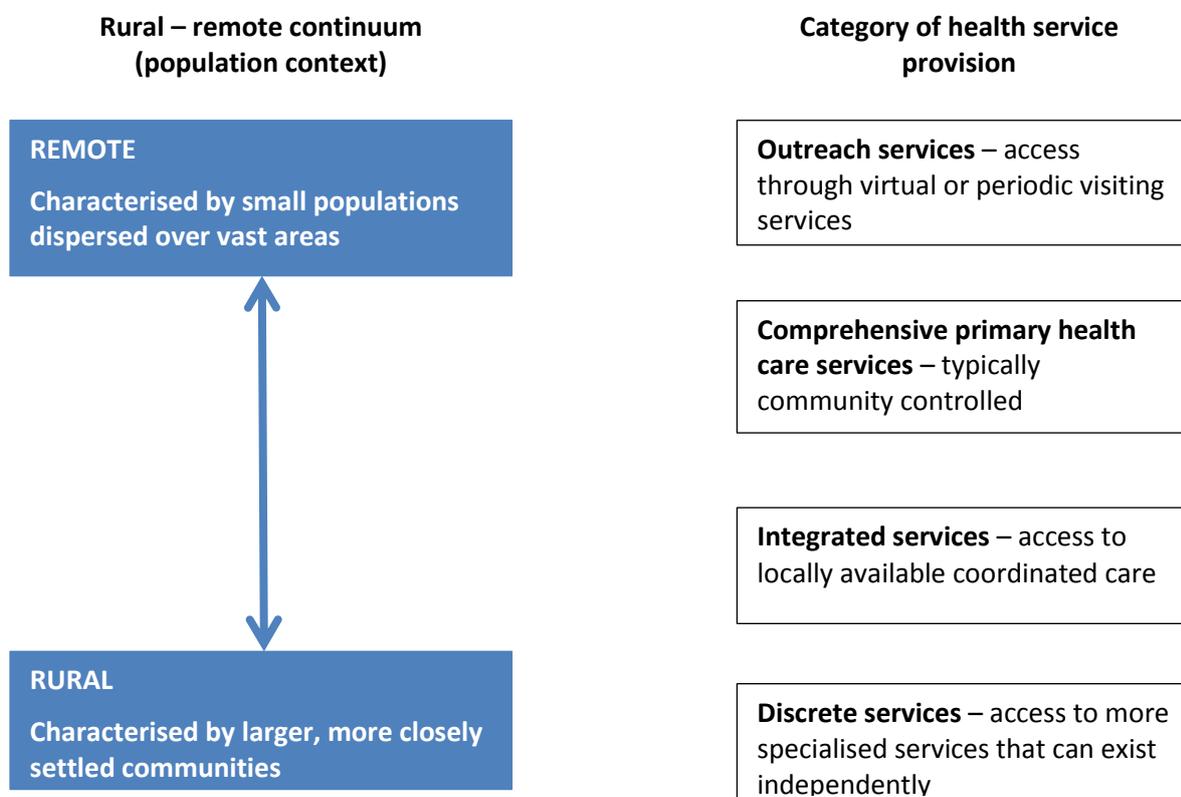
The other guidance provided is to associate higher cost services, which are generally provided for less frequently occurring more serious cases of mental illness, with higher population centres on the basis that the number of cases generated in such centres will justify the required infrastructure investment. Of course, for smaller population sizes the reverse applies, providing a simple ‘formula’ as shown in Figure 3.

Figure 3: Mental health services distributed on the basis of population size



The Victorian rural mental health framework is close conceptually to a broader and more influential model of rural (primary care) health service provision also based on population size (Humphries et al, 2008). This model is illustrated in an abbreviated form in Figure 4.

Figure 4: Typology of rural and remote primary health care service delivery models



It is possible, since both are based on population size, to draft a composite model which combines the elements of both the Victorian rural mental health framework (2007) and the model of Humphries et al (2008) to put meat onto the bones of the former framework and identify more explicitly what types of mental health service components might exist at each level of population. This is attempted in the Table below:

Table 2: Types of mental health service components at population levels

Population context	Mental health service examples
Populations of less than 1000 (small communities)	<ul style="list-style-type: none"> • Assertive outreach services • Tele-psychiatry assessments • Comprehensive primary health care services • Recovery
Populations between 1,000 and 5,000 (towns)	<ul style="list-style-type: none"> • Self-help • Shared primary health care / screening / specialist consultation - liaison and training support • Support services, especially accommodation • Consumer protection / advocacy
Populations between 5,000 and 20,000 (districts)	<ul style="list-style-type: none"> • Rehabilitation • Employment & occupation services • Multi-purpose services • Continuing community mental health care • Case management
Populations over 20,000 (regional centres)	<ul style="list-style-type: none"> • Acute care beds • Specialised community mental health teams • Crisis intervention / emergency care • Respite for carers

When viewed in this way the three models discussed above (Thornicroft and Tansella, 2004; Victorian Department of Human Services, 2007; and Humphries et al, 2008) begin to look very similar and essentially all default to resources availability models (since population size is closely correlated with funding availability, O’Kane and Tsey, 2004).

Harte and Bowers (2011) attempt to wrap up all of the above thinking in a ‘hub and spoke’ model of mental health service delivery. The ‘hubs’ are to be located in larger regional centres and along with providing a range of ‘discrete’ services (e.g. acute care facilities, mental health teams, secure rooms, etc.) they are specifically developed to provide support to rural and remote ‘spokes’. In the rural spokes there would be some embedded specialist mental health workers, but the majority of the mental health services would be provided by supported generalist, primary health care service providers. In the remote ‘spokes’ specialist mental health services would only be available on a virtual or visiting capacity, and in situ capacity would be limited to primary care services supported from the ‘hub’.

The value of this model is that it makes explicit what is only implicit in the other models — the responsibility of mental health services in larger population centres for supporting delivery of services in smaller and more remote population contexts. Harte and Bowers (2011) go further to implicate the need for urban mental health service providers to also take responsibility for supporting rural providers, a theme echoed by Henderson et al (1991) and more broadly by Gadiel and Ridoutt (1995), who advocated formal contracting out of rural specialist services (at least

specialist medical services) to larger and more resource rich urban services⁴. The Victorian Government Department of Human Services (2007) notes that, at a minimum, urban services can provide consultation – liaison support, tele-psychiatry services, child and adolescent mental health services, very specialised clinics, and clinical supervision and training support.

Mechanisms of collaboration

Calls for collaboration

As discussed in earlier sections mental health services in Australia are delivered across a broad range of settings by a wide range of specialist and community support services, each of which is funded and managed largely independently. Service fragmentation in this circumstance is hardly surprising. Calls to minimise the amount, and effects of fragmentation on the operation of mental health services through greater collaboration between service components has been a recurrent theme in the literature for many years (Hickie and McGorry, 2007; Whiteford and McKeon, 2012), nowhere more fervently than in literature for rural services (Fuller et al, 2004; Dunbar et al, 2007). All the current national and jurisdictional mental health policy frameworks encourage collaboration of mental health services, especially to enable delivery of recovery treatment models for mental health service clients.

The Fourth National Mental Health Plan (Gallagher, 2009) for instance focuses on a holistic response to mental health care within a population health framework. Therefore linkages between different government sectors and with community mental health services must be made to improve the mental health and wellbeing of the whole community. The Plan has five priority areas with designated actions that require a whole of government and community response.

“While recognising that different service types and locations are important, services across the spectrum of age and need should be developed and delivered in a way that reduces the risk of people falling through gaps, reduces unnecessary duplication and complexity and promotes information sharing. This depends on both collaboration between services at all levels, and integrated models of service delivery.” (Gallagher, 2009, p14).

Calls for collaboration should not go unchallenged through an act of blind faith. As Hoge and Howerstine (1997, p176) have noted:

“Despite the current value placed on service integration in the field of psychiatry, outcome research on the effects of integration (collaboration) has typically yielded an absence of positive findings in terms of impact at the client level.”

This perspective is shared by others who have extensively reviewed the literature (e.g. Goldman et al, 2002⁵). However, even those researchers who question the evidence at hand are still reluctant to dismiss collaborative effort, arguing that the concept of collaboration should not be sacrificed because of poor or inappropriate implementation. Hoge and Howerstine (1997, p176) wage this case succinctly:

“... the absence of demonstrated impact on clients (of collaboration effort) is difficult to interpret because, in most studies, actual service integration was not accomplished.... Certainly if implementation fails there is no reason to expect noticeable changes among clients.”

⁴ This was primarily to serve workforce issues, in particular recruitment and retention objectives, but there are clearly also potential service delivery benefits in terms of quality and continuity.

⁵ In recent times more positive evidence has been accumulating, for instance Foy, et al (2010) and Fuller, et al (2011).

We will return to this theme of appropriate types and levels of collaboration, and proper implementation (through sound governance arrangements) later in this report, noting here only that for components of the mental health system to start to recognise and collaborate with other services will require a major cultural and philosophical shift (Gallagher, 2009).

Ways of collaborating

The term ‘collaboration’ is broadly and fairly commonly understood to imply multiple service providers working together to deliver a coordinated and coherent package of services to individuals with multiple needs (Hoge and Howerstine, 1997). In reality, the term covers a range or spectrum of many different arrangements in which terms such as ‘networking’, ‘coordination’, ‘cooperation’, ‘partnering’ and ‘integration’ are subsumed.

Some examples of collaboration suggested in the national and some jurisdictional planning literature for mental health services (e.g. NSW Department of Health, 2001; Victorian Department of Human Services, 2007; Gallagher, 2009) are provided in the list below and illustrate the great variation in the way collaboration can be perceived:

- Develop [and contribute to] a national mental health research strategy to drive collaboration and inform the research agenda;
- Partner and work with other health services e.g. Alcohol & Other Drugs, General Practice, community mental health;
- Partner and work with government sectors outside health e.g. Housing, Justice systems (Courts and Police);
- Establish good will and common intent in mental health teams;
- Improve understanding of the roles, functions, responsibilities and limitations of each sector and services to develop models of service collaboration which include relevant information sharing and cross sector support; and,
- Collaborating partners to give up a part of their responsibility to another agency to create a better or more seamless service system.

Fuller et al (2011) created a taxonomy of ten linkage (collaboration) strategies across four broad collaboration categories. The categories and linkages are displayed in the Table below:

Figure 5: Possible taxonomy of linkage strategies

Broad linkage category	Service linkages
Direct collaborative activities	<ul style="list-style-type: none"> • Link working (organisational tasks connecting two or more services) • Co-location • Consultation liaison • Care management
Agreed guidelines	<ul style="list-style-type: none"> • Specific treatment protocols • Stepped care
Communication systems	<ul style="list-style-type: none"> • Enhanced communication (using formal processes) • Enhanced referral (expedited access etc.) • Electronic communication (telephone or video with two or more people)
Service agreement	<ul style="list-style-type: none"> • Service or formal work agreement (for instance a memorandum of understanding)

In a similar way Whiteford and McKeon (2012) identify nine discrete collaboration strategies from a review of the literature listed as follows:

- Joint service planning and information exchange with interagency coordinating committees and/or intersectoral /interface workers;
- A single multi-agency care plan for each client;
- Formal interagency collaborative agreements or memoranda of understanding;
- Staff Training, including joint training - ensuring staff have shared attitudes and consistent understanding;
- Information sharing using a single information system, shared case records or client tracking systems;
- Blended funding initiatives;
- Joint service provision through multi-disciplinary, multi-agency teams coordinated via regular communication;
- Service co-location; and,
- Service administration by a single lead agency.

Both the above classification structures essentially categorises collaboration effort on the basis of mechanisms or tactics. A similar but more general way of classifying collaboration efforts offered by Himmelman (2001) describes four basic strategies viz.: networking, coordinating, cooperating and collaborating. Each of these strategies is described as follows:

Networking — this involves the exchange of information for mutual benefit and requires limited sharing of knowledge between partners. Himmelman (2001) provides the example of general practitioners meeting monthly with clinical case management to discuss issues of mutual concern, such as referral issues.

Coordinating — this goes beyond simply exchanging information and includes altering activities for a common purpose. Himmelman (2001) provides the example of drug and alcohol services and clinical mental health services undertaking shared case planning (with client consent and involvement) with then a single case manager. This is the basic operation of current dual diagnosis treatment.

Cooperating — this involves sharing resources in addition to exchanging information and altering activities. This is the classic strategy for service co-location. Himmelman (2001) provides the example of the location of a clinician within a homeless support service to provide a multi-disciplinary response to people with serious mental illness who are homeless.

Collaborating — In addition to the other activities described, collaboration includes enhancing the capacity of the partners (for instance by training or mentoring) for mutual benefit and a common purpose. Collaborating requires partners to an arrangement to give up a part of their responsibility to another agency to create a better or more seamless service system. An example of this type of collaboration would be the integration of a mental health youth resource with mainstream complementary youth health and welfare services which involves shared resources and infrastructure.

A good example of a form of a 'coordinating' strategy is described by Perkins et al (2006). In a western NSW region psychiatrist visits from metropolitan services provided clinical and broader (educational) support services to community mental health teams, general practitioners and other agencies. The collaboration improved access to psychiatrists and increased total number of persons accessing mental health care.

An example of a ‘cooperating’ strategy is provided by Perkins et al (2010). They reviewed the establishment of a comprehensive primary health care service for rural mental health patients. The service involved the community mental health team holding a monthly clinic in a general practice to allow their mental health clients access to GP services for further mental and physical health care. The service achieved reduced referrals to acute inpatient care and referral patterns between GPs and psychiatrists also changed allowing a clearer division of roles (with GPs managing client’s issues).

These two examples are somewhat characteristic of much of the literature on mental health collaboration, which tends to focus consistently on collaboration of some form between specialist mental health services and the clinical primary health care services (see for instance Rothman and Wagner, 2003; Kates and Mach, 2007; Perkins et al, 2010). Fuller et al (2004) would argue that the preponderance of collaboration in this way, between these parties, is understandable given the relationships are easier to forge, the mutual respect higher, and the degree of shared (clinical) values and culture comparatively high.

Another example of primary mental health care collaboration that includes both coordination and cooperation but approaches closer to Himmelmann’s (2001) description of collaboration, is described earlier in this report (Thiel et al, 2013) — the Sandwell Integrated Primary Care Mental Health and Wellbeing Service. The recently introduced PIR initiative in Australia, in a similar way to Sandwell, demonstrates high levels of coordination and cooperation around individual clients. With its additional system based elements though (formally funded consortium arrangements and central agency support for resources development) and capacity to negotiate innovative partnership arrangements at the client and interagency level, it has the potential to deliver higher levels of collaboration.

Levels of collaboration

In some ways the classification structure proposed by Himmelmann (2001) represents a scale of collaboration effort intensity, from the low levels of engagement and risk and limited commitment requirements of ‘networking’ to the very high levels of engagement and associated risk of organisational commitment of ‘collaboration’ and integration effort. Reflecting again on the thoughts of Hoge and Howenstine (1997) regarding the relationship between implementation of collaboration effort and outcomes, choosing and achieving the right the level or degree of collaboration may be important. Like any investment, if the level of investment is too little to achieve the desired outcome then it is potentially no better than not making any investment.

Fuller et al (2011) for instance conducted a literature review to investigate the effectiveness of service linkages (different forms of collaboration) in producing positive client outcomes (see Figure 5 which lists the ten collaboration strategies). They concluded that the most effective service linkages in providing a positive effect were:

- Care management;
- Enhanced communication;
- Consultation liaison; and,
- Local protocols.

These linkages represented three broad collaboration categories — ‘direct collaborative activity’, ‘agreed guidelines’, and ‘communication systems’. Single strategy approaches (that is lower levels of investment in collaboration) produced generally poor outcomes. Fuller et al (2011, p8) concluded that:

“... successful collaborative clinical programs in mental health care use multiple linkages that impact on the direct work of clinicians, more so than on management level agreement across services.”

Of course this conclusion may be limited to certain types of collaboration, for instance collaboration of the type described above largely involving collaboration only between clinicians from specialist mental health services and general practices. Whiteford and McKeon (2012) while generally very supportive of the benefits of collaboration noted some cases where it might not work if not the right level or combination of collaboration strategies were not adopted. For instance, administrative strategies (shared records, co-location) might not be successful in the absence of associated efforts to foster a shared vision and agreed quality protocols. Similarly, centralisation of authority in the absence of collaboration measures between direct service workers could lead to reduced accountability at the individual client level with negative affects on service quality.

The Fourth National Mental Plan (Gallagher, 2009) advocates that collaborative efforts need to extend beyond both clinician and mental health sector boundaries and include other health services (including drug and alcohol services) and non clinical community services for example, rehabilitation NGOs, housing, vocational programs and justice systems.

Clearly there are no established rules or guides for determining the appropriate level of collaboration within any particular context or circumstance. However, some authors have attempted to hypothesise appropriate levels of collaboration in which specialist mental health services should engage for given circumstances. For instance several researchers have drawn a relationship between high volume mental health issues (so called high prevalence disorders) and a reduced level of direct intervention from the specialist mental health services (Victorian Department of Human Services, 2007; Boston Consulting Group, 2006), thus necessitating collaboration efforts with other providers. Similarly, a demarcation has been drawn between clinical services and life support and rehabilitation services, whereby the former is more likely to require direct intervention from specialist mental health service providers, and the latter require collaboration from specialist mental health services. By implication, if the specialist mental health services want to maintain some role in, or influence over, delivery of those services in which their direct intervention is likely to be minimal, they must do so through collaborative relationships.

In Table 3 an attempt is made to conceptualise the relationship between the previous models of mental health service delivery and a model of required depth or intensity of collaboration activity. Note that higher levels of collaboration do not automatically relate inversely to population size — indeed it is possible that at lower population levels the number and competence of resources at the ground level available for collaboration are simply not able to support an integrated model. Rather, clients in such circumstances need to be supported more directly by specialist resources (even if through virtual service delivery models).

Table 3: Relationship between mental health service model and collaboration requirement

Population context	Category of health service provision	Type and level of collaboration
Populations of less than 1000 (small communities)	Outreach services – access through virtual or periodic visiting services	<ul style="list-style-type: none"> • Coordination
Populations between 1,000 and 5,000 (towns)	Comprehensive primary health care services – typically community controlled	<ul style="list-style-type: none"> • Cooperation • Coordination • Collaboration
Populations between	Integrated services – access to	<ul style="list-style-type: none"> • Collaboration /

Population context	Category of health service provision	Type and level of collaboration
5,000 and 20,000 (districts)	locally available coordinated care	integration <ul style="list-style-type: none"> • Cooperation • Coordination
Populations over 20,000 (regional centres)	Discrete services – access to more specialised services that can exist independently	<ul style="list-style-type: none"> • Coordination • Cooperation • Networking

Factors that facilitate or impede collaboration

Hoge and Howerstine (1997, p177) note that service integration as a concept is simple to describe, but ...

“... prompting providers to engage in such collaboration on more than a superficial level has, in practice, been exceedingly difficult to achieve.”

They attribute this to the natural need for most organisations to establish and maintain boundaries, since they can be the key to an organisation’s survival and integrity, and help employees with direction achieve efficient and effective work performance. The ‘downside’ though of boundary maintenance is the effect this can have on collaboration, which requires acceptance of porous boundaries.

“The maintenance of tight boundaries ... facilitates a rigid identification by staff with a single provider agency ... and inhibits a sense of identification and membership in the larger community of caregivers. This ... impedes cross-agency collaboration.”

They go on to say that a key task in establishing and developing effective collaboration therefore is to promote the development of more complex and multifaceted organisational identities to which the staff of participating organisations can relate.

Whiteford and McKeon (2012) in a review of many successful collaboration efforts to deliver improved mental health services found several common factors including:

- Improvements in communication between services, and subsequently increased access to multi-disciplinary resources and staff-friendly networks;
- Strong senior leadership from each service sector supporting integration and mechanisms for early resolution of conflict/issues between services;
- A shared perspective, or some form of mutual understanding and increase in intersectoral empathy;
- Co-location of services;
- Intensity and number of linkages between services;
- Clarity of a chain of responsibility or accountability; and,
- The presence of a strategic plan, or coordinating body, which as a minimum undertakes on-going monitoring of joint service effectiveness.

Santos and Ridoutt (2005), who studied collaborative efforts of mental health service providers through a series of ethnographically structured interviews, fixed on the types of competencies required to support collaborative actions. They found a number of competencies (skills, knowledge and attitudes) critical to effective collaboration needed to be possessed by those engaged in setting

up and maintaining collaborative efforts. Among the key competencies they identified, not unsurprisingly, were that persons wishing to collaborate first had to understand their own organisation and perceived benefits it might extract from collaboration, have good knowledge of system, the players, service offerings and where their organisation fits, and be able to empathise with potential partners and articulate their needs (and benefits) from collaboration. A more complete list of the competencies they identified is provided in Appendix A.

Fuller et al (2004, p80) also identify competence issues especially in regard to the numerous differences between different service types:

“Differences related to workforce training, remuneration, conditions of work and status can lead to different expectations about what collaboration should achieve and how it should operate... Collaborations can be difficult to establish since it requires that each has a good understanding of how they collectively work, i.e. about broad treatment aims, priorities, client groups served, pathways to care and systems of case management.”

They go on to state that collaboration requires the willingness to share client management and aspects of decision making in relation to the role of others across mental health services. In addition, Fuller et al (2004, p82) identify that:

“Knowing what drives each service provider into a partnership is important Good partnership requires that partners have a good sense of their own role identity, a clear understanding of the concerns and role of others, and good partnership structure and leadership.”

Lessons can also be drawn from a number of collaborative mental health service studies that have been undertaken internationally. Theil et al (2013) in evaluating a coordinated care case study identified the following components required for the successful implementation of coordinated services for people with complex chronic conditions:

- Solidarity, mutual support, joint vision and buy-in of all involved in the services;
- Formal referral criteria in clearly defined relationships with external providers; and,
- Support of commissioners (or the funding body) to allow a reasonable time for the service to grow and prove itself compared with requiring immediate impact (results).

The Canadian Collaborative Mental Health Initiative (CCMHI) has developed an understanding of the fundamentals of successful collaborative mental health services (CCMHI, 2006) in which is included:

- The degree of consistency of legislation, policies and funding structures with the principles of collaborative mental health care;
- Funds and research findings that support it; and,
- Community strengths and needs, resources and readiness to implement it.

The CCMHI Framework provides four key elements considered essential to collaborative mental health care namely: accessibility, collaborative structures, and richness of collaboration and consumer centeredness. The CCMHI Framework places the consumer at the centre as can be seen in the diagram below. The Framework is based on the premise that:

“... collaborative mental health care will increase access to mental health services, decrease the burden of illness and optimize care” (CCMHI 2006, p1).

Figure 6: CCMHI Framework of collaborative mental health care

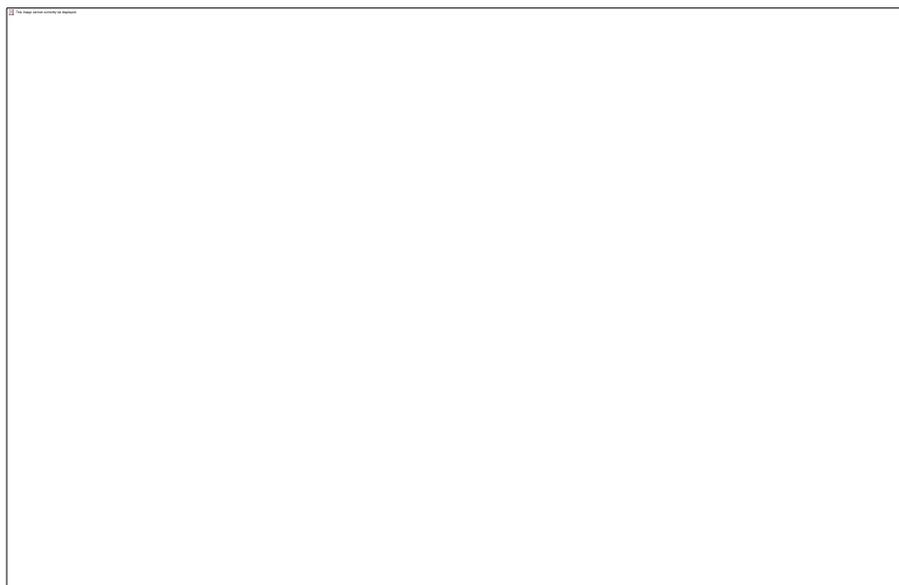


Diagram accessed at: <http://www.ccmhi.ca/en/who/images/Framework-diagram-EN.gif>

Based on the Framework, Haggarty et al (2010) developed eight toolkits to assist mental health services and communities with implementation. The toolkit most relevant to this report is the Rural and Isolated (R&I) toolkit. The R&I toolkit identifies eight key messages for successful collaboration:

- Access to services;
- Inter-professional education;
- Consumer involvement;
- Evaluation and research;
- Models of collaboration;
- Ethics;
- Funding; and
- Legislation.

Reflecting again on the findings of Fuller et al (2011) that successful collaboration requires multiple strategies that impact on the direct work of clinicians, some authors have argued that collaborative effort is best built from individual cases up or at least very local relationships between clinicians and other support services (e.g. Boston Consulting Group, 2002). Kendall et al (2007) explores mental health workforce development strategies (targeting the non clinician component of the workforce) that are based on consumer centred, case management teams and attempt to:

- Provide a better opportunity for fragmented services and workforce segments of the mental health system to practice connectedness through improved team functioning and care planning; and,
- Build a stronger motivational case for collaboration ('what's in it for me?') by enhancing structures that support service coordination.

Kendall et al (2007) canvasses establishing 'active learning partnerships' around more complex mental health consumers to promote an environment to both improve the ability of individuals to work together in optimising patient outcomes and to also gather new clinical and support skills from collaboration partners. In promoting the merits of team learning environments, Kendall et al (2007)

echo the sentiments of the Child Protection Learning and Development Strategy (DHS, 2006, p12) which argued inclusion of:

“... team-based learning in the workplace, which complements more structured learning opportunities. Team learning offers an opportunity to accelerate growth and development, recognising that teams, not individuals are the fundamental learning unit in the modern organisation.”

Governance issues

Concerns about governance arrangements

In previous sections the case for collaboration and partnerships has been built as a solution to fragmented mental health service delivery (in which consumers can be confronted by service gaps) and problems with continuity of care and, in rural areas, as a means of extending service capacity and to improve access and service quality to more remotely located consumers. Despite some ambivalence in the evidence in support of the effectiveness of collaborative efforts — while most studies find strong positive effects (Hassett and Austin, 1997; Foy et al, 2010; Fuller et al, 2011; Whiteford and McKeon, 2012) some others have shown no effect (Goldman et al, 2002) — there are generally high hopes that collaboration will deliver better client outcomes (Hickie and McGorry, 2007). This is reflected in the prominence of collaboration as a strategy in the Fourth National Mental Health Plan (Gallagher, 2009) and a range of jurisdictional mental health plans.

Many authors though have warned of the likelihood of collaboration not delivering on its potential if not well implemented with appropriate governance arrangements (e.g. Hoge and Howenstine, 1997; Krupa et al, 2004; Humphries et al, 2008). This includes both corporate and clinical governance, which are interrelated (Flannigan, and Power, 2008). Hickie (2009) notes that inadequate current governance arrangements are the biggest threat to changing and improving mental health services, especially since services remain largely unaccountable.

Strong governance structures

Corporate governance is simply defined by West and Scott (2008) as the act or function of exercising authority or control. Governance relates to a process and structure to support decision making in relation to:

- Roles & responsibilities of participating parties; and,
- Financial, contractual & business arrangements.

Flannigan and Power (2008) define corporate governance as the system by which organisations are directed and managed. Governance arrangements provide the structure through which the objectives of the organisation (or service entity) are set and the means by which attaining those objectives and monitoring performance are determined. It influences how the objectives of the organisation are achieved, how risk is monitored and assessed, and how performance is optimised.

West and Scott (2008) identify a number of elements of an ideal governance model, including:

- Arrangements support the clinical model;
- There are clear arrangements for:
 - allocating roles & responsibilities between parties covered by the arrangements (this is especially pertinent in governance of integrated service structures,
 - decision making between organisations, authority, delegation,
 - reporting to each others' respective organisations and to others,
 - day to day management arrangements,

- review & monitoring,
- resolving issues between partners & with others (possibly external to the governance structure).

They argue that good governance (corporate or clinical) is characterised by:

- Transparency and accountability;
- Clear decision making frameworks;
- Effective participation by diverse interests;
- Appropriate capacity and skills e.g. financial management; and,
- Not too complex, minimal bureaucracy.

Hickie and McGorry (2007) see one of the most important benefits of better governance arrangements to be stronger monitoring of system performance against widely agreed performance outcomes. They offer up a range of possible indicators for mental health services which include:

- Rate of suicide and death rates <3 and <12 months post discharge from a mental health facility;
- Rates of community follow up for people within the first seven days of discharge from acute care;
- Readmissions to hospital within 6 months of discharge;
- Waiting time for admission to a supported mental health place in the community;
- Consumer experience of being treated with dignity using agreed criteria;
- Proportion of persons using mental health services with access to stable housing; and,
- Participation rates by people with a mental illness of working age in employment.

Clinical governance is inextricably linked with corporate governance (Braithwaite and Travalia, 2004) but with a narrower focus on promoting quality and safety of clinical services through quality assurance and continuous improvement processes. Flannigan and Power (2008, p8) note:

“Clinical governance provides the system whereby clinicians and managers are accountable for the quality of patient care, making decisions based on both clinical effectiveness and cost effectiveness... Clinical governance should be patient focused, universally applicable and encompass a partnership between clinicians, managers and the public.”

The main elements of clinical governance are shown in Figure 7. Flannigan and Power (2008) note the one key point of intersection between corporate and clinical governance is the area of risk management.

Figure 7: Elements of a typical clinical governance arrangement



For some clinicians within the specialist mental health workforce, it is possible that clinical governance arrangements are more important than corporate governance. This is because they fear that wider participation in service delivery, including input into service delivery decision making, of the non specialist elements of the service model, could undermine quality and safety (Fuller et al, 2004). A mechanism they can trust that acts for the protection of quality service delivery can help clinicians commit to collaboration arrangements. Putting clinical governance arrangements in place though, even within a strong corporate governance structure, is not necessarily easy as researchers in the UK have found (Gask et al., 2008). This is particularly so in the context of collaborative services, where shared understanding of terminology, roles and objectives becomes essential, and an absence of this understanding makes clinical governance difficult with obvious threats to the quality of mental health care.

In rural settings, some argue that the need for, and difficulties in developing, appropriate clinical governance arrangements are multiplied (Victorian Department of Health, 2007, p19), especially:

“... where services have limited access to a consultant psychiatrist, where there is a heavy reliance on an overseas trained medical workforce, where there are sole mental health workers, or where small teams are operating in isolation, such as when co-located or integrated in mainstream services. These factors give rise to issues such as clinical supervision, skill maintenance, and the monitoring of service quality.”

Governance of integrated services

In the section above, the possibility that governance arrangements might need to be specifically developed for integrated service settings is raised, a notion supported by many authors (e.g. Perkins et al, 2006; Harte and Bowers, 2011 Fuller et al, 2011). The Victorian planning framework for rural mental health services is explicit on this point (Victorian Department of Health, 2007, p19):

“The development of robust corporate and clinical governance arrangements specific to the needs of integrated and/or co-located clinical mental health services are a central consideration, particularly where more flexible funding and service configurations operate together with a need to retain program integrity.”

Equally pointed is Jackson et al (2008, p57):

“... governments are increasingly attempting to work with non-government organisations and the private sector to maximise scarce resources in the face of increasing health care demand. Ambitious integration agendas must be underpinned by effective governance mechanisms that are appropriate to the undertaking, the stakeholders involved and the scale of delivery.”

Integrated or collaborative care, particularly at higher levels of collaboration, requires a change in focus from dominant forms of governance thinking (in which there is typically a single organisation with a single chain of command and line of accountability) to thinking about governance of care that can be provided across organisations for a community or patient group. It requires multiple independent service entities and consumer organisations to form effective long term working relationships and to move beyond the occasional informal partnership to a serious commitment to integrated health care delivery. Governance arrangements need to reflect this more dynamic context.

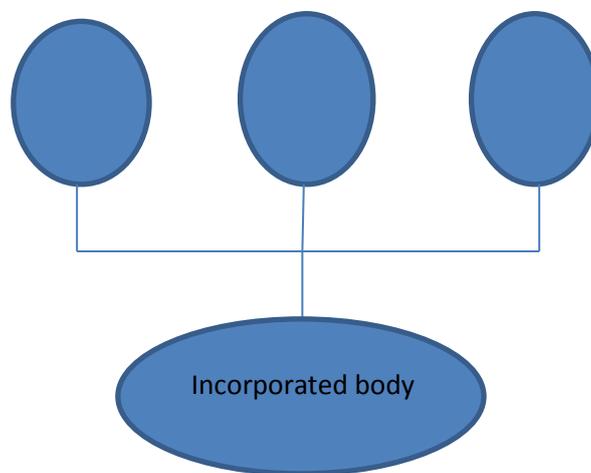
Most authors advocate formal structures for governance arrangements. West and Scott (2008) offer up several ways of formalising collaborative arrangements viz.:

- A memorandum of understanding (MOU);
- Contractual agreements (possibly between a funder and provider);
- Partnership agreement;

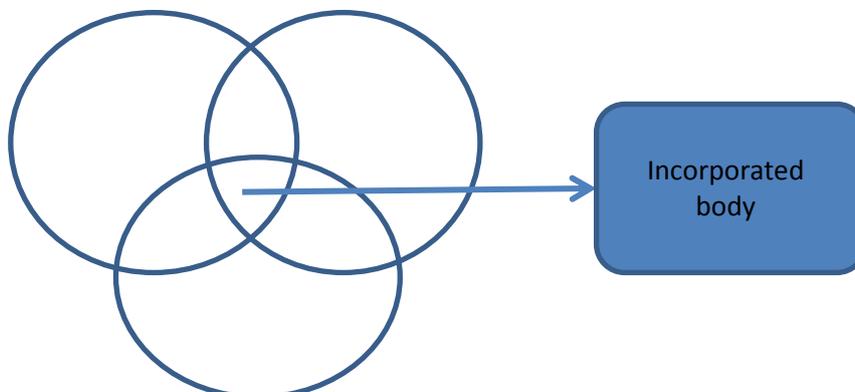
- An incorporated body for instance a company with ‘privately owned’ shares or a company – limited by guarantee (special form of public company); and,
- Some other less common form such as a trust.

Fuller et al (2011) have shown that deeper and more structurally significant arrangements (that is beyond a simple agreement or MOU, and involving “direct collaborative activities”) are more likely to produce positive benefits from collaboration. In this light, Jackson et al (2008) identified through a study of existing arrangements three main (feasible) options for integrated health care governance appropriate to the Australian health context. These are described and illustrated below.

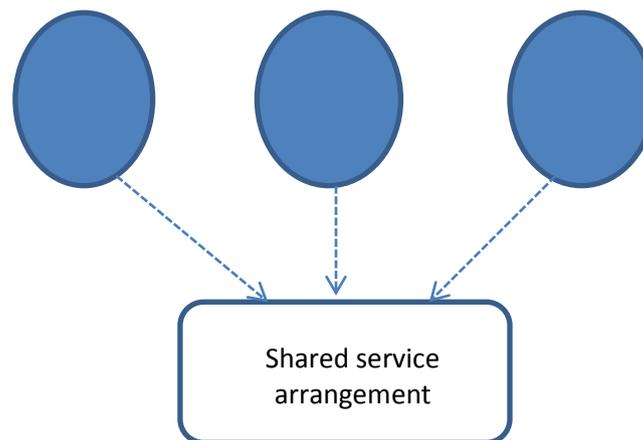
Arrangement 1: The creation of an incorporated body, with governance responsibility shared across the integrating organisations and with pooled resource allocation capability for a given population or region. There are several examples of this approach in the Northern Territory under that government’s regionalisation program, but before that the Multipurpose Centres remain good examples;



Arrangement 2: An incorporated body established by integrating organisations, with its own funding pool and responsibility, but only for defined areas of common business overlap between the organisations. Examples of this type of structure might be Primary Care Partnerships in Victoria — one might even argue that Medicare Locals are a form of this type of structure although their history (from Divisions of General Practice) represents a different pathway to collaboration effort;



Arrangement 3: A formal and agreed governance arrangement between organisations to share resources by delivering services across a finite geographical area, but still retaining independent governance arrangements (and funding) for each collaborating organisation. The 'PIR' initiative essentially delivers a 'collection' of services from a consortium arrangement where partners to the consortium remain independent bodies. Another example is the Housing and Accommodation Support Initiative (HASI) in NSW that delivers services through arrangements between a number of government agencies and non government organisations. A similar arrangement exists with Aged Care Workforce Innovation Networks (WIN), although these networks require less commitment (in terms of reallocated resources or loss of autonomy) than some other forms of collaboration;



A similar but more detailed set of service integration structures has been suggested by Hoge and Howerstine (1997). They include:

Creating an Umbrella Organisation — create a new consortium or umbrella organisation that encompasses the participating provider organisations;

Creating Integrative Task Groups —structuring a range of task groups that bring staff from multiple agencies together frequently in order to manage or regulate the treatment system;

Participatory Management — involves an approach to leadership that emphasises power sharing regarding the content of decisions while maintaining control of the decision making process and the accountability for outcomes;

Boundary Spanners —individuals in such positions are assigned to work at the boundary between two or more agencies;

Team Building —involves a structured effort to break through barriers to effective team work in highly bounded systems to develop awareness and understanding of each others' work. Team building is considered most useful at the boundary between clinical care, which is often defined as "treatment," and all other forms of service which are labelled and often devalued as "rehabilitation";

Multi-Agency Programming —involves combining resources from two or more agencies to create new services.

A number of these arrangements have been advocated or trialled.

Fuller et al (2004) suggested an "umbrella" structure to allow collaboration between services that includes all mental health service organisations, encourages staff to identify with new work arrangements and focus their efforts on the needs of their specific consumer community. This

structure was utilised in the SA regional mental health plan and proposed the following advisory groups to facilitate networking and collaboration efforts:

- an interagency liaison group;
- a consumer advisory group;
- integrated region-wide task groups on specific issues made up with key stakeholders organisations; and
- networking groups in locations across the region for local human service providers.

The Victorian Department of Human Services (2007) advocated development of area clustering models to enhance collaboration between rural areas and improve linkages with metropolitan areas that support:

- Access to more specialised services and workforce initiatives; and,
- Improved triage and bed management practices.

Within these cluster models the appointment of a ‘boundary spanner’ — a Regional Mental Health Coordinator — was recommended to act as a change agent and negotiate boundaries.

Kendall et al (2006) also advocated a boundary spanner, proposing appointment of ‘active learning partnership co-ordinators’ to facilitate initial consumer focused teams formation and to provide on-going support to each of the defined teams (especially to function as learning vehicles). To an extent they were also proposing team building efforts at least initially to overcome boundary issues between ‘treatment’ and ‘rehabilitation’ service providers. Kendall et al did not recommend the development of specific collaborative infrastructure, and accepted the argument instead (AIPC, 2005, p7) that existing structures should be protected:

“...from being undermined by the introduction of alternative policies and mechanisms aiming to achieve similar outcomes, and to provide appropriate resources to ensure they remain sustainable.”

In this context they identified in Victoria the Primary Care Partnerships, which in other States and Territories today would roughly equate to Medicare Locals.

Few examples of multi-agency programing or resource sharing in practice have yet to emerge. Surrendering decision making power over resources has proven difficult.

Barriers to effective governance

West and Scott (2008) identify a number of factors that if not properly addressed can undermine the effectiveness of collaboration and partnerships, and which governance arrangements need to address:

- Lack of communication;
- Lack of trust;
- Unclear, unrealistic or unaligned expectations;
- Anxiety, fear of the unknown;
- Different organisation cultures with different interests, financing and poor linkages; and,
- Insufficient time and commitment.

Jackson et al (2011) attempted to place the barriers to successful collaboration in order of importance. The following list is provided in descending order of importance:

- Communication barriers, including lack of information, unclear expectations, ambiguous roles, duplication;
- Structural barriers, including inadequate resources, staff turnover, financial restrictions; and,
- Cultural barriers, including lack of trust, eroded credibility, fear of change, unwillingness to innovate.

Some of the factors which facilitated better governance outcomes in integrated mental health service delivery contexts included:

- Having a shared purpose, clear goals;
- Flexible partnership structures;
- Common clinical tools;
- Clinician input in decision making;
- Suitable infrastructure;
- Team-based approach to service delivery; and,
- Client focus or community focus.

Application to MNC – initial considerations

Brief District context

The MNC LHD services a population of 215,000 with 5.8% (12,087) identifying as Aboriginal or Torres Strait Islander. The District is made up of five local government areas that stretch down the MNC of NSW bordered by the Great Dividing range in the west and the coast on the east. The furthest northerly (Coffs Harbour City Council) and southerly (Hastings Shire) LGAs have the greatest populations and the two largest urban areas (Port Macquarie and Coffs Harbour respectively).

Numerous smaller towns are distributed throughout the LHD. Nambucca and Kempsey Shire councils have the largest Aboriginal populations. The major towns within the District that have public hospitals are shown in the Table below along with relevant population details.

Table 4: MNC LHD population description for each LGA

LGA and total population	Major towns with Public Hospitals and Community Health Centres	Aboriginal population
Coffs Harbour, 70,933	Coffs Harbour,	3,405 (4.8%)
Bellingen, 12,886	Bellingen, Dorrigo	455 (3.5%)
Nambucca Heads, 19,286	Macksville,	1,617 (8.4%)
Kempsey, 29,188	Kempsey	3,715 (12.8%)
Hastings, 74,949	Port Macquarie, Wauchope	2,895 (3.9%)

Current distribution of services

Models for mental health services delivery predominantly discussed in the literature were arranged around:

- Level of resources - Thornicroft and Tansella (2004) offer three resource settings: low (within primary health care), medium (mainstream health care) and high (specialised / differentiated health care) but do not specify where the settings occur;
- Population size – Victorian Government Department of Human Services (2007), Humphries et al (2008) – composite model see Table 2; and
- Hub and spoke - Harte and Bowers (2011) a combination of the two models above.

An initial attempt has been made to position the service delivery models described earlier with the current MNC LHD public mental health services against the geographic spread of the District’s population in Table 5 below:

Table 5: Service delivery models against geographic population spread and public mental health services

Population context	Current service provision / resources ⁶	Category of health service provision – see table 2 above
<p>Populations of less than 1000 (small communities)</p> <p>For example, Eungai, Hyland Park, Scotts Head, Smithtown-Gladstone, Frederickton, Stuarts Point</p>		<ul style="list-style-type: none"> • Assertive outreach services • Tele-psychiatry assessments • Comprehensive primary health care services • Recovery
<p>Populations between 1,000 and 5,000 (towns)</p> <p>For example, Bellingen, Dorrigo, South West Rocks, Crescent Head, Bowraville, Macksville, Valla Beach, Urunga, Moonee Beach, Sandy Beach, Emerald Beach, Bonville, Sawtell, Korora/Sapphire Beach, Laurieton,</p>	<p>Public Hospitals at Dorrigo, Bellingen, Macksville,</p> <p>Community mental health services at Bellingen, Macksville</p> <p>Aboriginal Medical Service (Bawrungra) at Bowraville (larger drawing area)</p> <p>Outreach Drug & Alcohol services to Bellingen, Dorrigo, Macksville</p>	<ul style="list-style-type: none"> • Self-help • Shared primary health care / screening / specialist consultation - liaison and training support • Support services, especially accommodation • Consumer protection / advocacy
<p>Populations between 5,000 and 20,000 (districts)</p> <p>For example, Kempsey, Nambucca Heads,</p>	<p>Public Hospitals at Kempsey, Wauchope</p> <p>Community mental health services at Kempsey</p>	<ul style="list-style-type: none"> • Rehabilitation • Employment & occupation services • Multi-purpose services • Continuing community mental health care

⁶ Please note that a full mapping of all of the District’s mental health services has not been done in this literature review. Only services that were easily identifiable within existing documentation were included in Table 5. A more thorough mapping of services is advisable. There are no rehabilitation, NGO or private mental health services included.

Population context	Current service provision / resources ⁶	Category of health service provision – see table 2 above
<p>Toormina, Woolgoolga, Wauchope, Lighthouse Beach, Lake Cathie / Bonnie Hills, Camden Haven, Toormina</p>	<p>Drug & Alcohol Services at Kempsey – linked with Durri Aboriginal Centre and Bennelong Haven</p> <p>Aboriginal Medical Service (Durri) at Kempsey</p> <p>Outreach Drug & Alcohol services to Nambucca Heads and Woolgoolga from Coffs Harbour and to Wauchope and Camden Haven from Port Macquarie</p>	<ul style="list-style-type: none"> • Case management
<p>Populations over 20,000 (regional centres)</p> <p>Port Macquarie, Coffs Harbour</p>	<p>Public Hospitals, Community Mental Health and Drug & Alcohol Services at Coffs Harbour and Port Macquarie</p> <p>Aboriginal Medical Services Galambila at Coffs Harbour and Werrin at Port Macquarie</p> <p>Outreach Drug & Alcohol services to Youth services and Aboriginal Medical Services in Coffs Harbour</p>	<ul style="list-style-type: none"> • Acute care beds • Specialised community mental health teams • Crisis intervention / emergency care • Respite for carers

Note some drug and alcohol services are also provided through Community Health Centres. Community Health Centres are located in Woolgoolga, Coffs Harbour, Dorrigo, Bellingen, Macksville, South West Rocks, Kempsey, Port Macquarie, Wauchope and Camden Haven. Specific child and adolescent mental health workers are represented in community mental health teams servicing Port Macquarie to Coffs Harbour.

Models of care to be considered

The foregoing findings from a review of the literature has identified the types of mental health service components (*models of care*) that need to be considered to develop and provide a comprehensive and quality service for MNCLHD consumers. Strong suggestions can also be constructed for how these service components might be *distributed, linked and governed*.

In the subsequent final paragraphs of this report these suggestions will be canvassed. It is important to note first though that the consideration of these suggestions, and even more so the adoption and implementation of the suggestions, must be undertaken with reference to a better (researched) knowledge of the current LHD mental health services context and the available resources (both current and able to be obtained through increased or re-directed investment). One cannot assume unlimited investment potential, and current resources (in respect to workforce both number and quality in terms of levels of competence) will always present certain limitations to change and development. In this regard, taking a ‘strengths based’ approach to structural change and building on existing capacity mirrors in some respects the ‘recovery based’ approach widely advocated for individual consumers and shares the same potential for a less than optimally efficient pathway.

Having articulated these precautions, it is possible to outline some suggested broad features of future mental health models of care in the MNC LHD.

A prominent role for primary care

The findings of the literature review strongly suggest that the building the capacity of the primary (health) care sector is the best know way to significantly and pragmatically increase service access to a greater proportion of persons with a mental health problem in the MNCLHD, and improve the delivery of mental health promotion and the likelihood of earlier intervention. A useful definition of primary care is as follows:

“Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors 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.”⁷

As noted previously, primary care is normally considered synonymous with general medical practice, since general practitioners are widely understood to be the key ‘gate-keepers’ for entry to health services. Integrating GPs intimately into the services delivered to persons with a mental health problem is critical to expanding and improving the quality of mental health care, and there are a number of service models that well supported by evidence (e.g. consultation – liaison with psychiatrists; share care programs with community mental health services; advanced training programs; case management with Medicare funded resources; etc.).

⁷ Definition developed by the Australian Primary Health Care Research Institute for ADGP Primary Health Care Position Statement 2005, also included in the Australian Medical Association Primary Health Care position paper, 2006.

While they are most often the first level of care, including for mental health services, GPs are not the only first level source of care, even in the health system. Persons with a mental health problem are quite likely to present to an emergency department, to a child and maternal health service, a community health service or a drug and alcohol service, and their presentation might not be preceded by any previous history or diagnosis of mental illness. Almost as likely a person with a mental health problem could make their first contact with services through child protection, while seeking housing support, in the justice system through adult or juvenile justice workers, or through youth services. As Kendall et al (2007) pointed out all these types of health and social support workers can and should play a constructive role in prevention, early identification and support for persons with a mental health problem.

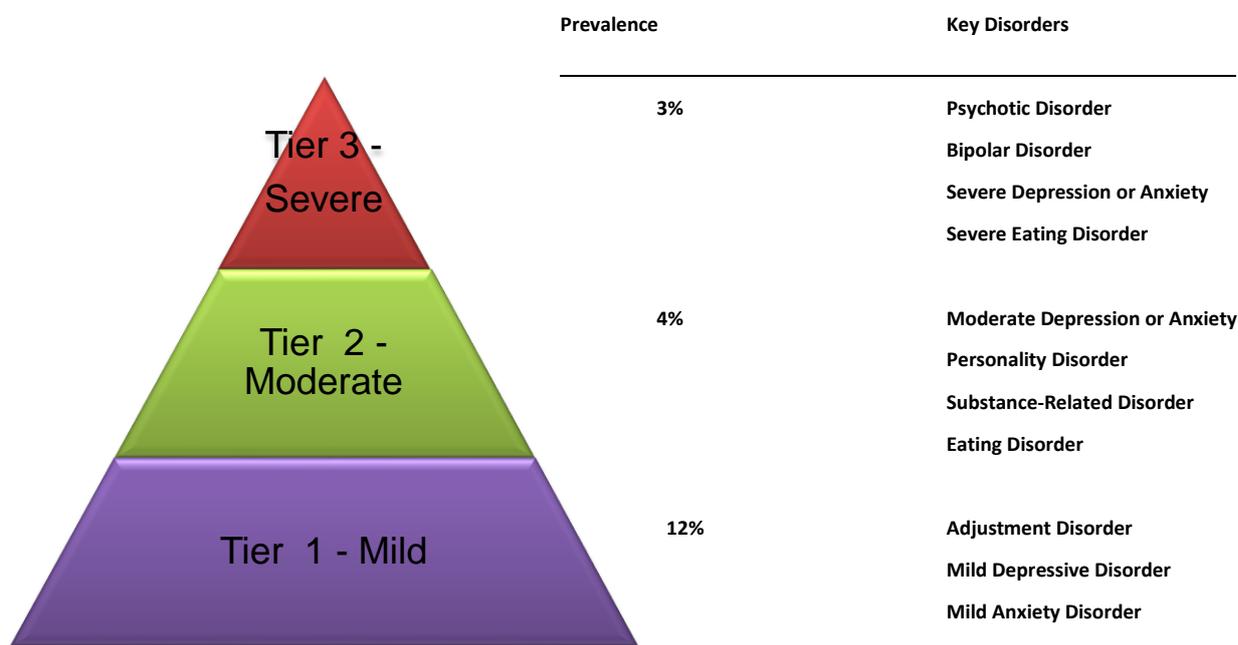
The main way primary care workers in rural areas can contribute to greater access to services identified in this literature review is through *broader geographic services deployment* — primarily providing services locally that currently consumers must travel to access. Partnerships with GPs, practice nurses, child and maternal health nurses, school nurses and counselors, youth workers, community health nurses, alcohol and other drug workers, etc. that build their competence and confidence to care for persons with a mental health problem can extend the reach of specialist mental health resources while potentially improving the overall quality of services. Table 2 suggested that in towns with populations between 1,000 and 5,000 persons primary mental health care could be the major means for consumers to obtain treatment and support, and this may even apply to larger towns between 5,000 and 20,000.

A second contribution primary care workers can make to expanded access is by increasing the types of mental health problems being treated. Gallagher (2009), quoting data from the *2007 National Survey of Mental Health and Wellbeing*, notes that only one third of persons with a mental health problem receive treatment. The Boston Consulting Group (2006) argued that the bulk of those not receiving support suffer from what are commonly termed high prevalence disorders (see Figure 8 below). For the Victorian population they estimated at any one time 12% of the population might be suffering such ‘mild’ conditions (that is approximately 70% of those with a mental health problem⁸) and not receiving care, certainly not from the specialist mental health services component.

It is argued that primary health care providers can (or should be able to) competently identify and manage adequately consumers with high prevalence mental health disorders, some might argue even better than specialist mental health providers, because they can simultaneously address other physical health and general welfare needs. Kendall et al (2007) considering this very issue conjectured a division of labour between primary mental health and specialist mental health care providers as shown in Figure 9, which uses the mental health disorder terminology and categorisation of Figure 8. A third layer of workforce which might be considered as having a ‘special interest’ in mental health, was also included in their thinking.

⁸ The Boston Consulting Group estimates are slightly different from but still largely in agreement with estimates by Gallagher (2009) for both the total proportion of the population with a mental health problem and the distribution of disorders between ‘mild’, moderate’ and ‘serious’.

Figure 8: Distribution of mental health problems in the general population (source, Boston Consulting Group, 2006)



Of course Kendall et al (2007) recognised that this distribution of work was only nominal and that it represented the preponderance of presentations but not the total. They clearly understood that primary mental health carers could under certain circumstances be treating persons with serious mental illness (for instance to maintain medication) or specialist services might be occasionally supporting consumers with mild conditions, even if only for training purposes.

Figure 9: Interaction of consumer population type and mental health workforce segment

Workforce segment	Consumer populations – Type of mental health problem		
	Tier 1 Severe	Tier 2 Moderate	Tier 3 Mild
Specialist mental health services (1)	↔		
Special interest workers (2)		↔	
Primary mental health care services		↔	

(1) Includes non-clinical psychiatric disability rehabilitation and support services delivered via the non-government sector and primarily targeted to adults aged 16-64 years.

(2) Includes workers who provide early intervention to prevent more intensive and costly treatment and reduce the impact of illness or level of disability. Such services are delivered by

primary care workers with advanced skills (e.g. GPs who have been accredited under the Better Outcomes scheme, or nurses with some mental health training), specialised health care providers (e.g. drug and alcohol workers), and community based health workers with counselling skills.

Role of specialist mental health services

In the proceeding section a very broad conceptualisation of a division of labour between service components was introduced. The role of the specialist mental health services, in the public and private sector and the not for profit organisation sector⁹, requires more attention, since it is the specialist services that have most influence over the direction but more importantly quality of delivery of the mental health services system.

A more complete description of the role of specialist mental health services would include:

- Almost exclusive responsibility for delivering acute services;
- Prime responsibility for crisis intervention;
- Providing a clinical response to, and managing all cases of, severe mental illness. Within the specialist services there is likely to be a more calibrated division of labour, with the non government organisations through the *Partners in Recovery* (PIR) initiative taking most responsibility of an ‘assertive’ case management role through specifically employed ‘support facilitators’ and the public sector specialist services being the primary ‘go to’ resources for clinical intervention¹⁰;
- Providing an outreach clinical response through routinely organised and co-located clinics (in general practices, community health clinics, youth services, etc.) that would primarily target cases of severe and moderate mental illness but would also provide time for consultation and training with primary mental health care workers;
- Providing consultant support (community liaison) to general practitioners and other primary mental health care providers for specific cases;
- Building the capacity of primary mental health care workers to manage more independently high prevalence disorders and contribute more to treatment of moderate cases of mental illness. Capacity building would occur in many ways including structured formal training processes, communities of practice, team learning opportunities (for instance see shared care plan below) and self-directed learning resources. In this regard it may be worthwhile adopting the Victorian PMHEI Team model, and assigning dedicated workers within the broader community mental health service to this role. The functions of this team would be to provide education, training and secondary consultation to primary health care workers and promote shared care arrangements between specialist mental health services and primary care providers; and,
- Specialist living support directed at persons with complex mental illness conditions for instance in vocational rehabilitation and supported accommodation (especially support directed through HASI).

Care plans

Many researchers over the years have lamented the fragmentation of service delivery in mental health a visible sign of which is multiple independently created and stored client records for

⁹ In this document, non-clinical psychiatric disability rehabilitation and support services who exclusively service mentally ill clientele and are located almost exclusively in the non government sector, are included in the ‘specialist mental health’ workforce. This approach is adopted from the policy approach in Victoria (see Victorian Government Department of Human Services, 2007), but recognises that some define ‘specialist’ services as only including the clinical workforce.

¹⁰ Case managers of course may choose to involve advanced trained GPs or private sector psychiatrists and other psychological therapists through Medicare or Better Access funding.

individual consumers. Whiteford and McKeon (2012) argued a single client information system accessible for all mental health service providers was optimal but hard to achieve. In the long term an accessible client record should be made possible through the national Personally Controlled Electronic Health Record (PCEHR) repository, registration for which has grown rapidly over the last year so that now over 600,000 health consumers are registered¹¹. In lieu of this optimum of a common record, having a shared care plan with regular communication between stakeholders in the plan could achieve much the same benefits (Whiteford and McKeon, 2012). A shared care plan along with a more systems targeted 'PIR Action Plan' is intended as an immediate outcome of PIR support facilitators' interventions, at last for the more seriously mentally ill population.

While a shared care plan has obvious clinical benefits, Kendall et al (2007) identified significant collaborative and learning opportunity benefits. They argue that the bulk of learning by workers occurs through responding to genuine workplace challenges and after reflection on practice. This is facilitated and learning significantly accelerated within a team environment around a specific case where the care plan provides a strong structure for the learning experience and where the different perspectives, knowledge and skills of team members becomes available to others. Kendall et al (2007) proposed that (in a specified area, like a LHD) a project officer or 'active learning partnership (ALP) coordinator' be appointed to facilitate initial team formation and to provide on-going learning support to each of the defined teams. They gave as an example of how a team that might be formed:

A maternal and child health nurse detects issues with a young mother on a routine home visit in attachment to the baby and feeding problems. A limited history of child protection issues was associated with the raising of a previous child. After administering the Edinburgh Postnatal Depression Scale and obtaining a high score the nurse initiates a conference involving the enhanced maternity service, a child protection case worker, local mothercraft nurse and a consultant from specialist mental health services.

With the advent of PIR support facilitators, whose role it is primarily to convene teams specific to individual consumers around a specific care plan, a de facto ALP coordinator has been already created, they just need to look at the team formed as being able to provide multiple benefits and facilitate them accordingly.

This type of learning fits neatly within a 'learning organisation' model or framework, which Birlleson (1998) argues is most appropriate also for developing the type of leadership desirable for mental health services. Such a model sets appropriate ways of behaving at all levels; managers with workers, workers with other services, clients and carers, all of which is based on mutual respect. The key characteristics of a learning organisation are:

- Daring and compelling leadership;
- Horizontally developed organisation design;
- Work design that emphasises whole jobs and inter-dependence;
- Data collection on work from consumers, reflection on practice, feedback from peers, experimentation;
- Openness to diversity, new ideas, difference; and,
- Motivational systems that emphasise creativity, experimentation, continuous improvement and coaching that include a high degree of trust and tolerance of error (in so far as they are a source of learning).

¹¹ NEHTA Scorecard, August 2013. More recent personal communication with NeHTA now suggests this figure is over 1.2 million, although the 'opt-in' system of registration might bias against persons with a mental illness registering.

Collaboration and governance

Collaboration around shared care plans between clinicians and other direct care workers is arguably the most effective single strategy (Fuller et al, 2011), but unlikely on its own nevertheless to engender desired benefits of collaboration. It needs to be embedded in more structural collaboration efforts. Currently within the MNC LHD there are already some collaborative and governance structures in place and these are detailed in Appendix B. Based on the review of the literature the following strategies are suggested, some of which restate strategies already discussed above:

- Formal consultation and liaison structures put in place particularly to support supportive relationships between scarce psychiatrist resources and general practitioners along with other primary mental health care clinicians;
- Commitment to shared care plans for at least all identified consumers with serious mental illness (through the PIR initiative) and support of wider shared care plans developed for consumers with moderate or even mild mental health problems through Medicare supported mechanisms (such as the general practice 'Enhanced Primary Care' MBS item numbers, Better Access referral plans and new MBS item numbers for psychiatrist support for care plans);
- Development of formal agreements and MOUs along the lines of those established between services that underpin the operation and governance of HASI;
- Co-locate specialist mental health outreach services with primary health care services in smaller towns (population 1,000 to 5,000) where there is currently no routine or an inadequate specialist mental health service;
- Development of a strategic vision for MNC mental health services that is designed through extensive consultation and shared by all mental health service stakeholders; and,
- Construct and implement cross service training workforce development initiatives that target 'clinical' competence deficiencies within the primary care workforce (for instance through interventions like the Mental Health First Aide Course) and foster collaboration between workers at all levels through shared training initiatives and workplace exchange programs like that established in the Central Coast (Santos and Ridoutt, 2005) — *'Walk a mile in my shoes'*.

Effective collaboration demands appropriate governance arrangements. The literature offers many approaches to governance without favouring a particular structure — the circumstances of each context will influence the choice of approach including collaborators' level of trust, willingness to take and accept risk and flexibility in the allocation and management of resources. By and large constructing shared services arrangements seems to have been the most favoured, most likely because these pose the least threat to existing organisation boundaries and sustainability.

Whatever governance arrangement is adopted it will need to overcome common barriers to success and therefore will likely feature:

- Strong commitment to full and transparent communication, ensuring full information, clear expectations (and good understanding of where expectations might vary), unambiguous roles, and reduced or eliminated duplication;
- Attendance to reducing cultural barriers, including lack of trust, eroded credibility, fear of change, unwillingness to innovate;
- Having a shared purpose, clear goals;
- Equal input into decision making of all those meant to be part of the collaboration, including (perhaps especially) consumers and clinicians;
- Flexibility in arrangements and a willingness to adapt to changing circumstances including of partner needs.

It takes time to establish relationships and put in place collaborative services and thereby demonstrate an impact. Expecting quick results damages the long term effectiveness of the model.

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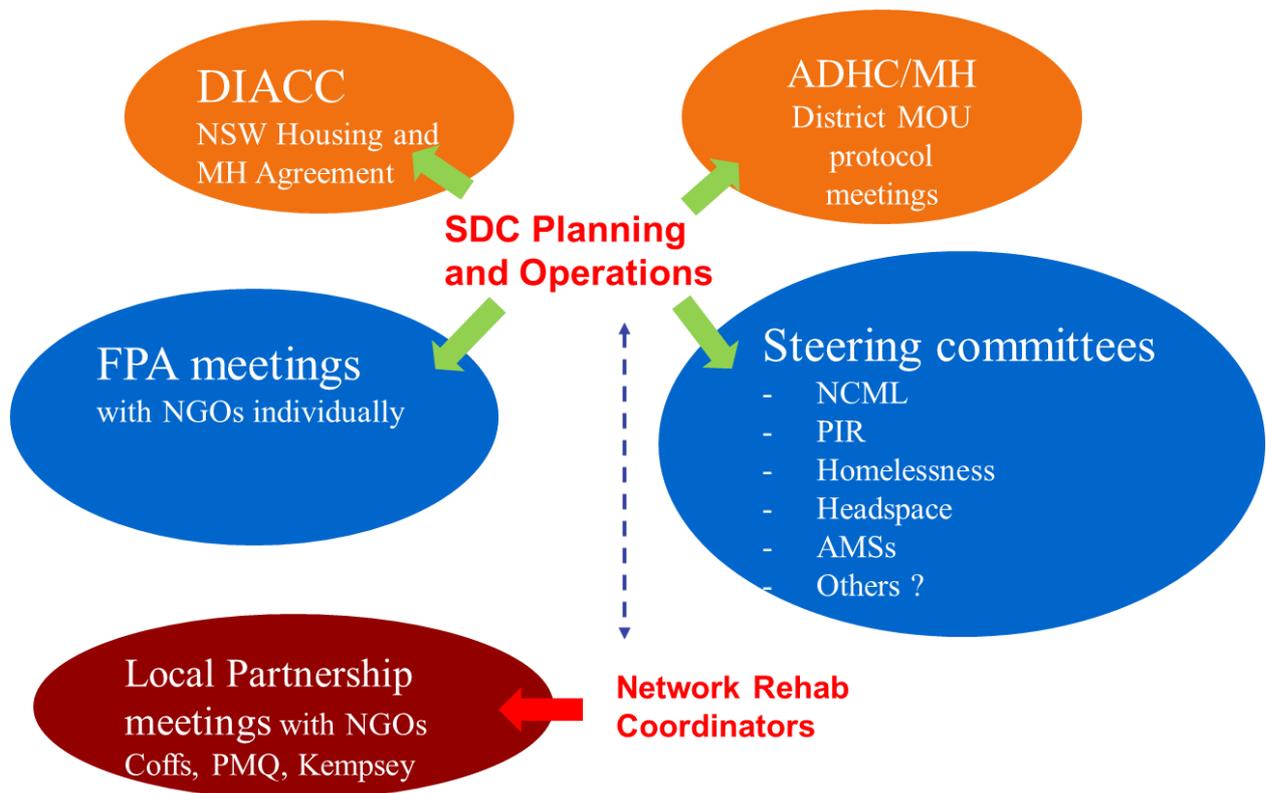
Appendix A: Competencies required for effective collaboration

Knowledge	Understanding of dual diagnosis (e.g. intellectually disabled often with mental illness as well)
	Knowledge of mental health system <ul style="list-style-type: none"> • Players, service offerings • Philosophical orientation of different organisations • How the system works • Referral procedures (proper referral vs. dumping)
	Why Partnerships are Important? What is the business case?
	Implications and meaning of ‘confidentiality’
	Knowledge of Own organisation’s role / contribution. Where do I fit?
	Knowledge of Legislation/regulations and Policies
Skills	Assess service capacity and identify potential partners to fill gaps <ul style="list-style-type: none"> • Assess strengths • Assess weakness • Assess partner fit against organisation’s goals, policy directions and standards
	Managing Partners’ Expectations (What can I do?)
	Mechanics <ul style="list-style-type: none"> • Identifying and accessing people who are key to collaboration decision making • Writing MOUs / agreements • Making collaboration systematic / institutionalising it vs. relying simply on personalities • Establishing relationships
	Communication Skills <ul style="list-style-type: none"> • Networking • Providing feedback to one another (even amongst professionals) / Two-way communication • Keeping communication lines open • Selling the idea of partnership
	Transfer of Skills <ul style="list-style-type: none"> • Capacity building / empowering others
	Express manifestation of valuing partners <ul style="list-style-type: none"> • Acknowledge, give credit to partner • “Equity” in partnership • Do not “tread” on toes of partner
	Involving Partners in Decision Making Process

	<p>Designing mutually beneficial arrangements</p> <ul style="list-style-type: none"> • Knowing/extracting needs/agenda of prospective partners • Identifying own needs • Building these into agreements
Attitudes	<p>Lack of respect for partners</p> <ul style="list-style-type: none"> • Not being able to value their specific contribution to service system or the specific competencies they have • Professionals not wanting to work with non professional and other professionals • Not being able to respect philosophical differences • Not being able to respect limitations
	<p>Lack of trust in partners' judgments</p> <ul style="list-style-type: none"> • Credibility problem for non professionals
	<p>Lack of commitment to partnerships</p> <ul style="list-style-type: none"> • Drop it when busy – never manage to be proactive
	<p>Propensity to look within rather than outside for solutions to fill gaps</p> <ul style="list-style-type: none"> • Some naturally inward looking • Some have critical mass within organisation (increasing tendency to look within for solutions)
	<p>Lack of honesty</p> <ul style="list-style-type: none"> • need to spell out their specific interests in partnerships • lack of honesty in sharing case details when referring to other services

Appendix B: Current mental health sector governance – MNC LHD

The diagram below attempts to encapsulate the current mental health system in the MNC LHD involving forums and activities that could benefit from stronger integration. Further details of each forum or activity in the diagram are provided below.



DIACC

The MNC Housing and Mental Health District Implementation and Coordinating Committee (DIACC) is responsible for implementing the NSW Housing and Mental Health Agreement in the MNC District. DIACC considers measures to improve coordination of services between providers in the housing, disability and health service system in order to deliver coordinated and integrated services to clients and to maximise client access to the full range of services for which they are eligible. Membership includes Housing NSW, MNCLHD Mental Health, Mission Australia Housing, Community Housing Ltd, Regional Homelessness Committee, and the Aboriginal Housing Office representative or NGO. The Work of DIACC is supported by Local Committees that are responsible for direct client engagement and support

Local partnership meetings

Local partnership meetings offer a networking opportunity between mental health services in the local area, community support programs and non government organisations. It is a forum for professional peer support and education, and can be a stepping stone for introducing new programs and identifying referral pathways. The meetings are also a valuable forum to share information and ideas available for people with mental illness and their family and carers. Membership includes mental health services, TAFE, New Horizons, Mission Australia, Centacare, Ontrack, Family and

Community Services, employment services, VERTO, CHESS, Benevolent Society, APM, Durri / Werrin Booroongendjugun Aboriginal medical services, MNC Community Legal Centre, headspace, Lifeline, Commonwealth Respite, Justice Health, Interrelate, Housing Providers, Housing NSW, Centacare Housing, Community Housing and Mission Australia Housing. The meetings occur monthly in Port Macquarie and Kempsey and bi-monthly in Coffs Harbour.

Funding and performance agreement meetings

These meetings occur monthly with individual grant-funded and HASI NGOs to review KPIs and discuss client issues and mutual service needs. Membership includes Rehabilitation Co-ordinators, Service Development Coordinator (Operations and Planning), NGO service Managers and Community Mental Health Managers.

ADHC/MH MOU Meetings

These meetings occur quarterly and are a regular forum for discussing and resolving issues that effect local area service provision. Such issues may include: resource and clinical management, and specific operational, policy and procedural issues. They work to clarify roles and responsibilities of staff members working in both services, establish joint clinical management of service users common to both services where appropriate through case discussion and clinical forums. They are also a vehicle for relevant local procedural development, review, dissemination and to provide a forum for feedback in relation to relevant policy.

HASI placement and selection committee

This committee was established to provide a three way HASI partnership between NSW Housing, Mental Health, and the NGO Support Service to select clients for HASI packages, to review existing client and service needs by partners. It meets quarterly in Coffs Harbour, Monthly in Hastings Macleay.

Steering committees and interagency meetings

There are a range of other steering committees across the LHD that have been established to manage individual partnerships, for example with headspace, PIR, NC Medicare Local and Regional Homelessness Committee. These have varying membership and frequency. There are also local interagency meetings that occur quarterly with other LHD services, police and ambulance.