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Final Report

One person, many stories

Consumer experiences of service integration and referrals in far western Queensland

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Institute for Social Science Research
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Glossary

Aboriginal Community Controlled Health Services (ACCHS): A primary healthcare service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health service, to the community that controls it, through a locally elected Board of Management

Comorbidity: The presence of one or more diseases or disorders in a person. In addition to a primary disease or disorder.

Consumer: A person living with mental illness or problems with mental health or substance use who uses, has used, or may use a human service agency.

Diagnostic overshadowing: Misattribution of a person's physical health symptoms to their mental illness, resulting in inadequate diagnosis and treatment.

Early intervention and prevention: The early identification of risk factors and provision of timely treatment, care or support for people experiencing early signs and symptoms of mental illness. It aims to reduce the incidence, severity, and impact of mental illness.

Hospital and Health Services: Statuary agencies established and funded by the Queensland Government to deliver a range of hospital and community services, plus public health and health promotion programs.

Mental health problem: Diminished cognitive, emotional, or social abilities but not necessarily to the extent that the diagnostic criteria for a mental illness are met.

Mental illness: A clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional, or social abilities. Examples include anxiety disorders, depression, bipolar disorder, eating disorders, and schizophrenia.

National Disability Insurance Scheme (NDIS): Provides eligible participants with permanent and significant disability with the reasonable and necessary supports they need to enjoy an ordinary life. The NDIS also connects people with disability and their carers, including people who are not NDIS participants and their carers, to supports in their community.

Substance use problem: Use of alcohol or other drugs to a harmful extent, and may also involve losing control over use and becoming dependent on the substance.

Warm referral: The individual making the referral makes first contact on behalf of the client, and explains to the referral organisation the client's circumstances and the reason they believe the client would benefit from the referral.

Abbreviations

ACCHS	Aboriginal Community Controlled Health Services
AMHI	Australian Mental Health Initiative
AOD	Alcohol and Other Drugs
CW	Central West Queensland
HHS	Hospital and Health Services
ISSR	Institute for Social Science Research
NDIS	National Disability Insurance Scheme
NW	North West Queensland
PHN	Primary Health Network
QMHC	Queensland Mental Health Commission
SW	South West Queensland
WQPHN	Western Queensland Primary Health Network

Executive summary

This report provides actionable insights into improving the ability of individuals with a lived experience of mental health difficulties, mental illness, and/or problematic substance use to take up referrals in far western Queensland. Evidence was gathered from a systematic review of national and international literature (Chapter 2), an analysis of Australian policies (Chapter 3), and qualitative research into the experiences of service users (Chapter 4).

Literature Review

Our systematic review of the literature regarding integrated models of care relevant for rural/remote communities indicated that:

- Recruitment of health professionals, social workers, and peer advocates improved clients' wellbeing and increased referral uptakes.
- Co-location of health and social services led to an efficient service delivery resulting in increased referral rates and treatment plans.

Establishment of practice guidelines, on the other hand, lacked formal evaluation to assess its effectiveness compared with other integration strategies.

We also determined from the review that the term *service integration* covers a variety of ways of bringing different levels of unification to services, and there is consensus that integration must be client focused and context specific to be beneficial to health and wellbeing. Themes in the literature relevant to the provision and acceptance of integrated support for consumers with complex needs are summarised below:

- Consumers' beliefs, previous experiences, and internalised stigma may act as significant barriers to service uptake. Consumer characteristics such as housing, employment, and education status can impact on their ability to access recovery services.
- Social supports may be valuable in the recovery process.
- Both warm and supported referrals were essential for improving uptake of referrals across services.
- Locally-driven approaches, designed within the capacity and limitations of local resources, were helpful for longer-term sustainability.
- Co-location of health and social services led to an efficient service delivery resulting in increased referral rates and treatment plans.
- Workplace culture and leadership were important for the introduction and sustainment of integrated care systems. Recruitment of skilled health professionals, social workers, and peer advocates improved consumers' wellbeing and increased referral uptakes.
- Communication in the forms of consumer information sharing and cross-agency relationship building was important
- Significant financial costs were a necessary investment to achieve integration but resulted in down-stream efficiencies.

Overall, our review of the literature showed that consumer-centred, holistic care is attainable for consumers with complex needs. It also showed that service integration can take many forms, and that implementation needs to be context specific.

Policy review

In general, our review of policies and procedures demonstrated strong support for a holistic response to consumers with complex needs and support for integration of services. We observed a cascading of policy and program recommendations from the national level, particularly from *The Fifth National Mental Health and Suicide Prevention Plan,* down to local policies such as the *WQPHN Strategic Plan*. Priorities from the *Fifth Plan* were strongly reflected in other policy documents, with planning elements and action points from state- and local-level policy documents clearly aligned with the *Fifth Plan*.

These policies set a clear definition of service integration at all levels and types of services and stipulate arrangements for the Australian Government, the Queensland Government, non-government organisations and other service providers to function together. They present clear and specific guidelines and action points; although some gaps were noted that future policies may address.

Overall, there is a strong policy environment to guide strategic approaches to service access, emphasising promotion, prevention, and person-centred responses as well as service providers working together to support consumer recovery and improved wellbeing.

Consumer perspectives

The qualitative research undertaken with consumers produced eight key findings:

1. Warm referrals enable service uptake.
2. Information sharing between service providers is largely accepted and valued.
3. Actual or perceived risks to service continuity can be a barrier to uptake, effectiveness, and integration for remote services.
4. Support networks can be leveraged in support of service integration, with scope to offset some of the challenges of distance.
5. Actual or perceived diagnostic overshadowing can limit the effectiveness of service referrals.
6. Physical infrastructure can be a barrier or enabler to service uptake.
7. Integrated service responses need to be culturally appropriate, including for Aboriginal and Torres Strait Islander and LGBTIQ consumers.
8. There is indicative evidence that consumers are open to online service delivery as part of a service integration model if applicable.

Themes pertaining to the actionable insights based on these were the importance of communication, providing a safe environment for consumers, and continuing professional development for service providers. This was particularly relevant to understanding the needs of consumers who identified as Aboriginal or Torres Strait Islander, or LGBTIQ.

Summary

Drawing together our findings from the systematic review of the literature, our analysis of the policy landscape and our findings from the qualitative research with consumers, we identify and synthesize a number of factors which contribute to consumers' ability to take up referrals and participate in integrated care. There is a need to:

- fully consider the consumer—their characteristics and their circumstances—in choosing a referral that is appropriate and practicably accessible

- fully engage the consumer as an active participant in their care and referral, informing them about the service, the practitioner and the benefit of the connection, and offering choices.
- overtly connect the consumer with the referred-to service or practitioner, following up to ensure that appointments are made, attended and that the consumer is appropriately supported.

Finally, there is a need for appropriate infrastructure to facilitate these needs: information sharing pathways and guidance; capacity for services to physically, professionally and sometimes electronically meet the consumer's needs; and continuity or sustainability of services to continue meeting these needs over time.

Many of these needs are common to all mental health consumers, rather than specific to those with complex needs or residing in rural and remote areas. However the scarcity of services and the inherent challenges of rural or remote locations throw them into sharp relief. The literature broadly reflects these needs and some effective solutions, and policy platforms exist to support implementation of strategies to address these needs, but much still depends on the skills and care of individual practitioners. The case for practical and infrastructural support for implementation of strategies at service level that leverage policy direction to care for the individual needs of consumers cannot be overstated.

1. INTRODUCTION

The Institute for Social Science Research (ISSR) was engaged by the Queensland Mental Health Commission (QMHC) to undertake qualitative research about the experiences of people with a lived experience of mental health difficulties, mental illness, problematic substance use, or comorbidity who have accessed (or attempted to access) human services in the geographic regions of Queensland's North West, Central West and South West Hospital and Health Service (HHS) regions.

The research identifies:

- enablers and barriers to consumers taking up referrals between services
- what individual consumers want, with a focus on meeting their needs holistically
- what good integration and referral processes mean to consumers.

Background

The Queensland Mental Health Commission's role is to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health, drug and alcohol system in Queensland. To support this role the Queensland Government has endorsed the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019* which aims to improve the mental health and wellbeing of all Queenslanders including those living with mental illness, mental health problems, and problematic alcohol and other drug use.

The need for better integration and coordination between services is a pillar of reform underpinning the Strategic Plan. The Strategic Plan also contains eight commitments to action including a commitment to integrated and effective government responses to strengthen the capacity of the State Government as a service provider and employer to meet complex and inter-related health and social needs. The Queensland Mental Health Commission's role, as well as developing the Strategic Plan, is to facilitate and support its implementation.

In 2014, the Queensland Mental Health Commission commissioned research into front line service providers' perceptions of service integration and referrals in the North West, Central West and South West Hospital and Health Service regions in Queensland. The project sought the views of front line service providers on the levels of integration and referrals between a wide range of services that support people living with mental health problems, mental illness, problematic alcohol and other drug use, as well as suicide prevention and postvention services. The *Service Integration and Referral Mapping for Mental Health and Alcohol and Other Drugs Regional Reports 2015* documented the findings. The Regional Reports and a summary document, prepared by the Queensland Mental Health Commission, were published on the Commission's website in early 2016 and are available at https://www.qmhc.qld.gov.au/work/promotion-awareness/rural-remote-mental-health/service-integration-and-referral-mapping/.

The Report identified a range of barriers and supports integration and effective inter-agency referrals to improve the system. The findings indicated that one of the main barriers was the ability of a person being referred to take up the referral or being reluctant to do so.

Many people have complex needs and need to access multiple services. Navigating different services can present significant challenges.

This project aims to examine the experiences of individuals with a lived experience of mental health difficulties, mental illness and/or problematic substance use who have accessed (or attempted to access) human services in the three regions, and how to improve their ability to take up referrals.

Project approach

In order to address these aims, the project approach comprises the following three elements, each of which addresses integrated care for persons with complex needs regarding mental health and substance use problems:

- a systematic review of the recent national and international literature examining appropriate and successful models of integrated care
- an overview and analysis of Australian policies with the capacity to influence the development and operation of services
- qualitative research into the experiences of service users in the South West, Central West, and North West regions of Queensland.

In this report we first present an analysis of the results from the systematic search of the literature. Second, we identify the policies that relate to integration and access to services in far western Queensland. Third, we outline the methodology used in our fieldwork and then present case study evidence about the lived experience of individuals with mental health difficulties, mental illness and/or problematic substance use in accessing services in Queensland (North West, Central West, and South West HHS regions). In our final section, we present actionable insights in relation to the barriers and facilitators for successful service integration for people with complex needs in rural and remote areas of Queensland.

2. LITERATURE REVIEW

KEY POINTS

- A total of 39 programs with relevance to understanding integrated service delivery for consumers with complex needs living in rural and remote communities could be identified, but few had been formally evaluated.
- Where evidence from program evaluations was available, it was evident that recruitment of health professionals, social workers, and peer advocates improved clients' wellbeing and increased referral uptakes.
- Co-location of health and social services also presented as leading to an efficient service delivery resulting in increased referral rates and treatment plans.
- Establishment of practice guidelines, on the other hand, lacked formal evaluation to assess its effectiveness compared with other integration strategies.
- Service integration can take many forms and implementation needs to be context specific.
- Based on the existing literature, it appears that consumer-centred, holistic care is both desirable and attainable to support consumers with complex needs to access relevant services.

2.1 Scope of the review

We undertook a systematic search of the literature to introduce scientific rigour to the literature review process by applying a clear set of inclusion and exclusion criteria and a transparent and replicable coding framework to the analysis of published and unpublished research material. This method systematically synthesises the research evidence and can determine the robustness of available information. As a result, our literature review provides an objective and defensible evaluation of the existing research evidence.We sourced and reviewed national and international material that:

a) examines the concept of service integration for people with mental health and substance use problems who have complex needs

b) identifies research, initiatives, or other mechanisms that are intended to support people with these complex needs to access relevant services and that considers their effectiveness

c) has been published in the past 15 years so as to have contemporary relevance.

We considered program evaluations of any service integration strategy which comprised primary health services, human services, social services, and housing. We also considered those with observational designs that specifically assessed service integration as an important factor for improved service utilisation and health-related outcomes. Related systematic reviews were excluded from our final list as these papers will be used during our comparative analysis and discussions.

Although our review aims to explore the perception of consumers, we also opted to consider findings from the responses of health workers and/or service providers. This triangulation of findings provides a more comprehensive assessment of the effectiveness of service integration initiatives. Moreover, our review also included studies which measured non-health related outcomes such as socio-economic status, quality of life, as well as process-related indicators. These indicators enable us to obtain ideas about improving service delivery.

Finally, we limited our search to countries whose health systems were comparable to that of Australia, to maintain relevance and applicability. Our search strategy and protocols for screening, selection, data extraction and quality assessment are detailed in Appendix 1.

2.2 Search results

The electronic database searches found a total of 3,976 studies comprising 1,508 from PubMed, 1,114 from PsychINFO, 730 from ScienceDirect, and 624 from Scopus. After the removal of 352 duplicates, 3,624 articles underwent titles and abstract screening. From this pool of studies, only 128 proceeded to full-text screening. Only 30 articles met all the eligibility criteria since the other 98 were mostly commentaries (n = 20), had no available full texts (n = 15), or were protocol papers (n = 12).

In total, 39 articles, with nine obtained from reference lists and Google Scholar searches, were included in the analysis. Figure 1 below outlines these results.This final list of studies does not include 16 studies identified from developing countries (see Appendix 2 for the list of these 16 studies), whose health and social support systems are less relevant to the Australian context.

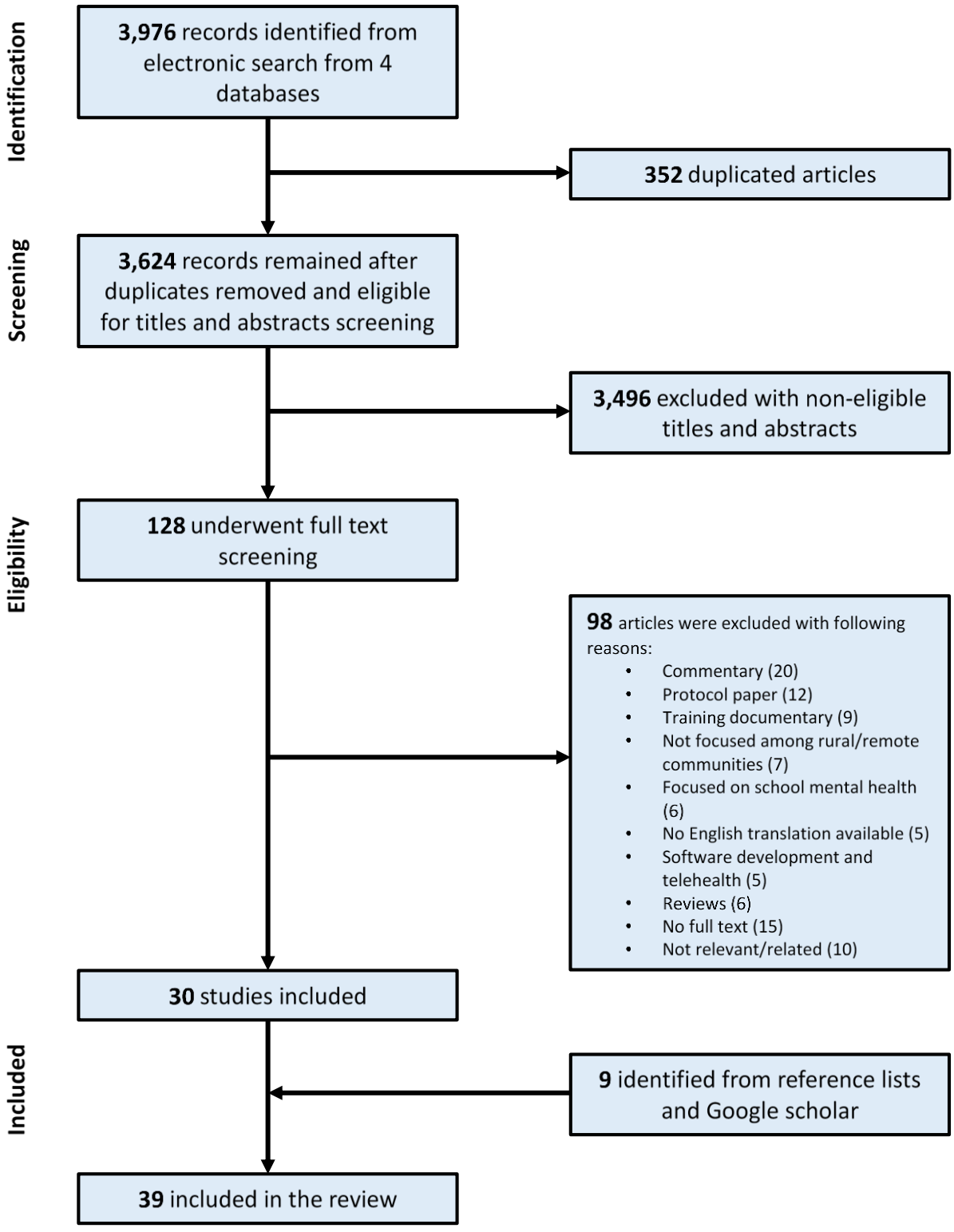

Figure 1. Search strategy

2.3 Overview of national and international integration models: a systematic review

2.3.1 Program evaluations of integration models

The following sections highlight specific features of the Australian and international programs studied. A detailed overview of the studies of integration programs included in this review can be found in Appendix 3 (Table 8).

Australian integration programs

Our search found a total of eight Australian-based integration programs, mostly from rural New South Wales (n = 4), Victoria (n = 2), South Australia (n = 1), and Queensland and Northern Territory (n = 1). Two major strategies were implemented:

- **Collaboration among health workers** (e.g. community mental health workers, general practitioners, psychiatrists, and alcohol specialists), particularly in New South Wales
- **Implementation of service delivery in a holistic approach**, which included screening, employment, legal, and social-support services.

Collaboration among health workers

The Aboriginal Community Controlled Health Services (ACCHS) developed in Western New South Wales aimed to deliver counselling services and health promotion programs among Aboriginal peoples with mental health and or substance use disorders (2). Apart from health services, ACCHS also enabled clients to access child protection, housing, and legal services via referrals from primary health care workers (PHCWs). Evaluative interviews revealed that there was a lack of collaboration among specialists from other agencies. There was also lack of trust among specialists towards PHCWs due to a lack of understanding about their roles and responsibilities.

A similar rural community program in New South Wales, the 'GP Clinic'—operated by community mental health teams (CMHTs) and visiting psychiatrists—offered services to address a range of mental health problems and substance use disorders (3). CMHTs primarily organise client appointments with their GPs and specialists. A document review from June 2007 to December 2009 by Perkins et al. (4) revealed that 40% of original clients were still using the clinic's services at the time of the evaluation. Interviews with 15 service providers found that they perceived the GP clinic to be a simple yet effective approach to addressing the needs of people with mental health problems as it prevented unnecessary admissions due to lack of service providers in the community (3, 4). Another CMHT-driven integration project in New South Wales, the *Far West Mental Health* project, focused on the re-organisation of health workers at various levels of care (5). The model was designed to mobilise CMHTs to conduct screening and referrals to GPs and psychiatrists. It also ensured that psychiatrists in community health facilities were available to conduct case reviews, mentor staff, and supervise CMHTs—apart from their usual specialised services. A three-year evaluation showed that 3,908 clients were seen by CMHTs and 380 clients were seen by psychiatrists. Analysis of the data, however, revealed poor collaboration among GPs and psychiatrists due to fast staff turn-over.

Another New South Wales program called *Nurse Practitioner-Led Primary Healthcare Mental Health Service*, which is a non-government–driven program, deployed mental health

nurses instead of CMHTs to perform quarterly visits for assessment, treatment, and referral to other services such as police services (6). An evaluation using 2011–12 records showed an 80% drop in the number of emergency cases related to mental distress and violent behaviour, from 152 in 2007 (a year before the program started) to 30 in 2011. Interviews among stakeholders revealed a successful 'integrated' delivery of health with other social services (i.e. housing, employment, transport). However, this was not the same for mental health and alcohol services due to some problems in the screening guidelines.

In rural Victoria, an integrated mental health program was launched with three different streams: Rural Depression Anxiety Research and Treatment Programme (DAR), Primary Mental Health and Early Intervention Programme (PMHI) and Eating Disorder Service (EDS). These three streams focused on capacity building of service providers to provide basic and advanced mental health services. Screening, monitoring, and treatment functions were delegated among GPs and community workers while specialist care functions were delegated among specialists. No evaluation was done for this integration program.

An holistic approach to service delivery

The Australian Mental Health Initiative (AMHI) for Aboriginal rural communities in Northern Territory and Far North Queensland was strategic, including health packages and guidelines at primary care settings (7). A routine clinical audit was undertaken to ensure the quality of care, and mental health screening guidelines to comprehensively assess patients at the primary care level were introduced. No published evaluation was done for this program.

In South Australia, another unevaluated mental health program for Aboriginal people (8, Table 1). Through its holistic approach, interagency collaboration occurred during meetings and case reviews.

The ORYGEN Youth Health program, although in West and Northwest Melbourne and not in a rural area, used a unique model to assist young people with psychotic symptoms (9). It highlights the importance of incorporating employment services conducted by an employment specialist. This specialist helped clients by conducting job capacity assessments and job searching. Motivational sessions were also part of the program to encourage young people to complete their education and pursue a career. A program evaluation based on fidelity scores showed a successful service integration within six months of implementation. Sourcing appropriate funding and workforce issues were identified as challenges that needed to be overcome to sustain good results.

In summary, four identified integration programs were found to be successful in terms of increasing referral rates and uptake of services. However, the literature describing these noted that lack of resources, especially from sectors other than health, may result in poor integration in the long term. Our search also showed that few Australian initiatives had undergone formal evaluation to measure their impact on health outcomes and service delivery.

There are, however, a range of locally driven innovations in Queensland. One recent and local example of regional service integration is the Logan Together initiative, based in South East Queensland and involving collaboration between government, non-government, and academic sectors. Although focused on child health and development, its emphasis on prevention and integration of service systems, with power-sharing between sector partners and support to build local competencies, is relevant to supporting those with mental health

problems. We have been unable to identify an evaluation of this program; however, it provides a model for how collaborative efforts may affect geographically-relevant and longer-term change in support environments.
Another such regional Queensland example is the Floresco Integrated Service Hub, originally based in Ipswich and recently extended to Toowoomba. These hubs are operated by a consortium of non-government agencies to deliver non-clinical community-based mental health services and support access to clinical treatment and related services such as employment and housing. This model aims to simplify access to the range of services likely to be needed by those with complex needs, but has not yet been evaluated. This evaluation is due to take place in 2018.

International integration programs

Our search identified sixteen programs from countries with health systems analogous to the Australian context: Canada (3), the United Kingdom (1) and the United States (12). The five major strategies employed included:

- Improving mental health referral systems
- Strengthening interagency partnerships
- Expanding mental health human resources
- Co-locating services
- Establishing service guidelines

Canadian integration programs

All the Canadian integration models were conducted in rural and remote Ontario. Of the three programs identified, two used the co-location approach as well as appropriately positioning service providers at various levels of care: counsellors and/or case managers at community level; GPs at facility level; and psychiatrists as facility managers. Paraprofessionals were also recruited to link clients with other services such as peer support, and those assisting with substance use, paediatric mental health, and housing. The other program employed a partnership model to help clients with psychosis.

Improving mental health referral systems

The Hamilton Family Health Team (HFHT) Mental Health Program was launched in 1994 in collaboration with the Ministry of Health in Ontario to promote collaboration between counsellors and specialists. The program clearly delineated the roles and functions of each service provider (e.g. counsellors, GPs, psychiatrists, other specialists) (10, 11). Each participating practice has counsellors (i.e. social workers), a GP, and a psychiatrist. It was expected that GPs and psychiatrists would work collaboratively instead of having separate/independent practices. GPs received all the referrals from the counsellors and created the treatment plan for the patients. Counsellors performed initial assessments and developed treatment plans. Lastly, psychiatrists acted as team leaders and led case reviews. During the latest part of its implementation, HFHT also recruited addiction and paediatric mental health specialists to increase the program's capacity to cater for clients with developmental and addiction problems (12).

A series of evaluations from 1994 to 2006 via facility registries and satisfaction surveys were conducted. There was an overall improvement in all of the outcome variables measured using Centre for Epidemiological Studies Depression Scale (CES-D), the Short Form 12 (SF12), Short Form 8 (SF8), and the General Health Questionnaire (GHQ) (11). Satisfaction surveys also revealed that 90% of clients were satisfied with the quality of care they received while 86% of GPs were satisfied with the available services for patients. A qualitative assessment (12) also showed improved access to various mental health services and reduced waiting times due to having all services in one location. Communication among service providers led to shared accountability and an efficient referral system.

A similar program in northern Ontario called the *Knaw Chi Ge Win Service System* recruited GPs, psychiatrists, and case managers (13). Case managers, who were psychology, social work, or traditional medicine graduates, provided counselling and assisted clients to access health, housing, and employment services. Reports from 2004 to 2007 showed reduced in-patient hospital admissions, waiting times, and professional isolation. Also, interviews and focus group discussions revealed increased satisfaction among service providers due to supportive working environments and increased satisfaction among patients due to the availability of traditional and modern behavioural therapies.

Inter-agency partnerships

The *Kingston Psychosis Prevention and Treatment program* is a partnership model developed to facilitate the promotion of early intervention among people with psychosis through inter-agency partnerships (14). Partnerships were formed with the government for funding and with a university for technical assistance and training. Community partnerships were also established among schools, GPs, psychiatrists, and services for housing, disability support, and addiction. The program's partnership model has seven major components: access, early identification, comprehensive assessment, treatment, psychosocial support, family education and support, and research and public education. In 2007, it was found that the program enabled a dramatic 5-year increase in the number of referrals among people with schizoid symptoms, with a shift from in-patient to outpatient referrals. Despite this success, there was still lack of staff to support the implementation due to the bureaucratic system of the funding institution.

Overall, the integrated mental health service programs in Canada showed improved service delivery of mental health and social services to patients, using a streamlined referral system and collaborative models among three major service providers: social workers/counsellors, GPs, and psychiatrists/specialists. There was also increased satisfaction among service providers due to supportive working environments and increased satisfaction among clients due to efficient referral processes. Conversely, internal processes within each sector required improvement to facilitate successful integration.

United States and United Kingdom integration programs

Twelve studies reported service integration practices in the United States, mostly from California (n = 4), Colorado (n = 2) and Virginia (n = 2); and only one study was found in the United Kingdom. Like the integration strategies in Australia and Canada, most of the integration programs recruited additional health workers to facilitate the service delivery.

Co-location was also undertaken to achieve an efficient provision of mental health services and an increased referral uptake. In other programs, practice guidelines were developed to prevent relapse of care and to enable sharing of patient information among service providers.

Expansion of mental health human resources

The *Behavioral Health Integration Program* (BHIP) in Washington state established a CMHT composed of primary care providers (PCPs), care managers and a psychiatrist (15). PCPs coordinated all the needed care of the patient while care managers collaborated with PCPs in conducting mental health assessments, education sessions, and behavioural interventions. Care managers were also assigned to refer patients to other agencies for legal and social services. Psychiatrists issued formal diagnoses of patients and usually handled more challenging patients. Program evaluation showed that a total 1256 clients were engaged within 18 months of implementation. Among clients meeting treatment goals, 788 improved their score on anxiety and depression measures. The PRISM-E study in Virginia evaluated a similar integration strategy for veterans with mental health and substance abuse through interviews with service providers (16). The program's deployment of an advanced practice nurse to community-based outpatient clinics enabled the sustainability of the program, indicating the interest of the community in this approach.

The Rural Care Program (RCP) in Pennsylvania also took a holistic approach, deploying social workers and nurses to increase the capacity of rural practices to include mental health services (17). Services were delivered through inter-agency collaboration, provision of educational and social support services, and the conducting of case reviews with a multidisciplinary team. Moreover, the CalMEND Pilot Collaborative to Integrate Primary Care and Mental Health enabled collaboration with social workers and health providers (18). Social workers were assigned to perform psychosocial assessments and to design a treatment plan for the patients, while registered nurses were asked to perform medical assessments and provide education. These two professionals worked together with an in-house psychiatrist and family members and, where necessary, with external social workers. Services included fitness planning, smoking cessation, diabetes management, and counselling. Despite the established program outline of RCP and CalMEND, no evaluation has been reported about these initiatives.

In other initiatives, non-health professionals were recruited. Drug treatment courts in three US states hired a specialist provider, with a bachelor's degree and four years working experience, to provide counselling and treatment services for drug court offenders (19). A survey among its 2,357 offenders showed that re-arrest rates were diminished by 5% at the post-program period. On average, it took longer for those who completed the program to be re-arrested compared with those who dropped-out. Another program trained and deployed peer resource advocates (PSA) who would meaningfully engage with women with alcohol, drug misuse, and mental health problems (20). Psychologists were also involved to provide trauma services such as bio-psychosocial group interventions. Evaluations through focus group discussions among clients revealed that PSA played a big role towards recovery by creating a healthy environment where the patient could express her concerns. It was suggested that clinical integration should be implemented with broader professional scope

through shared assessment, collaborative treatment planning, and efficient trauma assistance.

Service co-location

The Advancing Care Together program co-located mental health, substance use, and primary care services in 11 different practices in Colorado (21). Quantitative evaluation using practice records showed that 8 out of 11 practices successfully implemented their integration program, demonstrated by high referral rates and number of patients who received mental health services. Bunik et al. (22) presented an evaluation of another integrated program in Colorado from a survey among service providers. The analysis showed that integration sites were perceived to have higher access to psychologists and psychiatrists but not to social workers. Service providers also perceived that integration of mental services enabled them to screen more clients.

In Nebraska, another program called Integrated Behavioral Health Clinics (BHCs) located primary care and behavioural health services in a single facility (i.e. BHC) (23, 24). Physicians and nurses in primary care were able to refer clients to a specialist located in the same facility. A total of three BHCs assisted children and adolescents with mental health needs. Referral data in these facilities showed that 80% of the referred clients, mostly with inattention and hyperactivity symptoms, attended their initial appointment. Nearly 6 out of 10 clients with a treatment plan met their goal set during the initial appointment. Satisfaction surveys also revealed that most of the sessions were rated as having good treatment integrity.

Kilbourne et al. (25) reported three service integration initiatives in Alaska, California, and Michigan with a similar approach. Generally, these programs incorporated mental health services with regular medical services in a normal rural health facility. Despite these massive efforts, no evaluation has yet been done to assess its public health impact.

Establishment of practice guidelines

The last type of integration was the establishment of comprehensive practice guidelines in California and Scotland. The Adult Primary Care (APC) model in Kaiser-Permanente, California included the development of the Safety Interface Guideline to minimise the delay in the referral time between primary care providers and specialists (26). This guideline was employed not only to deliver services but also to properly educate patients and monitor patient health status. To facilitate this process, a centralised database was developed which enabled sharing of information among care providers.

Practices in Scotland implemented Integrated Care Pathways (ICP) guidelines to assist community mental health teams deliver health and social services (27). Evaluation of the ICP based on group discussions found that service providers were not fully implementing ICP, resulting in lack of integration particularly with social services—despite the perceived importance of the initiative.

2.3.2 Definitions and forms of service integration

Different forms of integration were reported on, but most were about integration of mental health services with primary health care and vice versa. Very few articles were about integration of mental health with social services.

Writing about mental health care in rural Australia, Fitzpatrick et al. (3) considered that Goodwin et al. (28 p. 3) captured the essence of integration when they described it as 'an approach that seeks to improve the quality of care for individual patients, service users, and carers by ensuring that services are well coordinated around their need'.

This definition is similar to Nover's (18) description of integrated care in relation to implementing a mental health and primary care partnership program in the United States. Nover defined integration as treating individuals holistically, 'taking into account their various medical and psychosocial needs, and including them in treatment planning'.

Barraclough and Barclay (6 p. 148), when describing the integration of a nurse practitioner–led mental health service in rural Australia, refer to a definition by Kodner and Spreewwenberg (29 p. 3) and highlight that 'integration includes coherence of "… administrative, organisational, service delivery … designed to create connectivity, alignment and collaboration"'.

In reporting on a study of consumer and provider experiences of integrated primary health care in Australia, Banfield et al. (30) referred to Kodner 's (31 p. 12) more recent definition of integration which teases out the various aspects of integrated care:

> *[a] multi-level, multi-modal, demand-driven and patient-centred strategy designed to address complex and costly health needs by achieving better coordination of services across the entire care continuum. Not an end in itself, integrated care is a means of optimizing system performance and attaining quality patient outcomes.*

Kodner concluded that the concept of integrated care is imprecise but that it centres around continuity-of-care and coordinated care. He pointed out that integrated care is particularly relevant for people with multiple problems.

In their report, Banfield et al. (30) delineated six necessary dimensions for effective integration: organisational, functional, service, clinical, normative, and systematic. They point out, however, that it is heavily weighted towards a professional perspective and that a consumer perspective may be more weighted towards relational aspects. The common feature of integrated care that was valued by both professionals and consumers was the sense of a collective attitude.

According to the World Health Organisation (WHO) (32), 'Integrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental care they need'. Ten principles have been identified for undertaking this integration:

1. Policy and plans need to incorporate primary care for mental health.
2. Advocacy is required to shift attitudes and behaviour.
3. Adequate training of primary care workers is required.
4. Primary care tasks must be limited and doable.
5. Specialist mental health professionals and facilities must be available to support primary care.

6. Patients must have access to essential psychotropic medications in primary care.
7. Integration is a process, not an event.
8. A mental health service coordinator is crucial.
9. Collaboration with other government non-health sectors, nongovernmental organizations, villages and community health workers, and volunteers is required.
10. Financial and human resources are needed.

Although these principles are for undertaking integration within the health sector, the ninth principle shows an understanding of the need for linking with the non-health sector and the community. When examining a broader conception of integration, authors generally referred to Leutz's (33 p. 78) definition of integration which is still relevant nearly twenty years later:

> *…the search to connect the healthcare system (acute, primary medical, and skilled) with other human systems (e.g. long-term-care, education, and vocational and housing services) in order to improve outcomes (clinical, satisfaction, and efficiency).*

Leutz explained that integration could include:

> *…joint planning, training, decision making, instrumentation, information systems, purchasing, screening and referral, care planning, benefit coverage, service delivery, monitoring and feedback*

After examining integration in the United States and the United Kingdom, Leutz concluded that integration occurs through linkage and coordination, and that full integration is not always necessary for successful outcomes. The notion of flexibility in implementation of integration according to the specificity of context has echoes in later reports and evaluations.

A succinct definition of integration between health and social sectors is also provided by Killackey and Waghorn (9), following an initiative for youth in Melbourne which integrated employment services with public mental health services. They saw integration as linking clinical recovery efforts to functional recovery.

The message from the Nuffield Trust report (2011) on integrated care in the United Kingdom's national health system was that the patient's perspective is central to integrated care and should be the organising principle of service delivery. One of the key lessons articulated in the report is that 'one form of integrated care does not fit all'. Referring to Leutz's conceptual framework (33 p. 21), the report identifies an intensity of integrated care triangle, building up from **linkage** at the base (most common form) to **coordination** (next most common form) to **full integration** (least common form). The WHO working document on *Integrated care models: an overview* (2016) further comments that as well as, there are other dimensions to intensity of integration, such as type and mechanism, and that no specific model best supports integrated care:

> *Any integrated model development is strongly contextually-bound, nearly impossible to replicate and can only be successful if it does account for unique needs and characteristics of the population it aims to serve.*

A table presenting the continuum of integration (see Appendix 4) can be found in the Queensland Council of Social Services (QCOSS) guide to integrated service delivery (34). The five types of service provision on the continuum range from autonomy (where services act

without reference to each other) through to integration (where they act as a single unit). The in-between levels are cooperation, coordination, and collaboration.

In summary, the term *service integration* covers a variety of ways of bringing different levels of unification to services, and there is consensus that integration must be client focused and context specific to be beneficial to health and wellbeing.

2.3.3 Evidence of what works to support people with complex needs to access the services they require

Integration at operational level can be viewed from two perspectives: that of service provision and that of the consumer. Most of the literature in our systematic review focuses on organisation/service systems. Very few are from a client perspective or about individualised integrated access.

The *Service Integration and referral Mapping for Mental Health and Alcohol and Other Drugs* regional report (35) identified the perceptions of service providers of the most significant barriers to integration and successful referrals. Three of those barriers relate to the characteristics of rural and remote health and social services:

- lack of access to services due to distance or cost to clients
- lack of access to specialist services
- lack of services to refer to.

The fourth barrier relates specifically to clients' individual reasons for not engaging—the major focus of our study:

- client reluctance or ability to take up referral.

The regional report also listed a number of strategies that service providers use to successfully manage these barriers:

- building relationships
- interagency forums or regular meetings with key agencies
- promoting own agency's role and function
- delivering training and/or resources.

Studies in our systematic review of the literature on evaluated models of service integration confirm the benefit of these strategies for providing better access for clients.

When we considered the literature on successful integration from a consumer perspective, a number of specific themes emerged:

- Consumers' personal characteristics and circumstances affect their ability to take up referrals. These include their environmental influences, beliefs and attitudes, demographic characteristics, and the support available to them.
    - Education at all levels—consumers, community, service providers—may be a key enabler to overcoming personal barriers of beliefs, attitudes and internalised stigma.
    - Integrating services to address housing, employment and education may be helpful.
    - Social supports may be valuable to numerous parts of the recovery process
- The way in which referrals are made has a significant impact on their success.

    - Both warm and supported referrals were essential for improving uptake of referrals across services.
- Organisational and service features can act as barriers or enablers: context, workplace culture, leadership and capacity are important issues.
    - Locally-driven approaches that were culturally informed were helpful for longer-term sustainability.
    - Recruitment, support and leadership of skilled health professionals and peer advocates improved consumers' wellbeing and referral uptakes.
    - Co-location of services supported efficient service delivery and collaboration
    - Communication in the forms of consumer information sharing and cross-agency relationship building was important.

Overall, our examination of what works for people with complex needs to access the services they require, showed that consumer-centred, holistic care is attainable. Significant financial costs were a necessary investment to achieve integration but resulted in down-stream efficiencies. It also showed that service integration can take many forms, and that implementation needs to be context specific.

Personal characteristics and circumstances that impact on accessing services

The factors emerging form the literature that enable or deter a client's ability to take up referrals are discussed under four headings:

- Environmental influences, beliefs, attitudes, and vulnerabilities
- Demographic characteristics
- Available support
- Referral process.

Environmental influences, beliefs, attitudes, and vulnerabilities

It is important to note that cultural climates and systemic attitudes such as stigma and community beliefs may impact on individual self-beliefs. The Queensland Rural and Remote Mental Health and Wellbeing Action Plan 2016–18 noted that a culture of self-reliance, stoicism, and personal resilience was a reason why some people in rural and remote areas were reluctant to seek help. It was also noted that this barrier increased when there was concern about confidentiality and the reactions of others. This is supported in the studies we reviewed.

When reporting on a service integration model for women, Veysey and colleagues (20 p. 22) discussed conservatism in rural areas, highlighting how 'small town and rural gossip poses risks for women' who have multiple problems because concern about breaches of confidentiality may prevent them from contacting services. In small rural towns, members of the police force and staff members of services are part of close-knit community life. Privacy is limited (17, 36). Veysey et al. (20) explain that women with multiple problems may fear that disclosure to a service provider may result in a breach of confidentiality, leading to social exclusion, loss of child custody and, if there is domestic violence, retaliation from their husband/partner.

The need for privacy can be related to stigma; and individuals with problems relating to mental health and or substance use may internalise stigma—that is, they absorb and accept other people's negative view of people with these problems. This negative belief by the consumer about themselves may then hinder them from accessing treatment (37, 38).

Education at a community level about mental health and substance use can bring about changes in community attitudes that can be expected to reduce the stigma attached to having these problems. Evidence from this review points to the value of community support in individual recovery (20, 39), and that education of all community members, including the client, reframes notions of service provision because of a more accurate understanding of mental health and substance use disorders.

Previous experiences—whether positive or negative—can influence client take-up of referrals (3, 37, 40, 41) as well as anxiety about the unknown (38).

For people with mental health difficulties and/or problems with substance use, these problems themselves may inhibit their ability to take up a referral or access a service (38, 42). Having one condition may be a sufficient deterrent to accessing services, but when an individual has multiple problems concerning their mental health and substance use, the barrier may be seemingly impenetrable. Priester and colleagues (42) review treatment access barriers and disparities among people with comorbid mental health and substance use disorders, and provide examples of how symptoms of mental health and substance use disorders (e.g. psychosocial instability, lowered motivation and energy, impaired cognition, distress and disorganisation) may, individually and in combination, prevent treatment access. Therefore, this barrier—the person's health condition—may also be a barrier to accessing other health and social services. The Priester review concludes that service providers may need to understand the difficulties that people may be experiencing due to their disorders, and tailor their service and referrals accordingly.

In rural and remote Australia, barriers to accessing services may be connected to a person being Aboriginal and Torres Strait Islander or having a culturally and linguistically diverse (CALD) background. Aboriginal peoples' holistic view of health as '*incorporating cultural, social, spiritual, physical, and emotional wellbeing*' (8 p. 341) may mean that existing pathways of care do not meet all of their needs. As well as mismatched expectations and practices from service providers, they may also perceive or experience discrimination on the basis of their ethnicity (8).

Services that take into consideration the cultural beliefs of Aboriginal and Torres Strait Islander peoples and people who have a CALD background provide cultural safety that acts as an enabler to service access for these people. Nagel's (43) randomised control trial of an early intervention strategy that incorporated local Aboriginal perspectives of mental health and mental illness is an example of a culturally sensitive and effective strategy. There were no specific examples in the literature reviewed of what works for people who migrated from a different country (i.e. people with a CALD background).

Barriers and enablers to service access by people who identify as lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ) received little or no attention in the literature included for this review.In brief, consumers' beliefs, previous experiences and internalised stigma may act as significant barriers to service uptake. Education at all levels—client,

community, service providers—appears to be the key enabler to overcoming personal barriers of beliefs and attitudes.

Demographic characteristics

There are a number of demographic characteristics that influence a person's ability to access services. Some of these characteristics—such as age, gender, and location—cannot be changed and, therefore, service provision needs to be tailored appropriately to meet the demographics and the personal characteristics of the client population. Other characteristics—such as, housing, employment, and education status—can be changed as service providers and policy makers can provide opportunities for improvement in these areas. Mental health and alcohol and drug use may be impacted by both sets of characteristics.

A recent study in Brisbane (44) found that homelessness was a barrier to accessing health services because ill health and homelessness worked in unison. Health care integrated with the ongoing provision of housing and social services, however, enabled illness self-management and control, and was associated with improvement in health seeking (44). The authors found that housing and the resources provided by social service providers acted as social determinants to promote healthcare access and positive health. Integrating housing and social services with healthcare thus directly enhanced people's capacity to benefit from health resources that were available (44).

The study by Killackey and Waghorn (9), noted in section 2.3.2 above, specifically reported on the integration of an employment service with a youth mental health service in Victoria. The program also included supported education because those implementing the program recognised that not having the necessary education was a barrier to employment and that this was particularly relevant as many of their clients had experienced disruption to their education because of mental illness.

In a review of strategies for implementing mental health and problematic substance use services (45), supported employment, along with peer group treatments and residential treatments, had the strongest evidence for effectiveness.

Support available

The important role of social support in recovery was highlighted in some studies (20, 38, 39); although, no specific association with improved access of services was examined. However, findings from a qualitative study of a small sample of rural woman in the United States showed that social support and provider support enabled the women to seek help for their mental health problems (37).

Referral process

Abrahams and Gevers' (38) interviews with women from a post-rape sexual assault centre illustrate the inadequacy of a passive/cold referral (i.e. a letter to another service), with some women not following up on referrals due to fear of the unknown and lack of knowledge about the service referred to. Both were seen as a strong deterrent to taking up a passive referral (17, 38).

The perception a consumer has about a service can influence whether or not they will take up a referral. Thus, consumers' perception—that they will be respected and that the service is well run, that staff members are competent, person-focused, friendly, and available—can influence their use of services (30). Educating consumers about a service they are being referred to, and actively linking the consumer to the referred service has the potential to increase take-up of referrals (17). However, if the service is not well run, and the staff members are incompetent, uncaring, distant, and unreliable, the service needs changing, not the client's perception of the service.

The CheckUP report (p. 37) further distinguished between 'warm' and 'supported' referrals and reported they were the most commonly used among service providers in the far western Hospital and Health Service regions:

> ***Warm referral****: the individual making the referral makes first contact on behalf of the client, and explains to the referral organisation the client's circumstances and the reason they believe the client would benefit from the referral.*
>
> ***Supported referral****: accompanying the client to the initial interview, assisting the client to attend the appointment by assisting with support needs e.g. arranging travel, providing an interpreter.*

Organisational and service barriers and enablers

The characteristics of an organisation/service that supports people with complex needs to access their service and other services are discussed under the broad headings of context and capacity.

Context

Context is an over-arching term used to encompass the location of service provision and workplace culture.

In rural and remote areas, people with complex needs face geographical barriers in accessing services, whether they be for health or social (e.g. housing, education, employment, financial) reasons. These geographical barriers of distance and small population size understandably increase the cost of service provision and lessen its ready availability (17, 46). There may also be barriers and enablers associated with the *rural locale* effect which, according to Bourke et al. (47), is defined by the social relations and infrastructure that occurs in response to the geographical characteristics of a particular place. Accordingly, locales are distinguished by such factors as the type and state of their economies, political and cultural values, and networks of power (3). In Australia, rural and remote locales share broad common characteristics but also have their own specific identity.

When this specificity is taken into account and the implementation of service provision is locally driven, an increased effectiveness of mental health care services in rural and remote areas is more likely (16). A study into the effect of context in mental health care in a rural town in New South Wales by Fitzpatrick and colleagues appears to support this (3). They found that local solutions were pivotal to the effectiveness of service delivery. Locally-driven approaches, designed within the capacity and limitations of local resources were also suggested for longer-term sustainability (3).

Local approaches in rural and remote areas may be directed specifically at Aboriginal communities. In these communities, effective outcomes depend heavily on gaining understanding about Aboriginal beliefs in traditional healing and outcomes (8, 13, 43). In Australia, there is a strong focus on holistic social and emotional wellbeing approaches and culturally competent service delivery, as well as services delivered by Aboriginal Community Controlled Health Services (ACCHSs)(48). The consequent concept of healing through culture and cultural activities is widely accepted but implemented only in some programs, such as one remote rehabilitation program in western NSW (49). In a further step, a mental health clinic for Aboriginal people in rural Canada included traditional healing in the suite of treatment options (13). The traditional treatment was delivered in the clinical setting and followed a protocol that was established after extensive consultation with Aboriginal community members. The respect shown for traditional treatment resulted in clients being open about their treatment preferences and use of traditional treatment. Similar examples of traditional healing inclusions are not available in Australia.

Workplace culture

Work places have their own established cultures. For example, some services may be formal in their internal staff communications and other services may favour informal discussions (16). Moreover, some workplace cultures will not be as compatible as others with providing an integrated service either from within their service or in conjunction with other service providers. Thus, a workplace culture that has a rigid clinician hierarchy and a lack of understanding or appreciation of the roles of other clinicians in the same workplace may find it difficult to integrate internally and externally (2, 50). Other authors identify the discriminatory mind sets of staff members in some areas of service provision as a barrier to integration (2, 3). Fitzpatrick et al. (3) note how stigma can become institutionalised within services. They explain that this may arise from judgements about non-attendance at appointments by people with mental health and or substance use disorders or it may be a judgement about perceived drug-seeking behaviour, and that this becomes the accepted view within the workplace.

Vision and leadership

A clear vision for integration that was understood and shared by all staff members was found to be an enabler to integration (2, 15). McGough and colleagues (15) also point out that referring people to other services needed to be seen as a supportive measure to provide optimal care rather than perceived as an ‘offloading’. Also, staff members need time to understand and adjust to changed operational processes and roles; a vision that takes a long-term view, allowing services to build on integration successes, was considered to be most effective (3, 14, 26).

A strong team leader can drive integration (8), providing a vision for improved care; however, a leadership change can de-rail a model of service delivery if the delivery relies too heavily on the leader and the model is not incorporated into workplace policy and practices that take into account the community context (16). Leadership needs to be multiple and dynamic so that progress continues even if leadership individuals change (8).

Capacity

Lack of capacity (infrastructure, finances, time, and knowledge) was identified as a reason for lack of integration (3, 25) which in turn acts as a barrier to people with complex needs accessing services.

Infrastructure

The location of a service can facilitate integration and access, and co-location is seen as an important enabler (6, 21, 22). It can lead to improved communication and team work among different service providers (21), as well as greater confidentiality, and a reduction in the stigma that some associate with services for people with mental health or substance use disorders (23). Common patient check-in areas can establish familiarity for consumers and also provide a measure of privacy, particularly if waiting-room protocols to protect privacy are in place (17, 25). This protection of privacy can reduce the fear of being stigmatised, and make it much easier for a person to access a service (51). For example, co-location of needle and syringe access at multiple service sites in country towns was seen as a way of improving use of sterile equipment for injecting illicit drugs (36).

Co-location also facilitates ease of referral to a variety of on-site practitioners, allowing health practitioners to focus on their speciality and not spend time on areas where others have more expertise. Practitioners that were co-located were also more likely to be informed about consumers following through with referrals and other treatments on site. Co-location fostered collaboration with other health and behavioural practitioners, and was considered to improve the quality of care provided (23, 24).

Co-location with social services was also beneficial (9, 44). In the Parsell et al. (44) study, where a permanent supportive housing complex for people who had been chronically homeless had an onsite multidisciplinary team, the team provided integrated healthcare ‘by acting as a conduit between tenants and mainstream healthcare systems’ (44 p. E). Integrated social and health care gave people with complex needs a greater control over their life, encouraged self-management, and solved barriers to access.

McGough et al. (15) found that it was important to have information technology tools that facilitated communication, registries, monitoring, and metrics when integrating behavioural health into primary care. Other researchers (21, 51) also point to the need for monitoring of referrals and follow up when referrals aren’t taken up.

Finances

Instability of funding was a difficulty for some programs that were designed to increase accessibility to services, as reflected across most services. When services had the financial stability to plan ahead, provision could be made for better integration of services and accessibility (17, 52). Organisations have to deal with the expectations of funding bodies, and these may make integration more difficult (8). Some of the expectations from centralised funding/governing bodies may not take into consideration the realities of local service provision, and can hinder collaboration and integration (8). The studies reviewed here highlighted that funding and central governing bodies may fail to understand the cost benefits of integration—that integration, and particularly co-location, enables efficiencies that are cost-effective while providing added benefits to consumers (8, 17, 25).

Workforce

Capacity to provide client-centred care within and between services necessitates a suitably trained and skilled workforce. This means training existing staff and recruiting suitable people (15). Staff need to be available, competent, and friendly; keep to appointment times, communicate well; provide client-centred care; and demonstrate a shared attitude to integration (30).

Training around integration issues allowed staff to see that integration can improve effectiveness and efficiency rather than adding to workload (15). Interdisciplinary training was reported to be successful in enhancing sectorial links as well as increasing the professionalism of staff and improving service quality (8, 16).

Lack of time—to educate staff, collaborate with other service providers—has been raised as a barrier to implementing strategies that improve access (52). Service providers have competing demands (2), and strategies to improve client access and service integration may seem less important than providing core services, particularly treatment.

Assisting people with complex needs to access other services relies on providers having the flexibility within their role to provide practical support in linking them to other services (27). Providing service providers with guidance on workflow and operational issues was identified as increasing their capacity to link with other services (25).

The level of connection between service providers can heavily influence whether clients access the multiple services they require. For example, Kowanko et al. (8) found that having alcohol and drug services and mental health services operating as silos prevented effective coordination of care. Lockhart (53 p. 13) reported on the '*mutual antagonism and poor communication*' between GPs and community mental health services in one rural and remote health service region in Australia. Lockhart considered the lack of connection between GPs and mental health workers to be related to their work practices: GP consultations of 10 to 15 minutes compared with mental health workers longer and less regimented interactions with clients.

Lack of face-to-face communication may hinder services connecting effectively. A Canadian report on integrating mental health services into primary care noted that when referring physicians and mental health clinicians met face-to-face, communication lead to better coordination and continuity of care (11). Face-to-face communication between service providers was seen as important by many of the researches and, though it can be fostered in various ways such as regular meetings (13), co-location was reported as an important factor (6, 13) whose benefits outweighed the challenges (9).

Suggestions for overcoming barriers to service linkage were establishing memorandums of understanding (MoUs) between services and increasing the security of shared medical records (25). To facilitate the widespread use of MoUs, it was recommended that templates be readily available. It was also thought that confidence in the security of medical records would make it easier for some clinicians to bridge a perceived professional or cultural divide.

3. POLICY AND PROCEDURES

KEY POINTS

- The policy landscape is multi-layered but demonstrates strong support for integration across mental health and related services.
- The complexity and diversity of mental health and AOD issues in rural and remote areas are comprehensively discussed and addressed through guidelines and proposed activities with both short and long timeframes.
- The involvement of non-health services such as housing, employment and legal services is highlighted to further facilitate holistic, integrated, and client-centred service delivery.
- The scope of specific initiatives such as guidelines for information exchange can be expanded from government-funded services to include community-based services.
- Strategies to promote community participation, particularly including local leaders, should also be strengthened to ensure locally-appropriate services, encourage program ownership and promote integration at all levels.

In this section, we examine the formal policies and procedures that are available for guiding service integration and the referral process for people with complex needs in far western Queensland. Policy plans are in place at local, state, national, and global levels, and we examine the context they provide and whether these plans encourage service integration and improve access to services.

3.1 The policy landscape

Providing access to mental health services for those living in rural and remote areas imposes unique challenges. The Australian mental health policy landscape is complex, with significant interplay between national, state, and local levels. Policies are also informed by the international context.

We describe these multi-level policies in some detail, with emphasis on the critical components relating to service integration for rural and remote mental health services. We recognise the significant evolution of these policies and plans in recent years, and so we outline here the most recent policies which may affect service integration.

3.1.1 Global priorities

At a global level, the *United Nations Principles for the Protection of Persons with mental illness and for the Improvement of Mental Health Care* (1991) provides the basis for planning the delivery of mental healthcare, and it informs the *WHO Comprehensive Mental Health Action Plan* 2013-20. The four major objectives of the Action Plan are to:

- strengthen effective leadership and governance for mental health
- provide comprehensive, integrated and responsive mental health and social care services in community-based settings
- implement strategies for promotion and prevention in mental health

- strengthen information systems, evidence and research for mental health.

3.1.2 Overarching national policies

The Australian Government launched the *Fifth National Mental Health and Suicide Prevention Plan* in October 2017, after an extended consultation period which allowed its content to influence state-based policies. In line with previous Plans, the most recent iteration emphasises a 'national approach for collaborative government effort' to reduce the impact of mental health issues and to improve suicide prevention.

The *Fifth Plan* describes integration as being about building relationships between organisations so that consumers and carers have better experiences and outcomes. Two of the eight targeted priority areas stipulate the importance of integrated and coordinated approaches to service delivery. These are Key Priority 1: 'Achieving integrated regional planning and service delivery' and Key Priority 3: 'Coordinated treatment and supports for people with severe and complex mental illness'.

To support these strategies, the Australian Government delegated Primary Health Networks (PHNs) to plan and commission services according to local needs, and to implement the required integration and coordinated care at local levels. The Australian Government also provides support and tools for local PHNs to implement integrated service delivery. One example of this is the implementation guide for Stepped Care, made available through the Department of Health web page specific to PHNs.

Through the National Mental Health Commission, a consortium of government and non-government agencies issued the 2016 *Equally Well Consensus Statement*—a pledge to support and improve the physical health of people living with a mental illness. The *Consensus Statement* articulates the range of needs of people living with mental illness, including secure housing and accommodation support, meaningful education, training and employment, financial security, enough nutritious food, spiritual and cultural healing, opportunities to contribute to society and connect with community, and a safe environment free from discrimination, racism, abuse, violence and trauma. In order to address this range of needs, the *Statement* outlines six essential elements and respective programmatic actions to guide service providers. These elements include:

1. A holistic, person centred approach to physical and mental health and wellbeing
2. Effective promotion, prevention, and early intervention
3. Equity of access to all services
4. Improved quality of health care
5. Care coordination and regional integration across health, mental health, and other services and sectors that enable a contributing life
6. Monitoring of progress towards improved physical health and wellbeing.

Notably, element five specifically addresses the issue of care coordination and integration.

Also relevant to the issue of integration in delivering mental health services is the *National Drug Strategy 2017 –2026,* which speaks to the complexity frequently added to mental health issues by the use of alcohol, tobacco and other drugs. The *National Drug Strategy* provides a national framework and identifies priorities of the Australian Government. The *Strategy* outlines partnerships, coordination, and collaboration as key principles to enable harm minimisation—an integrated and holistic care which **address barriers to recovery and issues such as physical health, mental health, social, economic, legal, or housing needs**.

The *Strategy* also suggests the involvement of communities to promote culturally appropriate community events, to allow for greater engagement in identifying key alcohol, tobacco and other drug issues.

Finally, the National Disability Insurance Scheme (NDIS) also has potential to play a significant role in the landscape of integrated care for mental health consumers. The NDIS aims to support Australians who experience co-occurring disabilities or problems with mental health and AOD issues. This will have significant implications for service provision, as it places the consumer in a position to 'purchase' an individualised suite of supports to meet their range of needs. While the NDIS is being rolled out gradually at both national and state levels, with specific operational plans for each state, the impact on service provision and integration, particularly in rural and remote areas, is yet to be fully understood.

3.1.3 Policies and procedures shaping Queensland's mental health systems

In 2014 the Queensland Government outlined its commitment to improving the mental health and wellbeing of Queenslanders in the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019.* The Queensland Mental Health Commission developed and monitors the whole-of-government Strategic Plan. The Commission is currently leading a renewal of the Strategic Plan which is expected to be published in late 2018. The current and renewed Strategic Plan have a focus on service integration and collaboration.

The current Strategic Plan resulted in the development of Queensland Health's *Connecting Care to Recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services* as a new plan to support mental health and alcohol and other drug services. This was informed by national- and state-level planning frameworks, as well as epidemiological and performance data, and consultations with service providers, consumers, and external stakeholders.

This plan sets five priority areas in order to facilitate person-centred and recovery-oriented services through Hospital and Health Services (HHS) and community-based agencies:

1. Access to appropriate services as close to home as practicable and at the optimal time
2. Workforce development and optimisation of skills and scope
3. Better use of ICT to enhance clinical practice, information sharing, data collection and performance reporting
4. Early identification and intervention in response to suicide risk
5. Strengthening patient's rights.

Implementation of service integration is deliberately emphasised in this plan, particularly for the first three of these priorities.

Priority 1 suggests creating referral pathways across the care continuum: community treatment services, community support services, hospital bed-based services, and community bed-based services. This is to ensure coordinated and efficient service delivery across sectors. An example of this in action is a recent joint initiative by Queensland Health and the Department of Housing and Public Works: the Mental Health Demonstration Project. This introduced an integrated housing, health, and social welfare support model to improve housing stability for people experiencing mental illness or related complex issues.

Priority 2 suggests joint planning between PHNs and HHSs to optimise the skills and scope of practice of clinical and non-clinical workforces. The capacity building activities proposed include information and communication technology (ICT) to improve coordinated care and collaboration with Aboriginal and Torres Strait Islander organisations to ensure culturally appropriate service delivery.

Priority 3 suggests establishing an integrated medical record application to incorporate mental health and general health records. Such an information system aims to improve data availability for private and other state-funded services and thus assist implementing the shared-care approach.

The *Connecting Care to Recovery Plan* also highlights the specific needs of rural and remote mental health. Community-based treatment services were considered an important component for rural and remote populations. Mapping of existing facilities and resources in the community was considered essential to operationalise coordinated care in each catchment area.

The Queensland Health 2014 *Queensland Rural and Remote Health Service Framework* recognises the need for hospital and health services catering to rural and remote communities. The framework supports HHSs in their planning to improve access to mental health services in the community. Multi-purpose health services (MPHS) provide opportunities to integrate health and aged-care services for small rural communities in Queensland, enabling family members to participate in care planning and healthcare teams to streamline health assessment activities. Designating rural and district hospitals as referral facilities also allows integration of services for patients requiring complex services.

The QMHC developed the *Queensland Rural and Remote Mental Health and Wellbeing Action Plan 2016–2018* which focuses specifically on populations in rural and remote areas. This plan specifically aims to reduce the incidence, severity and duration of mental illness, reduce suicide, and prevent and reduce the adverse impact of alcohol and drugs by undertaking action points under three priority areas. These highlight an integrated approach to support families and promote social inclusion by facilitating access to housing, education, and employment in addition to health services. Integration of service providers with the community is also believed to strengthen communities' capacity and connection and improve resilience, especially during disaster and drought. Such integration can create core groups within the community to mobilise health, housing, and social services/sectors to support this strategy by conducting community events and workshops.

The *Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016–2021* aims to eliminate 'the gap in mental health outcomes between Aboriginal and Torres Strait Islander Queenslanders and non-Indigenous Queenslanders'. This aligns with the recovery-oriented treatment approach of the *Fifth Plan* and aims to ensure that that Aboriginal and Torres Strait Islander Queenslanders with severe mental illness receive culturally capable mental health services. In line with Indigenous concepts of health as being multidimensional in nature, rather than focusing separately on mental health, physical health and social/emotional wellbeing, this Strategy focuses on integrating care across mental health and social and emotional wellbeing services from both Queensland Health and non-government organisations, and developing integrated case management mechanisms that are particularly relevant for those with complex needs and comorbidities.

In mid-2016 the National Disability Insurance Agency, the Australian Government, and the Queensland Government issued an *Operational Plan* for the roll-out of the *National Disability Insurance Scheme* (NDIS) in Queensland. The operational plan will guide continuous collaboration between these three agencies to develop detailed phasing strategies and implementation approaches to increase readiness during this transition period.

We also assessed a number of procedures and guidelines which support the above-mentioned strategic plans. It is important to note that this was a scan of readily available documents rather than a full systematic search. The available documents include general guidelines such as the *Queensland Health Dual Diagnosis Clinical Guidelines and Clinician's Tool Kit (2010)* which, although dated, provides guiding principles for the management of co-occurring mental health and alcohol and drug problems and direction on how to provide coordinated, holistic, and collaborative care.

The Queensland Health *Queensland Mind Essentials: Mental Illness Nursing Documents and Information Sharing Guidelines* are also relevant to progressing integration and the referral process in far western Queensland. The *Mind Essentials* resource guides nurses in treating patients with mental disorders. *Information Sharing* is a guide for sharing information between mental health staff, consumers, family carers, and others. It is important to note that data sharing described in the *Information Sharing Guideline* is an essential component of integrated care systems in rural and remote communities. This was also highlighted as the third priority in *Connecting Care to Recovery*. This *Guideline* assists facilities and service providers to share information within service delivery networks to facilitate integrated care. It also addresses the important issue of consent for information sharing and defines the conditions under which such sharing is appropriate.

One particularly relevant guideline is QCOSS's *A guide to integrated service delivery to clients.* This document describes a continuum of integration, ranging from autonomy through to cooperation, coordination, collaboration, and integration. QCOSS defines integrated service delivery, but goes further in suggesting types of integration activities, including:

- Service initiated case conferencing which enables sharing of information among a number of agencies involved;
- Integrated case management involving providers from various services to provide assessment, planning and client management; and
- Collective impact approaches bringing in government, business and community to address broader social problems.

3.1.4 Mental health systems in far west Queensland

National and state-level policies encourage collaboration between government and non-government agencies to optimise the delivery of mental health and AOD services. Such collaboration includes the Primary Health Networks (PHNs) and Hospital and Health Services (HHSs). These agencies play a major role in building an efficient health system for people living with mental health and AOD issues in far west Queensland.

The **PHNs** are funded by the Australian Government to ensure effective and efficient coordination between primary and specialist mental health services. They commission and manage community-based services to support service integration at regional level and support service providers with shared care pathways, triage protocols, and local treatment planning.

On the other hand, the **HHSs** are funded by the Queensland Government to provide health services and implement national clinical standards in the respective local area. HHSs are considered the principal providers of public health and hospital services but are expected to work with other providers and PHNs. For example, nine Queensland HHSs, including South West, Central West, and North West, were expected to employ senior clinicians to facilitate the integration of clinical care and community support in rural and remote areas as part of Queensland Health's *Tackling Regional Adversity through Integrated Care* (TRAIC) initiative.

Cooperation between the two systems is evident in far western Queensland in the partnership between the Western Queensland Primary Health Network (WQPHN), the South West, Central West and North West HHSs, Aboriginal and Islander Community Controlled Health Services (AICCHSs) and other NGOs to develop the *Mental Health, Suicide Prevention, Alcohol and Other Drug Services Regional Plan 2017-2020*. This plan aims to improve mental health, prevent suicides and address alcohol and other drug issues using a sustainable approach. In this plan, WQPHN proposes an integrated system (see Figure 2) to respond to issues on remoteness, inadequate health workforce, poor public transport system and limited telecommunication.

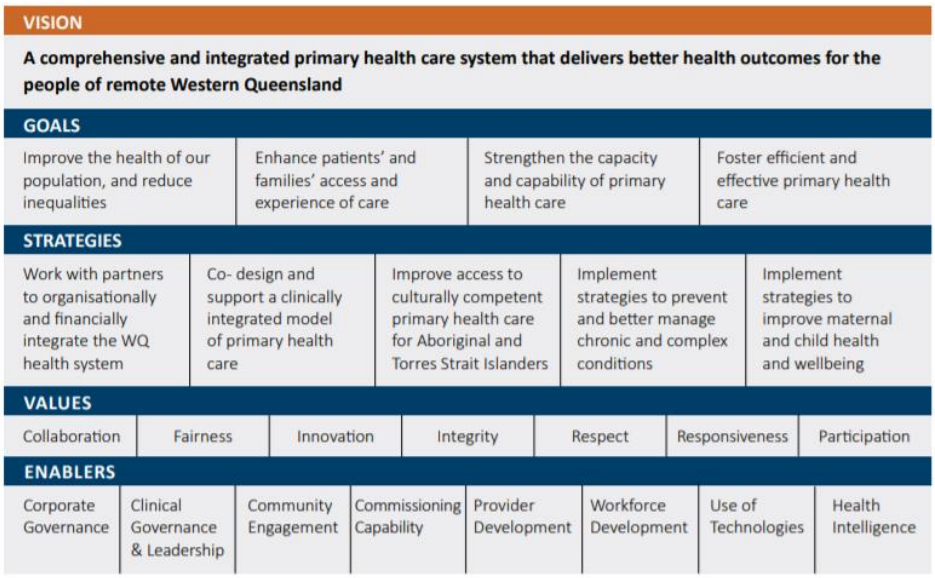

Figure 2. WQPHN Strategic Framework

WQPHN's primary care model focuses on patient-centred and GP-led care. GPs are expected to collaborate with service providers from other agencies to deliver culturally safe services, especially for Indigenous clients, to implement the use of digital technologies for information and telehealth access, and to apply a stepped-care approach for efficient and coordinated care. This places them at the core of service integration. As the cross-cutting element of this strategic plan, stepped-care responds to clients' needs by introducing a

hierarchical strategy of evidence-based interventions, supplemented with culturally competent services to ensure holistic care and prevent further emotional harm.

In this current service delivery model, the South West, Central West, and North West HHSs are also mobilised to provide primary care services and mental health and AOD services. Because of the limited in-patient services in Western Queensland, HHSs are delegated to provide mental health teams to carry out shared care plan and provide medications, intensive therapies, psychosocial support, and support to GPs. These teams may include:

- psychiatrists
- psychiatric registrars
- team leaders
- nurses (mental health nurses)
- psychologists
- social workers
- occupational therapists
- Aboriginal and Torres Strait islander health practitioners
- Indigenous mental health workers
- administration officers.

HHSs also serve as resource to increase capacity among GPs and mental health teams.

In light of this, HHSs are well placed to lead joint planning groups to perform the functions essential to implement service integration in the far west:

- plan and coordinate services regionally and within localities
- develop mechanisms to promote greater integration of specialist services
- support shared data arrangements to support measurement and improve service effectiveness
- support the development of clinical directories that document care pathways locally, regionally and State-wide, with the aim of ensuring seamless transition from primary to specialist services and back (particularly for those people who need to access specialist services out of the region) and ready access to specialist advice for general practice teams
- optimise access to all available funding, including co-commissioning pooling of funds
- establish procedures to follow-up clients to ensure a clear recovery pathway in coordination with case managers and GPs.

In addition to PHNs and HHSs, we also note the critical role of non-government organisations in the overall mental health system. Their participation in providing services, assisting with coordination and also in the development of WQPHN's strategic plan, are essential to ensuring better mental health outcomes and wellbeing in the rural and remote region.

3.2 Policy analysis

We identified the following policy documents relevant to service integration, particularly in rural and remote areas:

- Fifth National Mental Health and Suicide Prevention Plan
- National Drug Strategy 2017–2026
- National Disability Insurance Scheme

- Equally Well Consensus Statement
- Connecting Care to Recovery 2016–2021
- Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019
- Queensland Rural and Remote Mental Health and Wellbeing Action Plan 2016–2018
- Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016–2021
- Queensland Rural and Remote Health Service Framework
- WQPHN's Mental Health, Suicide Prevention, Alcohol and Other Drug Services Regional Plan 2017–2020
- QCOSS's A guide to integrated service delivery to clients.

In this section, we analyse these policies using a set of attributes drawn from our experience in policy, from international standards such as the World Health Organisation's key principles for mental health integration, and from the literature describing successful service integration. For these analyses, we excluded procedures and guidelines, as these tend to cover only specific aspects of service integration (e.g. information sharing or clinical guidelines). The attributes we examined were:

1. Commitment to the value of service integration starting from the primary care level
2. Commitment to resourcing service integration with a whole-of-system approach including inter-sectoral collaboration
3. Appreciation of the complexity and diversity of consumer needs in broader and/or local context
4. Evidence of related guidelines and/or procedures to support the operationalisation of policy (e.g. capacity building, logistics, infrastructures)
5. Commitment to information sharing between service providers
6. Prioritisation of people living in rural and remote area as reflected by (proposed) action points
7. Recognition of community participation as an essential component for a sustainable and culturally responsive service delivery.

In general, the policies demonstrated strong content in terms of the first four attributes, as shown in Table 1. We observed an effective cascading of policy and program recommendations from the national level, particularly from the *Fifth Plan,* down to local policies such as the *WQPHN Strategic Plan*. Priorities from the *Fifth Plan* were strongly reflected in other policy documents, with planning elements and action points from state- and local-level policy documents clearly aligned with the *Fifth Plan*.

These policies set a clear definition of service integration at all levels and types of services and stipulate arrangements for the Australian Government, the Queensland Government, NGOs, and service providers to function in order to achieve their aims. At the national level, policies highlight care coordination and regional integration by involving other services such as public housing, welfare, legal, and economic services. At the state level, policies refer to elements of integrating clinical services with community-based programs in rural and remote areas. For example, the *Connecting Care to Recovery* plan highlights the importance of partnership and integrated care models in partnerships between PHNs and HHSs to enable continuity of care. A person-centred approach also emerged strongly as a common theme to produce holistic services available for clients. At the local level, the WQPHN's *Strategic Plan* proposes to implement stepped care to achieve recovery, wellbeing and

resilience. This includes the integration of general practice teams with social services (e.g. psychological services, general practice, and youth mental health) at primary care level. As the clients' condition becomes complex, early interventions and case management are to be implemented.

All of the strategic plans present clear and specific guidelines and action points. For example, the NDIS plan for Queensland specifies deliverable elements and timelines for reaching inter-sectoral arrangements and introduction of service delivery models to facilitate systems readiness during NDIS state-wide transition. The QMHC's *Queensland Rural and Remote Mental Health Plan* proposes evidence-based programmatic actions which include funding, inter-agency meetings, support service roll-out, and policy development to support its three priority areas.

We also noted some gaps that future policies or action plans may address. Policy directions on information sharing mechanisms were limited in some state-level policies. For instance, *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019* proposed the development of shared assesment forms that can be accessed by service providers. Operationalisation of these across multiple service providers and utilization of shared IT platforms to enable sharing would be useful into the future. The Queensland Health *Rural and Remote Service Framework* maps out health facilities from community to district level but does not provide potential vertical and horizontal sharing procedures. Some policies demonstrate well-defined action plans to promote data exchange among service providers. The WQPHN's *Strategic Plan* proposes to implement a 'shared health intelligence' system to support clients who are participating in prevention and recovery programs in far west Queensland. Data sharing arrangements are to involve service providers, Queensland Health and GP networks to develop shared electronic health records and care plans (e.g. WQPHN Qlik Sense).

Table 1.Analysis of mental health, drug and alcohol policies

Policy documents	Policy attributes						
	Valuing integration	Resourcing integration	Acknowledge complex needs	Guidelines	Information sharing	Rural/remote prioritisation	Community participation
Fifth National Mental Health and Suicide Prevention Plan	✓	✓	✓	✓	✓	✓	✓
National Drug Strategy 2017-2026	✓	✓	✓	✓			✓
National Disability Insurance Scheme	✓	✓	✓	✓	✓	✓	✓
Equally Well Consensus Statement	✓	✓	✓	✓	✓	✓	✓
Connecting Care to Recovery 2016-2021	✓	✓	✓	✓	✓	✓	
Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019	✓	✓	✓	✓	✓	✓	✓
Queensland Rural and Remote Mental Health and Wellbeing Action Plan 2016-2018	✓	✓	✓	✓	✓	✓	✓
Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016-2021	✓	✓	✓	✓		✓	✓
Queensland rural and remote service framework	✓	✓	✓	✓		✓	✓
WQPHN's Mental Health, Suicide Prevention, Alcohol and Other Drug Services Regional Plan 2017-2020	✓	✓	✓	✓	✓	✓	✓
QCOSS's A guide to integrated service delivery to clients	✓	✓	✓	✓	✓		

Legend: ✓-Fully exhibited the attribute; ✓- Partly exhibited the attribute; Unchecked-Did not exhibited the attribute

Commitment to prioritise rural and remote areas was not overtly emphasised in some national-level policies. For example, the *Equally Well Consensus Statement* provides a general statement about access issues for people in rural and remote areas but no specific program recommendations. The *National Drug Strategy* does not reflect macro-level elements for people in regional areas. Conversely, most state-level policies articulate stronger support. Queensland Health's *Connecting Care to Recovery* plan suggests flexible and sustainable care models to improve access to early intervention and specialist services. These models include the state-wide clinical e-CYMHS (Child and Youth Mental Health Service) and the Ed-LinQ initiative which aim to engage primary and secondary students with emerging mental health problems.

A number of the policies examined recognise community participation as an integral component of successful integration. The *Fifth Plan* includes the rate of social/community participation as a national indicator for meaningful life. The policy has a clear discussion about the link between community participation and employment and housing outcomes. Joint care plans were encouraged—not only with consumers but also with social/community groups. In rural and remote Queensland this is believed to promote social inclusion which can prevent suicide and problematic AOD issues in the long-term. Activities encouraging community ownership are proposed to ensure that programs being implemented address the local needs of the community. In terms of HHSs, Queensland Health's *Rural Health Service Framework* discusses MPHS facility as a platform to co-design care plans with the community. Some national-level policies also emphasise the inclusion of cultural components to improve service delivery for Aboriginal and Torres Strait Islanders. However, these failed to discuss specific program directions to operationalise collaboration between service providers and the community.

3.3 Conclusion

There is strong policy support for integration and for better access to services and there is direction for the expanding and strengthening of guidelines to support the implementation of policy in these areas. These policies and procedures guide strategic approaches to service access, emphasising promotion, prevention, and person-centred responses as well as service providers working together to support consumer recovery and improved wellbeing.

4. QUALITATIVE RESEARCH WITH CONSUMERS

KEY POINTS

Qualitative interviews with consumers yielded a number of actionable insights:

- Warm referrals enable service uptake
- Information sharing between service providers is largely accepted and valued
- Actual or perceived risks to service continuity can be a barrier to uptake, effectiveness, and integration for remote services
- Support networks can be leveraged in support of service integration, with scope to offset some of the challenges of distance
- Actual or perceived diagnostic overshadowing can limit the effectiveness of service referrals
- Physical infrastructure can be a barrier or enabler to service uptake
- Integrated service responses need to be culturally appropriate, including for Aboriginal and Torres Strait Islander and LGBTIQ consumers
- Consumers may be open to online service delivery as part of a service integration model if applicable:

As noted, most of the evidence found during the literature review focussed on organisation- and system-level factors influencing the success or otherwise of service integration. Little published material was found reflecting the views or needs of individuals, particularly in rural and remote areas. To address this important gap in the evidence and to understand the experiences of people with a lived experience of mental health difficulties, mental illness or problematic alcohol and other drug use accessing and being referred to human services, we conducted a program of in-depth qualitative interviews of individuals with first-hand experiences.

The choice to undertake qualitative interviews with people was informed by the key finding in the Regional Report (3) commissioned by QMHC that service providers *perceived* that one of the key barriers to integration and effective referrals was 'the ability of the person being referred to take up the referral or being reluctant to do so'.

People with mental health and substance-use difficulties require tailored approaches to treatment and support that take into account their complex needs and their resulting degree of vulnerability. People in remote Queensland face additional challenges in accessing services that are specific to their area. It could be argued that only by listening and documenting their stories can we enable service providers to provide appropriate consumer-centred care and wrap-around services. Examining the experiences of those seeking help—what works for them and what does not—informs the ability of services, and the service system as a whole, to meet their needs.

Our insights from the qualitative interviews on practical approaches to improve the ability of individuals to accept and be able to act on referrals are analysed with reference to elements noted by the literature as important to service integration (e.g. warm referrals, information-sharing). We also consider how the insights from our participants reflect on the policies and procedures described in Section 3. This systems analysis allow us to consider

the adequacy of current policies and procedures for implementing approaches based on these insights.

4.1 Methods

Recruitment

We recruited individuals in the South West, Central West, North West HHS geographic regions. Figure 3 below shows the location of these regions. The overarching criteria for sampling were that individuals had a lived experience of mental health difficulties, mental illness and/or problematic substance use and had accessed (or attempted to access) human services in the three regions. We extended eligibility to parents of children accessing services for their child.

We took a multi-pronged approach to recruitment, enlisting support and assistance from neighbourhood and community centres with the support of QCOSS and from local service agencies identified through service directories and personal contacts. Service personnel identified potential participants and linked them with the interviewer. There were also some peer referrals (snowballing). Suitability to participate was established by the interviewer, either in-person or by phone, using pre-set criteria. If individuals met the selection criteria, they were invited to participate in an interview. Participants were permitted to have a support person present if they desired.

Interviews

A total of 39 in-depth qualitative interviews were conducted by a senior researcher. The interviews lasted approximately one hour, and were held face-to-face at a location convenient for the participant (i.e. service agency, neighbourhood centre, or café). Questions centred around five set themes:

- the experience of accessing multiple service types
- perceptions of service effectiveness and quality, exploring what was helpful and what wasn't
- perceptions of efficiencies or inefficiencies in service integration
- experiences of interpersonal and/or system issues impacting on their likelihood of taking up a service referral
- socio-demographic characteristics impacting on the likelihood of successful service referrals

Participants received $60 for their participation.

Ethics

The research complies with The University of Queensland's Guidelines for the Ethical Review of Research Involving Humans, and the project has received approval from the University of Queensland Human Research Ethics Committee (#2017000499).

We also benefited from consulting with the project advisory group and co-designed our research engagement strategy with them.

Data analysis

Interviews were recorded and transcribed verbatim. Data were analysed thematically using the computer program NVIVO.

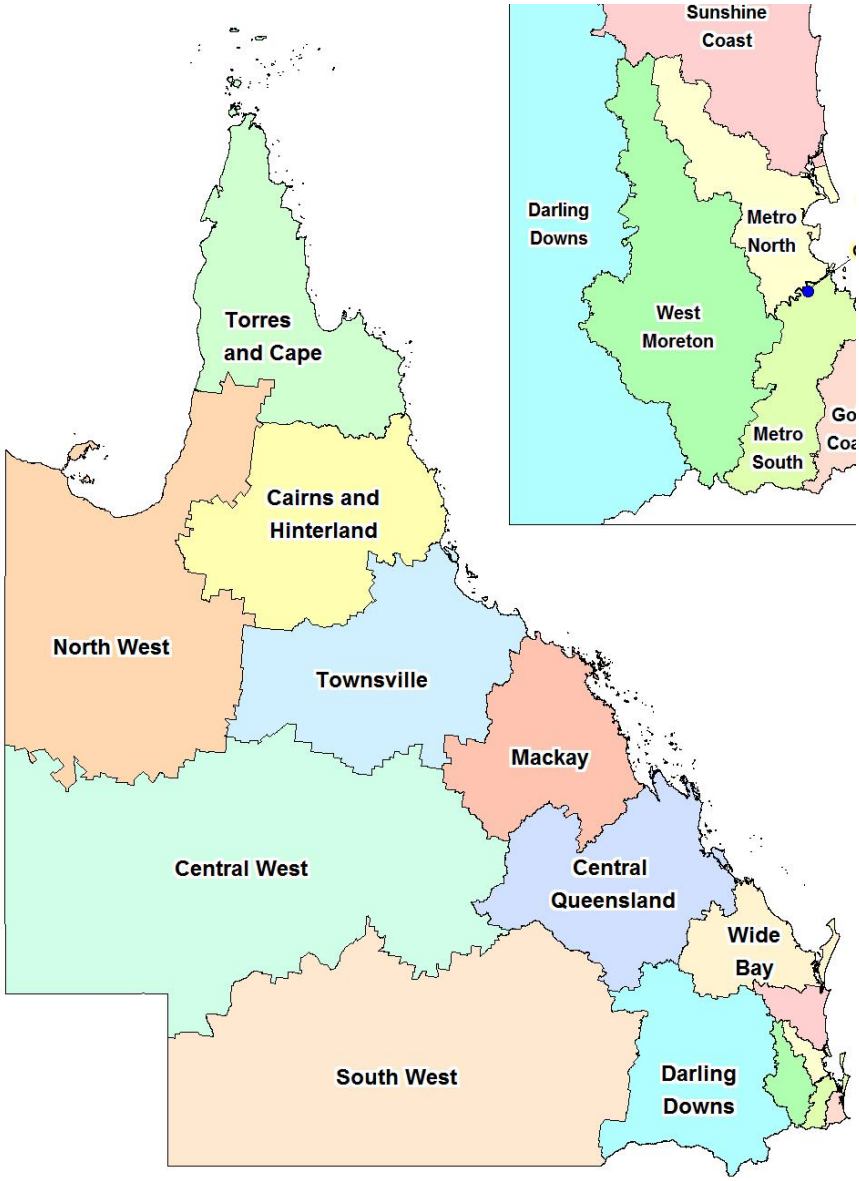

Figure 3: Queensland Hospital and Health Service regions

4.2 Participants and contexts

Locations

Of the 39 people recruited in far western Queensland, 17 were from the South West, 11 from the Central West, and 11 from the North West. To support diversity of participation, we recruited from 10 towns in the three HHS regions. The major regional service centre for each region was included: Roma (SW), Longreach (CW), and Mount Isa (NW). The locations of these towns are shown in Figures 4-6 below.

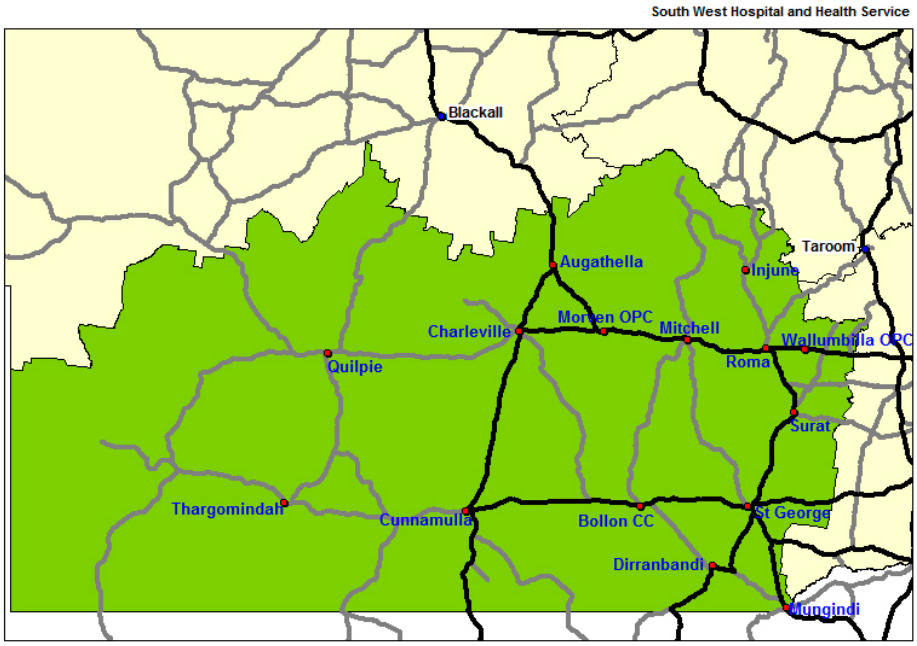

Figure 4: South West Hospital and Health Service: population 26,722

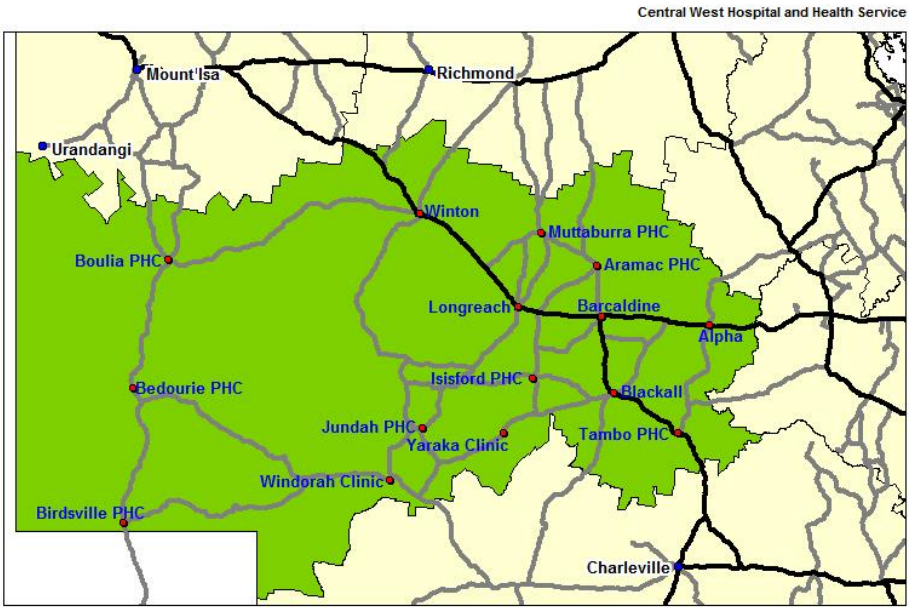

Figure 5: Central West Hospital and Health Service: population 12,428

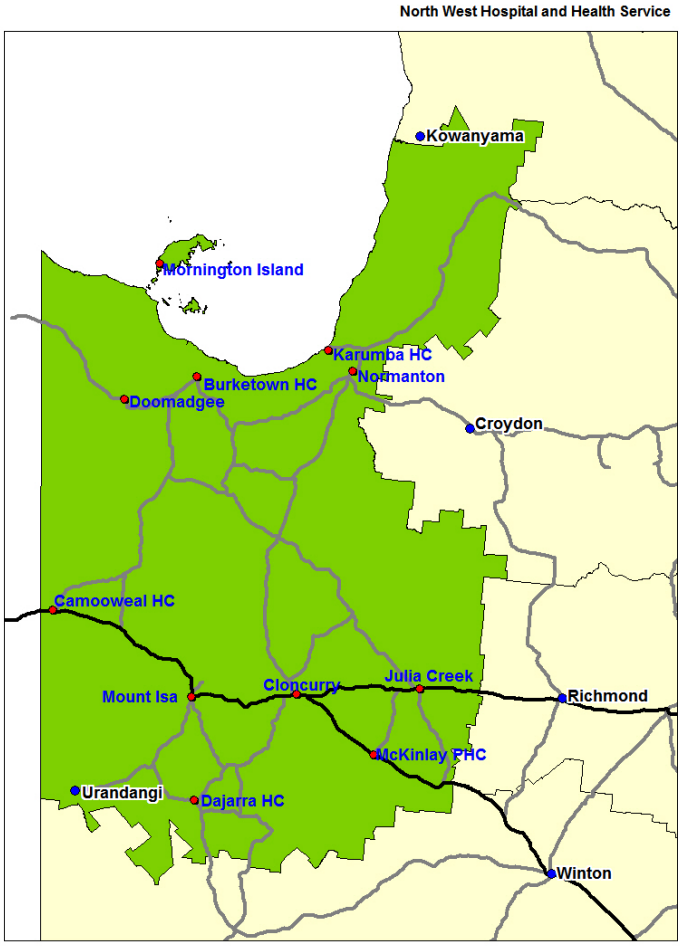

Figure 6: North West Hospital and Health Service: population 32,621

The Central West is more noticeably remote due to its distance from the coast and the South East, its small population, and a circuit of small towns grouped around the modest-sized town of Longreach (the hub). In contrast, the South West is the closest to Brisbane and the south-east corner of Queensland and its hub, Roma, is classified as outer regional rather than remote by the Australian Statistical Geography Standard (ASGS) Remoteness Structure (54). Although the North West region is at the top of Queensland, its population is relatively large, mainly due to Mt Isa, a well-established mining town with a population approximately the same size as the whole of the Central West region.

Participants

The sample size of 39 consumers was sufficient to capture the diversity of the population being sampled and yet obtain an appropriate level of saturation on the main themes. Selection of the sample was not designed to be statistically representative but to be sufficiently large to offer insights and experiences from a wide range of participants, and to provide recommendations for practical approaches to improve referral and integration processes.

Participants ranged in age from 19 to 72 years, 21 were male and 18 were female. The majority of participants were not in the workforce and most lived in a town. We wanted to ensure that we included Aboriginal peoples, people with a CALD background, and people

who identified as LGBTIQ. Recruiting people who identified as Aboriginal happened organically and 17 participants identified as Aboriginal or Torres Strait Islander. We targeted recruitment of LGBTIQ people and five participants identified as being lesbian, gay, bisexual or transgender. Unfortunately, our efforts to recruit people with a CALD background were unsuccessful (See Appendix 5).

Table 2. Participants

Pseudonym	Age (years)	Marital status	Aboriginal	LGBTIQ	Employed
SOUTH WEST					
Evita	53	married	no	no	yes
Jeff	30	single	yes	no	no
Jack	37	partnered	no	no	yes
Patrick	19	single	no	bi-sexual	no
Ruthie	51	married	yes	no	yes
Nanette	20	single	yes	no	no
Renay	36	single	no	no	no
Vina	34	single	yes	no	no
Margo	46	married	yes	no	no
Tony	40	single	no	no	no
Lea	32	married	no	no	no
Stavros	49	single	no	no	no
Charles	22	single	no	no	no
Terry	32	single	no	no	no
Caroline	72	married	no	no	no
David	37	partnered	yes	gay	no
Aaron	47	partnered	yes	gay	yes
CENTRAL WEST					
Michael	43	partnered	no	no	no
Arlene	30	partnered	no	no	no
Thomas	40	single	yes	no	no
Veronica	42	single	no	no	no
James	61	single	no	no	no
Andrew	42	separated	no	no	no
Marie	45	partnered	yes	lesbian	no
Gloria	42	partnered	yes	no	no
Dean	29	partnered	no	no	no
Peta	50	married	no	no	yes
Frances	64	widowed	no	no	no

NORTH WEST					
Brad	20	single	yes	no	no
Dan	41	single	no	transgender	no
Florence	61	single	no	no	no
Marcus	35	single	yes	no	no
Barry	51	single	yes	no	no
Sarah	55	single	no	no	yes
Ann	50	partnered	yes	no	yes
Cassie	42	married	yes	no	yes
Timothy	53	single	yes	no	no
Michelle	55	widowed	no	no	yes
Bill	44	single	yes	no	no

4.3 Case study evidence

The qualitative interviews with consumers yielded a rich body of evidence. Our findings are structured below under eight themes which emerged during the analysis. Direct quotes from our consumer participants, using pseudonyms, illustrate these points.

Warm referrals enable service uptake

The qualitative data from consumers in this study demonstrate that a warm referral constitutes an enabler to service uptake. As identified in our literature review, warm referrals support service integration by enabling a three-way connection between the consumer, the referring service provider, and the service to which the consumer is referred. This '*mutuality and trust*' between providers has been described as, '*a tight circle of people with detailed knowledge doing their best for the person at the centre*' (55). From the consumer perspective, an effective warm referral involves more than their referring service provider contacting another service on their behalf or providing background information; it is characterised by consideration of the consumer's personal capacity to take up the referral, explanation for the referral, and monitoring by the referring organisation.

Previous research, conducted in the same Queensland regions that were visited during our study, reported that most service providers believe they are providing warm referrals to consumers (35). From the perspective of service providers (35), a warm referral entails making first contact on behalf of the client with the referral service and, with the client's consent, sharing information with the service about why the client is being referred. Our results show that consumers appreciated being contacted by the service they were referred to in order to arrange their first appointment. James expressed his satisfaction with the way he is referred by his GP, '*he does a form up, he sends it off, and they ring me and make an appointment … I love it.'* Sarah was grateful that her referral to a social worker was organised for her, '*They arranged it all … It's wonderful*.' The significance of proactive actions taken by the 'referred to' organisation can be further gleaned from the experiences of consumers where this active warm referral process was absent. The experience of some consumers indicates that without such proactive practice they will not engage with services that they have been referred to. Andrew, for instance, said that if the referral service had

not contacted him, he wouldn't have taken up the referral '*If they didn't ring. I wouldn't have done anything*'.

Although arranging the first appointment for consumers was a common practice, notable exceptions demonstrated how difficult it was when this was not the case. Vina was sometimes worried about phoning referred organisations to organise initial appointments. Because of the trepidation she felt about making the first contact, Vina said that she '*would prefer it if the paperwork went through to them and then they would ring me*.' Having the referral service contact consumers to arrange the first appointment was a strong enabler for her.

Although the elements of warm referrals described by the service providers were appreciated by consumers, further components were helpful in optimising effectiveness. For consumers like Dan, understanding the rationale for the referral was important. Dan would have liked the referrer to discuss the referral with him, and be given the opportunity to think about whether it would help him or not. As he said, '*you mightn't have thought that it might help you, but if you knew more about it, you might be more amenable*'. As well as understanding the rationale, consumers also appreciated having some information about the referred service/clinician. For example, Arlene felt that if she knew more about a provider it would give her '*the strength to go*'. She explained that it was difficult '*not knowing their background, but they're knowing my background*'. Arlene felt that being given information about the new provider as part of the referral process was a '*mark of respect*'.

Our data showed that a warm referral was effective when the referring service provider made the referral on the basis of a comprehensive assessment of what the consumer needed and of their capacity and willingness to take up the referral. This capacity took a number of forms. Charles shared how difficult it could be to take up a referral when it involves a day's travel. '*It's fuel money, accommodation … and it's two weeks' notice to get there or less sometimes*.' For Timothy, who had strong ties to his Aboriginal culture, travelling to and from an appointment in Townsville was not straightforward. The obligations to family meant that he took a circuitous route and, on his way home, he was stranded at a small town until he had sufficient money to complete his journey. A consumer's health status was a barrier in some instances. Frances described how incapacitated her illness could make her and prevented her from acting on a referral. '*I just don't want to do anything. I can't get out of bed, I can't function, I can't do anything*.'

Obtaining transport to local appointments was less problematic as many service providers were able to arrange it for consumers living in town. When not arranged, the location of some hospitals on the perimeter of towns could be a deterrent to consumers taking up referrals, particularly during the summer months. As Arlene commented, *'it gets so hot and* [walking] *is just undoable and then we're paying $10 both ways* [for a taxi]*'.*

For those living some distance from a town, fuel money to attend services was an issue, particularly when cash flow was affected by drought, '*money was tight. We couldn't just come into town all the time*'.

Charging of gap fees was not an issue raised by participants as most were unemployed. Only one participant (who was employed) said that she was unable to take-up a referral to a mental health clinician because she '*couldn't afford it*'.

Other types of support may also be required for a warm referral to be effective, such as accompanying the consumer to attend a service for the first time and/or provide transport. Charles appreciated having his NDIS support worker/mental health worker accompany and advocate for him when they went together to an employment agency '*Whereas I wouldn't have asked for anything … she was a bit more assertive*'. Charles's support worker was able to secure work for him that was more suitable to his skills and interest. Margo shared how having the referrer with her, when she went to a housing service for people on low incomes, helped her to apply correctly, '*She filled it out with me, asking me the questions and all the rest of it … and got me on a lease'*. For some consumers it was also paramount to be given choices about the level of support they might require. Brad explained that when he was attending his first appointment at a referred service, staff at the organisation that was helping him '*would stay with you so you get more encouragement … Sometimes they just wait in the car and sometimes they're like, "Do you want me to come?" "No, it will be all right*"'.

The effectiveness of a warm referral may also be influenced by additional factors, such as services that offered consumers options. Ann was impressed that a mental health service offered her counselling at home or at their facility. She elected to have the sessions at the facility because she saw it '*as my little breakaway*' and gave her time away from home '*just to focus on myself*'. It helped that '*They came and picked me up, they dropped me off*'. Referrals were not always limited to health and social services. In Vina's case, a referral to a gym was of great benefit as it also helped her interact socially: '*I can't thank her* [service provider] *enough for signing me up to the gym because I've met a couple of other new ladies*.'

Another essential element of successful referrals and service integration—even when there are resource constraints—is referrals to the most appropriate person or service. It was observed that many service providers participated in organised networking that enabled them to get to know and understand the skills and roles of other service providers. Thus, providers could provide information about the person or service they were referring the consumer to, and they could also link the consumer to a service provider that they were likely to engage with. For Stavros such referrals have been life-changing: '*They* [housing service provider] *put me in touch and pointed me in the right direction for all the different facilities and stuff around here … It all fell together … there was no run around … just all straightforward … relevant services*.' He is now feeling '*the best* [he's] *been in a lot of years*'.

Active and appropriate engagement by the referred-to service is therefore essential. Cassie lived in a small remote town and eight months ago her GP gave her a warm referral to a visiting psychology service. She had since visited her GP two more times for a referral to the service but still had not heard from the service at the time of the interview: '*I still haven't heard again … I don't really hold hope'*. In Cassie's case not being contacted by the referred service was frustrating and heightened her feelings of isolation and helplessness. Her unsuccessful attempts to access a psychologist highlight the need for follow-up by the referrer to ensure the referral has happened. Other consumers, such as Ruthie, commented on how important it was to them to be able to report back to the referrer, '*because you've got nobody* [else] *to dob them* [the referred service] *into if they're not going great*'. A warm referral thus creates the conditions for consumers to be active participants in the process.

When consumers are active participants, they are likewise in a positive position to benefit from the resources available.

The experiences of consumers and the way they benefited from warm referrals challenges the assumption that people do not take up referrals because they are disengaged or service resistant. Our findings illustrate how not taking up a referral can instead be a product of the referring service provider not fully taking account of how the consumer could practically access the service.

These findings therefore point to the importance of soft skills and capacity-building for service providers to facilitate effective warm referrals. The uniqueness of each consumer's needs was apparent and it was clear that in order to meet consumer needs holistically, service providers need the flexibility to respond appropriately to the individual. Operational support (e.g. guidelines, information about what services are available) and continuing education about using the full range of referal options available in far western Queensland may also be needed. The WQPHN strategic plan presents ways to support effective warm referrals via corporate governance, clinical governance and leadership, community engagement, commissioning capability, provider development, workforce development, new technologies, and health intelligence.

Actual or perceived risks to service continuity can be a barrier to uptake, effectiveness, and integration for remote services

At times, a provider's impermanency impeded their ability to fully understand a consumer's specific needs and circumstances, and to tailor care accordingly. Continuity of service provision is a key component of good integration and referral processes (30); however, this may be compromised when there are changes in staff or changes in the way a service is provided.

Short-term service providers were often perceived as a risk to continuity. Short-term service providers can contribute different skills and insights into treatment and care but their lack of permanency may come with lack of knowledge about the most appropriate services for referrals, inhibit the development of relationships with other service providers and, hence, effective integration. Moreover, their impermanency may hinder the development of therapeutic relationships with their clients.

Francis identified that for her '*as a mental health patient, the more that the people that are treating you know you, the better off you are*.' In her experience, case managers often took the job for only three months and that this short length of time was insufficient to build an effective relationship and that it also meant that '*you don't have anybody here all of the time.*' The lack of a strong therapeutic relationship due to frequent changes of service providers can prevent consumers from exploring core issues in sufficient depth. Charles explained that '*It eventually just feels like you're almost in a cycle of always forming that relationship and never quite getting far enough to really work through issues as much. Like you work through a few every time you form that relationship, but you never really get into the bulk of it'.*

Knowing that a service provider would be working in the region for more than a few months encouraged consumers to develop that trust and commit to addressing their problems.

Dean had commenced working on his drug and alcohol problems with a counsellor who '*said she would be there for at least two years*'. He was relieved that he didn't have to continue to retell his story and was optimistic about the benefits of having permanency in his therapeutic relationship. Continuity allows trust to develop in the client-counsellor relationship and there were some matters that consumers could only address once this trust had been established (56). This is often a source of frustration, as in Veronica's case: '*by the time you earn their trust, and they trust you and you trust them, they're gone agai*n'. Further, as was shown in Charles's words, issues may never be completely addressed because the therapeutic relationship did not last long enough for trust to develop.

Interruption of a service can be traumatic for consumers living in remote areas due to their isolation and lack of alternative services. It may impact even more severely on consumers who rely on visiting services and who do not have the reassurance of the physical presence of service organisations in their town. Thomas felt abandoned when his counsellor retired, '*when I lost X, my counsellor, I thought, "Oh no, my life's going to end*"'. For Thomas, the regular visits by this counsellor were a major part of his life. Living in a remote town further increased feelings of powerlessness. In the words of James, '*The best counsellors I've ever had, just left. And they haven't replaced them yet'.* James needed daily support from a recently appointed nurse navigator, '*I got so bad about three weeks ago that she came for half an hour every day to my place*'. Gaps in continuity of service also mean that there is no handover of the consumer to the new provider. Thomas's counsellor was unable to provide an effective introduction to her replacement. Even though Thomas had support from other service organisation, he was continuing to struggle, '*I've had a bit of a downward thing going on*'.

These examples illustrate the need for service providers to develop protocols that allow continuity with consumers even when breaks in service provision occur. The importance of good communication is well recognised in planning and in procedural guidelines. Providing consumers with information about services and about policy decisions can allay fears about risks to continuity of service provision. Feeling safe contributes to wellbeing, and this feeling was jeopardised when consumers didn't know when a service provider was visiting their town, if a visit was cancelled, whether a new psychiatrist had been appointed, whether the service they relied on was going to continue to be funded, or why changes were necessary.

Maintaining continuity of care was particularly challenging in remote Queensland where it is difficult to recruit and maintain permanent staff in health and social organisations. Whereas some service providers did keep their clients informed, consumers in rural and remote areas were particularly vulnerable to uncertainty and lack of continuity. It was in these areas where the need for strategies, which can be implemented readily, was felt more strongly. Consumers living in remote regions wanted to know that these would be in place when their health and wellbeing begins to deteriorate.

A stabilising influence that offsets the lack of continuity was having a facility where consumers could go to on an informal basis without a referral. For Peta, who lives in a town where the only visible service agencies are the hospital and the police station, knowing she is welcome at the hospital provided her with a feeling of safety and security, '*if I'm starting to feel like I'm getting really down, getting to the point where I want to not be here anymore, I can actually go and see them fellas until the services* [GP, psychologist, etc.] *come up*'. Arlene appreciated the informal support she received from the community

development officer at the local neighbourhood centre. She calls in and '*chats every now and again, but it's not* [a counselling session] *it's social*'. Vina also valued '*just having a chat and having a laugh*' with a particular service provider. Michelle expressed the need in her life for somewhere similar, '*It would also be good too if you didn't just have referrals. You don't always want to be referred, but if you could just drop in*'.

These findings indicate that there are measures that can be taken to mitigate the negative effects of breaks in continuity of service provision. Once again, the evidence from our research indicates that soft skills need to be utilised. Lower-cost, lower-intensity services used as an adjunct to clinical-care interventions may assist consumers in remote areas in dealing with less than ideal levels of continuity.

Information sharing between service providers is largely accepted and valued

Consumers widely understood the reasons for and benefits of information sharing between services. They trusted service providers to share their information in responsible ways, and they moreover endorsed the practice on the recognition that sharing their information between services, under conditions of professional confidentiality, represented their own service and health interests. Consistent with the literature (26, 33), consumers appreciated that the more knowledge providers had about them, the better placed providers were to assist them. Cassie illustrates this by explaining that information sharing meant that her service providers are *'getting the whole picture'.*

One specific benefit of information sharing was that all of a consumer's service providers could contribute to a comprehensive plan for recovery. David was particularly keen for this to occur because he was unable to develop a plan himself, '*I can't come up with a plan at all … I've thought about it heaps'*.

Consumers in our study generally expressed a high level of trust in their service providers being mindful of their privacy when sharing information with other providers. Indeed, many understood that privacy was a professional practice that their health and social service providers were committed to. For example, Vina said, '*I know that I can trust them and I know they keep everything very confidential*'. There was also awareness among the consumers that they needed to consent to information sharing and that this gave them a degree of control over their own information.

A tangible barrier to information sharing was the short-term nature of GP employment in far western Queensland. Our findings showed that GPs may be excluded from some information sharing due to their lack of permanency, which in turn could prevent them from building relationships with other service providers. Andrew explained that, because he '*sees a different doctor each time'*, information sharing between his providers was primarily between his counsellors who were more permanent.

Another issue with sharing information with a GP was making sure they received a full and accurate account about a consumer and their capacity to take full advantage of the information they received. Caroline had experienced breakdowns in ongoing information sharing between the Mental Health service and her GP. She felt that the Mental Health service interacted poorly with her GP: '*They probably didn't communicate with the GP as well as they should* have', and that the service providers expected too much of her GP who had a heavy workload. This example highlights the need for clearly defined ways that

providers can regularly communicate, and for investigation of ways to support GPs with managing information from other providers (e.g. utilising practice staff).

Other consumers wanted limits on information sharing regarding sensitive issues such as their historical sexual abuse and trauma because they did not recognise any benefit in their treating clinician sharing this information with other service providers. They wanted their privacy protected in these specific areas, but welcomed information sharing about their current situation. This points to the need for diligence in protecting the privacy of vulnerable individuals, and underscores again the unique and non-static needs of each consumer. Consumers' concerns about the sharing of specific sensitive information, and how they may not know exactly what information is shared or for what purpose, emphasises the relevance of the warm referral discussed in the previous section. Some of the concerns about what information is being shared can be addressed by the detailed consultative process that characterises the warm referral.

Information sharing between providers is a vital component of good integration and is supported by strategic plans at local, state, and national levels. For the consumers in this study, information sharing between service providers contributed to the effectiveness of their care and treatment.

Support networks can be leveraged in support of service integration, with scope to offset some of the challenges of distance

There is evidence that context-specific service integration approaches are more likely to be successful (20, 37, 38). In far western Queensland, the challenges of context include a small population spread over a vast area, remoteness from major service centres, long distances between many of the towns, and limits on telecommunication and public transport. With such contextual challenges, all available supporting mechanisms for service provision may need to be engaged and consideration given to supports that are beyond what is provided by clinical services and service organisations.

In our study, support provided by consumers' family and social networks contributed to effective referrals and service integration. This indicates that, in the context of positive individual relationships, a consumer's family and social networks may be able to be leveraged to support consumers in taking up referrals. Support to consumers from family included assisting with transport, assisting with organising appointments, and accompanying the consumer to appointments. For example, Thomas was able to borrow his mother's car to attend hospital appointments. Renay's mother oversaw Renay's medications and accompanied her to doctors' appointments. David's partner made appointments for him '*first thing in the morning*' when there was less chance of him being overwhelmed by people around him. Such attentive assistance reflected an underlying level of care and concern by family members that can potentially be harnessed to benefit service integration.

Emotional support from family created an environment that encouraged consumers to connect and remain connected with health and social services. Nanette, who has mental health and substance use problems, valued the company of her mother and the responsibility of babysitting her young sister. She was reassured by their physical and emotional closeness and admitted it helped in controlling her alcohol and drug use. Ruthie

valued the personal support and encouragement she received from her sister and husband, '*He has a real sense of home and family and that sort of stuff*'. Terry who has schizophrenia said that his mother '*helps me through my sickness and helps me to get through things*'. In these cases, family support was an enabler towards service engagement and integration.

However, family networks proved to be a barrier in some circumstances. This was more likely when family members lacked knowledge and understanding of the nature of mental health and substance use problems. In some cases, well-meaning actions by family can become a deterrent to consumers engaging in further treatment down the line. Patrick was wary of engaging with mental health clinicians due to what he perceived as inappropriate interference by his family, who had him forcibly hospitalised after a mental health episode. Another consumer, Bill, believed his family and friends were supportive but he had stopped engaging with a number of service providers because spending time with his family and friends led to joining them in alcohol and drug use.

Other consumers who sought supportive social networks other than family members found making these connections difficult, particularly in rural areas and smaller towns. Our findings showed that a soft approach of encouraging participation in group activities was another way of developing effective support networks for consumers and supported higher-intensity interventions and integration. Besides the direct benefit of group participation, it familiarised consumers with a service organisation, facilitated taking-up a referral with the organisation, and provided the opportunity for peer support from people with similar problems and difficulties. Group activities are a part of holistic care and may be of assistance to consumers with problems of varying degrees of severity and complexity. In this context, our study found that low-cost, low-intensity group activities that are both creative and therapeutic helped consumers break their isolation. Margo appreciated being able to attend such groups which were organised by her local Aboriginal Community Controlled Health Service (ACCHS). Others could not take advantage of activities when they were only offered at limited times, as in the case of Gloria who could not participate at the community gardens in her town because they were only open on Saturdays. Some group activities were organised for older people and several younger consumers attended these groups because there were no other available options for their age group. Ann, who was in her late thirties, went to a healthy ageing group. Veronica, who was in her early forties, went to exercise classes and a card-game group designed for older people. Andrew attended a Men's Shed but he said '*they're all retired, they're all 20+ years older than me and there's an element of being a fifth wheel*'. These participants wished they could join groups of people closer to their age group. Joining a group activity encourages social inclusion and may lead to further community participation (e.g. volunteering, employment), which is considered an integral component of successful integration (as featured in the *Fifth Plan*).

Besides providing avenues for consumers to make new social networks that support them to seek recovery, the effectiveness of existing networks can be improved. This can be facilitated by service providers engagement with family members, to achieve a better understanding of consumers' needs and provide effective support to the consumer in their family. Consumers in our study expressed the need to be understood and how receiving this understanding from family and friends supported them to take up referrals. Sarah was grateful that she was able to talk to a member of her family network about her depression and was encouraged to follow through with a referral. She credited both the referred

clinician and the network member with her recovery, '*I don't think I would be here if I hadn't gone to them*'.

These two strategies, encouraging the effectiveness of a consumer's existing network and facilitating new effective networks via group activities, are both in line with existing plans for service integration (*Fifth Plan*; *Mental Health, Suicide Prevention, Alcohol and Other Drug Services Regional Plan 2017–2020*).

Actual or perceived diagnostic overshadowing can limit the effectiveness of service referrals

Diagnostic and treatment overshadowing in people with mental illness occurs when treatment is delayed or overlooked because symptoms of physical illness are attributed to a consumer's mental health problem (57). The mental health condition takes precedence and consideration of physical health problems is neglected. It has been argued that this may contribute to the lower life expectancy of people with mental health problems (58). Our findings showed that there were cases of diagnostic and treatment overshadowing which could have had serious consequences due to the consumer's physical health continuing to deteriorate, and the likelihood of inappropriate mental health referrals being made.

The reasons for diagnostic and treatment overshadowing are not clear from the results of our study but may include stigma, hidden discrimination, lack of understanding about mental health and substance use, poor diagnostic skills, and time constraints (58, 59). In remote Queensland, it may also relate to the lack of continuity of providers in areas where providers are primarily short-term, and the challenge of treating a serious mental illness has meant that long-term physical care may be repeatedly overlooked.

In our study, concerns about physical health were raised by consumers' family members, which again reflects the unique role of carers as advocate for consumers. In Ann's case, her mother repeatedly raised concerns about Ann's physical health during a time when Ann was being treated with medications for an acute episode of schizophrenia. It was only following a routine echocardiogram, that these medications were found to have been adversely affecting her heart. Terry was receiving medications for schizophrenia but his physical health was being overlooked and he had become obese. When Terry's mother confronted his doctors about her son's deteriorating physical health, a more holistic approach was taken to his healthcare and his overall health had improved. Both these cases were examples of tunnel-vision rather than integrated service approaches; consumers had severe mental illnesses and their treating clinicians had not taken sufficient consideration of their physical health.

These research findings reinforce the need for holistic care that considers the consumers physical and mental health. Although there may be complex and inter-related reasons for neglecting physical health in people with a mental health illness, stigma has been identified as a major contributor (58, 60) and needs to be continuously addressed.

Physical infrastructure can be a barrier or enabler to service uptake

Co-location of services, ease of physical access, privacy, welcoming reception areas, and provision of informal areas were all enablers of service uptake. Research indicates that a

well-designed physical setting plays a role in people's wellbeing in clinical settings (61, 62). As anxiety is a common mental health problem, feeling comfortable in a service provider's surroundings can become an enabler to service uptake.

Consumers appreciated it when service organisations were housed independently yet physically close to each other in the centre of town. In the Central West region, there was co-location of some services in one building in the region's hub, which appeared to work well. However, a prime example of co-location was the purpose-built neighbourhood centre in Winton, which houses a number of agencies and has space set aside for visiting service providers. The centre is in the main street of Winton and is clearly signed, but its entrance is relatively discreet in a laneway at the side of the building. Consumers from the town liked the ease of access and the co-location of services as it meant that '*they're always doing something there'.* They appreciated that the centre was a community space for activities and a '*good*' place to visit.

How people regard an organisation, and their willingness to attend an organisation may be influenced by its physical setting. In the commercial world, emphasis is placed on attracting people into premises based on certain design characteristics such as aesthetic appearance (e.g. colours and placement of signage), way-finding (e.g. easy to identify entryway with clear layout), and de-stressing facilities (e.g. greenery) (63). Besides practical aspects such as wheelchair access and availability of convenient parking spaces, such design characteristics may also encourage or deter entry to service provider premises, and there were examples of agencies that had these welcoming design characteristics. With service provider premises, however, some consumers may appreciate an entrance that affords a degree of privacy while still being clearly distinguishable.

As noted elsewhere (17), reception areas set the tone of a service and can put consumers at ease. A well-positioned reception desk, comfortable seating, and a water cooler were all attributes that sent a 'welcome' signal. Observations were backed up by comments from Ruthie who said it was important to her that the reception area is '*a welcoming space*'. She didn't want it to be '*homely*' but to be a professional looking and well-designed space. Where service providers wanted to provide informal spaces as well as formal spaces for counselling sessions and meetings, converted suburban houses worked well. For instance, at one centre, having a kitchen, lounge, and courtyard that clients could use throughout the day assisted the consumers to feel comfortable in being there. As one consumer who visited there regularly said, '*it shows that they care here*'. She went on to say that feeling comfortable at the centre was '*a big number one thing*'. It had become a safe place to go for companionship and more intensive support when required.

Some physical settings of service providers in western Queensland may present barriers to service uptake. A common location barrier was the position of hospitals on the outskirts of towns, necessitating the use of transport to access services. Location barriers were also observed in two of the hubs where, although many services were grouped together in the centre of town, some service providers were further out and would require transport to be reached from the town centre. Some service providers were housed in independent buildings with no attempt to make the entrance inviting or private. Reception areas were occasionally shabby with inadequate seating, and no water cooler; and in some centres, the receptionist was positioned behind a glass partition—a physical barrier that could be perceived as signalling segregation and distancing from the consumer.

Our findings and observations suggest that physical infrastructure is critical to service uptake and integration, and it deserves attention. Co-location affords benefits besides ease of assess for consumers as it allows service providers to develop relationships among themselves and increases understanding of other services and what they provide. As noted by others (6, 20, 21), these stronger links between services facilitate more effective referrals and monitoring of a consumer's progress. Design features in the service provider's physical setting that allay consumer's anxiety may also be effective in facilitating service uptake.

Integrated service responses need to be culturally appropriate, including for Aboriginal and Torres Strait Islander and LGBTIQ consumers

The need for culturally appropriate responses to consumers is well documented (e.g. Your voice, one vision Consultation report 2017). In our study, consumers who identified as Aboriginal and/or LGBTIQ, mainly reported positively on service delivery. Their stories, however, suggest that a more nuanced approach could enhance their ability to take up referrals.

Aboriginal and Torres Strait Islander consumers

It is important to acknowledge the efforts made to date to promote effective referrals through knowledge sharing between frontline service providers and Aboriginal consumers. The 17 Aboriginal consumers in our study were a heterogenous group with a similar spread of characteristics to the total sample. They did not necessarily attend Indigenous services even when they were available, with most attending services based on what was available and what best met their needs. Community Controlled Health Services (ACCHSs) were highly regarded by both Aboriginal and non-Aboriginal consumers.

However, a lack of anonymity when attending an ACCHS in a small town may pose a barrier to successful service referrals as some consumers were unwilling to attend due to privacy concerns. This highlights the need for services to present consumers with options when referring and for the consumer to be given sufficient information to make an informed decision.

There were examples of effective responses from non-Indigenous services but there was also failure to communicate sensitively or adequately by some of these services. Communication is an essential component of an effective therapeutic relationship and failure in this area can alienate consumers, negatively affecting their take-up of referrals, and consequently their health. Aboriginal consumers reported they were spoken to in a convoluted manner that failed to pass on clear messages. As Margo said, '*It's got to be straightforward, blunt*' but with '*courtesy and respect*'.

Cultural influences may affect a consumer's ability to take-up a referral. Some Aboriginal consumers explained that because of cultural obligations they struggled with taking up referrals that involved travelling considerable distances outside their region. Like all of the consumers in our study, those who identified as Aboriginal wanted to be understood and respected, and the principles articulated in the *Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016–21* provide direction in this (i.e. culturally capable services, person-centred care) as does the *Connecting care to recovery 2016–2021* plan for Queensland's state-funded mental health and alcohol and drug services. Access

points and referral pathways should '*take into account when, where and how individuals prefer to seek assistance'.* Thus, policy is in place to provide responsive, person-centred care for Aboriginal peoples. At the service delivery stage, it appears from our research that improvements could be made in respectful and meaningful communication between service providers and Aboriginal consumers.

Consumers who identified as LGBTIQ

Five consumers identified as LGBTIQ: one identified as a lesbian, two identified as gay, one identified as bi-sexual, and one as transgender. Their individual stories highlight the need for further education about LGBTIQ terminology and the meaning of each term, as well as the importance of peer support. Service providers' lack of knowledge and understanding about sexual orientations, gender identity, and intersex status can lead to inappropriate referrals. For example, Dan who identified as transgender believed he had received misguided referrals from his GP because his GP did not fully understand his identity as a transgender person, confusing being transgender with sexual orientation, '*he's trying to put me onto all these gay and lesbian support groups and stuff. They* [GPs] *know about that but they don't know about trans people*.'

There is evidence (64) to suggest that people identifying as LGBTIQ in rural and remote Australia experience more challenges than their inner-city peers, particularly in regard to connectivity with other people of the same gender or sexual identity. Peer support was seen as important for wellbeing as it can assist in fostering social inclusion; facilitating such support is likely to increase the effectiveness of an integrated service response.

In our study, peer support was particularly important for consumers without a partner. Dan was grateful that his local Sexual Health Clinic had arranged contact for him with four other transgender people in his region's hub. Knowing that he was '*not alone*' and there were other transgender people in the area was reassuring and comforting in itself, but being able to link by phone with them was even more helpful, '*It was just wonderful … We talk every now and then if you're having a bad day*.' Dan had benefited greatly from the service provider being attuned to his needs and linking him with other transgender people.

Patrick did not have the same degree of peer support as Dan but he benefitted from meeting other people in his area who identified as being bisexual, '*when I started to meet other people* [who were bisexual] *I didn't feel as alone*'. Patrick had severe anxiety and this was a barrier to participating in the same level of peer support that Dan enjoyed. Rather than connecting by phone or meeting in person, consumers like Patrick may prefer connecting with peers via the web and other electronic avenues. Aaron reported that efforts to set-up a support group for LGBTIQ people in his town had been unsuccessful due to people not wanting to attend meetings in person.

Consumers identifying as LGBTIQ also experienced or perceived stigma more acutely in remote areas, and were more hesitant to identify publicly as LGBTIQ (64). Non-disclosure may limit the ability of service providers to provide optimal referral pathways. LGBTIQ consumers in our study were open about their LGBTIQ status but spoke about the lack of privacy in their communities, '*Everybody knows everybody's business*'. They tended to shield themselves from discrimination in their communities by limiting their social interaction to those they felt comfortable with. David said, '*you keep to yourself and you do your own thing … and the people you are around with are comfortable*'. Service providers can

encourage participation in local group activities that don't pose a risk of discrimination to foster broader social inclusion. Education at a community and service provider level should be prioritised to increase knowledge and understanding which, in turn, will lessen discrimination and strengthen social network support.

Consumers may be open to online service delivery as part of a service integration model if applicable

Findings from this research indicate that the service integration model can incorporate online service delivery successfully depending on the following steps being taken care of. First, consumers should be introduced to and understand the potentials of the medium. Their uptake may be reliant on providing a local safe place for consultations and some in-person support/care as well an adequately trained workforce and a service provider network that includes online providers. Most consumers expressed preference for face-to-face consultations but they were also appreciative of help they received from linking electronically with specialist clinicians. Veronica's words capture a common sentiment expressed by consumers, '*It's not the same as in-person, but, yeah, it's okay*.' Initial reticence to engaging online was overcome once consumers realised the benefits from their online consultation. For example, Vina was nervous about having a video consultation with a psychiatrist she had not met in person, but she was thrilled when she obtained clear and comprehensive answers to her questions, and that the change the psychiatrist made to her medication improved her health, '*it was amazing*'. Once she realised the benefits of online service delivery, Vina continued to have regular video consultations.

Consumers in remote areas recognised that online service delivery is potentially more efficient and timely than either relying on visits by clinicians or travelling to take-up a referral to a clinician in a major centre outside of their region. Realised benefits included that consumers could remain in their own community and access their familiar support network and, more importantly, that they did not need to disrupt their lives by travelling outside of their region for long periods of time and incurring travel costs. It became clear that such disruption placed stress on consumers whose health was already compromised due to mental illness or problems with mental health or substance use. Jack, for instance, preferred having regular consultations with his psychiatrist via video link '*because it's a lot less stressful trying to find the money to get down to Toowoomba and see someone and all that*'.

Being able to link electronically also meant that consumers could receive assistance from specialist clinicians based on clinical need. As part of an integrated response to clinical deterioration, online consultations can be arranged in a timely manner, without the delay that a face-to-face consultation would entail, again due to factors associated with travelling long distance. For example, when Caroline's daughter's mental health deteriorated sharply, she was able to take her daughter to the local hospital for a video link consultation with a psychiatrist.

Our research indicated that online service delivery worked effectively when it was incorporated into a plan of service delivery for consumers that followed an integrated model. Some face-to-face contact with a local care coordinator was still needed to provide continuity. Some providers engaged with consumers both online and face-to-face and were

observed to be part of the local service provider network. Being part of the local provider network, should not be overlooked by online providers because, as already noted, effective communication between service providers strengthens the warm referral process (55).

In conclusion, consumers were open to online service delivery, with some caveats. These included establishing a trusting relationship with someone they had not met in person, missing the contextual and personal richness of a face-to-face consultation, and uncertainty about what measures would be in place if the online consultation triggered a severe deterioration in their mental health. These concerns were not seen as insurmountable. Concerns about the quality of the consultations were likely to abate once consumers and providers had adjusted to the medium. Building a trusting therapeutic relationship online is a skill that providers can be taught and there is strong support in relevant plans for workforce training (e.g. *Connecting Care to Recovery 2016–2021,* WQPHN's *Strategic Plan* and the strategic plans for all three HHSs). Professional development will also build on the knowledge clinicians already have about not placing consumers at risk during an online consultation. Moreover, guidelines for consumer safety during an online consultation can be followed, particularly if the consultation occurs in an appropriate environment (e.g. a room at the local hospital).

Consumers' acceptance of online service delivery in remote Queensland indicates that the use of this medium in integrated service delivery can be and should be further expanded.

Actionable Insights

1. **Warm referrals enable service uptake:** Service providers need the flexibility to respond appropriately to individual consumers. They may also need operational support (e.g. guidelines, information about what services are available) and continuing education about local treatment options.

2. **Information sharing between service providers is largely accepted and valued:** For the consumers in this study, information sharing between service providers contributed to the effectiveness of their care and treatment.

3. **Actual or perceived risks to service continuity can be a barrier to uptake, effectiveness, and integration for remote services:** Measures that can be taken to mitigate the negative effects of breaks in continuity of service provision include developing protocols for when there are breaks, keeping consumers fully informed about policy decisions relating to service delivery, and having a facility/service that consumers can frequent on an informal basis.

4. **Support networks can be leveraged in support of service integration, with scope to offset some of the challenges of distance:** Two strategies that can be employed to support the uptake of referrals are encouraging the effectiveness of a consumer's existing network and facilitating new effective networks via group activities.

5. **Actual or perceived diagnostic overshadowing can limit the effectiveness of service referrals:** Stigma is a major contributor to diagnostic and treatment overshadowing and needs to continue to be addressed through continuing professional development.

6. **Physical infrastructure can be a barrier or enabler to service uptake:** Co-location affords benefits of access and may improve the quality of service provision due to better communication between service providers. Design features in the service provider's physical setting that allay consumer's anxiety may be effective in facilitating service uptake.

7. **Integrated service responses need to be culturally appropriate, including for Aboriginal and Torres Strait Islander and LGBTIQ consumers:** A more nuanced approach could enhance the ability of Aboriginal and Torres Strait Islander and LGBTIQ consumers to take up referrals. Continuing professional development may help combat stigma against both groups, ensure that communication between service providers and Aboriginal consumers is respectful and meaningful and improve service providers' understanding of sexual orientations, gender identity, and intersex status. Encouraging consumers to participate in local group activities that do not pose a risk of discrimination may foster broader social inclusion.

8. **Consumers may be open to online service delivery as part of a service integration model if applicable:** Consumers' acceptance of online service delivery indicates that the use of this medium in integrated service delivery can be and should be further expanded.

5. CONSOLIDATED FINDINGS

In this section, we looked for congruence between findings based on our in-depth interviews with consumers and those from our systematic review of literature specific to integrated service models to address complex needs and rural/remote service delivery. We also examined whether there are provisions in the policies we have reviewed to support implementation of these findings.

As is evident in Table 3 on the following page, most of the distilled findings from our consumers reflect needs articulated in the published literature, and in some cases, the service models evaluated as successful. Examples include the necessity for information sharing among collaborating service providers and the utility of warm and supported referrals to improve uptake of services offered. Interestingly, concerns raised over privacy related to information sharing were also reflected in our literature. Policies at all levels from global down to local speak to the need for communication protocols; guidelines for this are specified in some.

Information from consumers extended the requirements for effective warm referrals to include full consideration of consumer needs and capability to access the next service when choosing the referral, explaining fully to the consumer the benefit of the referral and sharing information about the referral service with the consumer. Detailed guidelines on these considerations may be helpful.

For some findings such as the benefits of peer supports, the issue was raised more generally in the literature and in policy documents, such as their broad utility in the recovery process, but the leveraging of peer networks to overcome challenges imposed by distance have not been previously described.

Others, such as the issues of diagnostic overshadowing and the need for culturally appropriate responses for people who identify as LGBTIQ, were not raised in our specific literature, but are well recognised in the broader mental health literature. Australian policies have for some time paid significant attention to cultural appropriateness for Aboriginal and Torres Strait Islander consumers; more recent Queensland policies also note the need for services appropriate to those with alternate gender or sexual identities. This may reflect more universal needs for service integration for these groups. On the other hand our research suggests in-depth understanding of the issues related to gender and sexual identity may be lacking amongst service providers in rural and remote areas and this may impact on service integration for LGBTIQ consumers with complex needs.

Finally we note that there is an evident disconnect between articulated policy and consumer experiences with respect to some findings. Further attention to implementation of the features of successful service integration described here, including appropriate resourcing, may lessen this disconnect.

Table 3. Alignment of case study findings with other evidence

	Findings from consumer perspective	Support of this concept in the literature	Provision in policy documents to support action
1	Warm referrals enable service uptake	17, 21, 35, 38, 51	WQPHN Strategic Plan
2	Information sharing between service providers is largely accepted and valued	20, 26, 33, 11-15, 25;	At local, state (QCOSS), national and global levels (Information Sharing Guideline)
3	Actual or perceived risks to service continuity can be a barrier to uptake, effectiveness, and integration for remote services	3-6, 30, 17, 52	Recognised need for sustainability across sectors inc NGO (Connecting Care to Recovery 2016-2021)
4	Support networks can be leveraged in support of service integration, with scope to offset some of the challenges of distance	Broad utility of peer support in recovery widely recognised: 17-20; 37-39	Fifth Plan; Mental Health, Suicide Prevention, AOD Services Regional Plan 2017–2020
5	Actual or perceived diagnostic overshadowing can limit the effectiveness of service referrals	Stigma, but not specifically diagnostic overshadowing in this literature review (e.g. 42); addressed in the wider mental health literature (57-60)	Fifth Plan; Equally Well Statement; Connecting Care to Recovery 2016–2021; Mental Health, Suicide Prevention, AOD Services Regional Plan 2017–2020
6	Physical infrastructure can be a barrier (e.g. physical design) or enabler (e.g co-location) to service uptake	Limited in this literature review (e.g. 17) but addressed in the wider mental health literature	Only obliquely
7	Integrated service responses need to be culturally appropriate, including for Aboriginal and Torres Strait Islander and LGBTIQ consumers	For Aboriginal and Torres Strait Islander consumers (e.g. 8, 17, 43) Not directly in this literature review for LGBTIQ consumers; extensive in broader health literature	Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016–2021 Connecting Care to Recovery 2016–2021
8	There is indicative evidence that consumers are open to online service delivery as part of a service integration model if applicable	Not specifically in this literature review	Connecting Care to Recovery 2016–2021; WQPHN's Strategic Plan; strategic plans for all three HHSs

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7. APPENDICES

Appendix 1: Literature search strategies and protocols

A1.1 Search strategy

We searched articles using four electronic databases (PubMed, Scopus, PsychINFO and ScienceDirect) with the following key terms: remote, rural, country, regional, psychiatric health, mental health, mental disorder or difficulty, depression, anxiety, substance abuse or misuse, drug abuse or misuse, problematic alcohol use, alcohol use disorder or AUD, integration or integrated services, collaboration or collaborative services, inter-sectoral services, multi sectoral services, holistic services, social services, human services, multiple services, social support, housing, financial, family support, legal services, primary health care, primary care, and education support. Articles published from 2000 to 2017 in English were considered eligible for screening. The detailed search strategy for each database is shown in the tables below. In addition to these electronic databases, we incorporated reference lists of reviews and commentaries, and performed Google Scholar searches to increase the pool of identified articles.

A1.2 Screening and selection

We used the PRISMA guidelines (1) during the screening and the selection of relevant studies. During the initial stage, we examined the titles and abstracts of each searched article. Afterwards, all the remaining studies underwent full-text eligibility screening using defined criteria: service integration programs or interventions implemented in rural and remote communities in developed countries, aimed at people with mental health difficulties and/or experiencing problematic substance use.

We considered program evaluations of any service integration strategy which comprised primary health services, human services, social services, and housing. We also considered those with observational designs that specifically assessed service integration as an important factor for improved service utilisation and health-related outcomes. Related systematic reviews were excluded from our final list as these papers will be used during our comparative analysis and discussions.

We also opted to consider findings from the responses of health workers and/or service providers. This triangulation of findings provides a more comprehensive assessment of the effectiveness of service integration initiatives. Moreover, our review also included studies which measured non-health related outcomes such as socio-economic status, quality of life, as well as process-related indicators. These indicators enable us to obtain ideas about improving service delivery.

A1.3 Data extraction and quality assessment

Data were extracted and tabulated according to the following criteria:

- Type of intervention
- Types of respondents
- Type of outcome
- Comparative analysis with the results of past review/s of similar topic
- Barriers and enablers of programs

Quality was assessed independently by two authors using PRISMA guidelines. Any disparities were resolved by consensus.

Table 4: PubMed search strategies

Search	Query	Items found
#34	Search (((((remote) OR rural) OR country) OR (region* OR regional))) AND ((((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic alcohol use) OR ((alcohol use disorder) OR AUD)) OR (mental AND (disorder OR difficult*)))) AND ((((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery))) AND ((((((((((((((social OR social services)) OR (human OR multiple OR multiple services OR human services)) OR (intersector* OR inter sector)) OR (multisector* OR multi-sector OR collaborat*)) OR holistic service) OR social support) OR housing) OR financ*) OR family support) OR support) OR legal support) OR primary health care) OR education support) OR education) OR mental))) Sort by: Relevance	1,508
#33	Search (((((remote) OR rural) OR country) OR (region* OR regional))) AND ((((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic alcohol use) OR ((alcohol use disorder) OR aud)) OR (mental AND (disorder OR difficult*)))) AND ((((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery))) AND ((((((((((((((social OR social services)) OR (human OR human services)) OR (intersector* OR inter sector)) OR (multisector* OR multi sector)) OR holistic service) OR social support) OR housing) OR financ*) OR family support) OR support) OR legal support) OR primary health care) OR education support) OR education) OR mental))) Filters: Publication date from 2000/01/01; Humans	965
#32	Search (((((remote) OR rural) OR country) OR (region* OR regional))) AND ((((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic alcohol use) OR ((alcohol use disorder) OR 'AUD')) OR (mental AND (disorder OR difficult*)))) AND ((((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery))) AND ((((((((((((((social OR 'social services')) OR (human OR 'human services')) OR (intersector* OR 'inter-sector')) OR (multisector* OR 'multi-sector')) OR 'holistic service') OR social support) OR housing) OR financ*) OR 'family support') OR support) OR 'legal support') OR 'primary health care') OR 'education support') OR education) OR mental))) Filters: Publication date from 2000/01/01; Humans	964
#31	Search (((((remote) OR rural) OR country) OR (region* OR regional))) AND ((((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic alcohol use) OR ((alcohol use disorder) OR aud)) OR (mental AND (disorder OR difficult*)))) AND ((((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery))) AND ((((((((((((((social OR social services)) OR (human OR human services)) OR (intersector* OR inter sector)) OR (multisector* OR multi sector)) OR holistic service) OR social support) OR housing) OR financ*) OR family support) OR support) OR legal support) OR primary health care) OR education support) OR education) OR mental))) Filters: Publication date from 2000/01/01	1,269
#30	Search (((((remote) OR rural) OR country) OR (region* OR regional))) AND ((((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic alcohol use) OR ((alcohol	1262

Search	Query	Items found
	use disorder) OR 'AUD')) OR (mental AND (disorder OR difficult*)))) AND ((((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery))) AND ((((((((((((((social OR 'social services')) OR (human OR 'human services')) OR (intersector* OR 'inter-sector')) OR (multisector* OR 'multi-sector')) OR 'holistic service') OR social support) OR housing) OR financ*) OR 'family support') OR support) OR 'legal support') OR 'primary health care') OR 'education support') OR education) OR mental))) Filters: Publication date from 2000/01/01	
#29	Search (((((remote) OR rural) OR country) OR (region* OR regional))) AND ((((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic alcohol use) OR ((alcohol use disorder) OR 'AUD')) OR (mental AND (disorder OR difficult*)))) AND ((((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery))) AND ((((((((((((((social OR 'social services')) OR (human OR 'human services')) OR (intersector* OR 'inter-sector')) OR (multisector* OR 'multi-sector')) OR 'holistic service') OR social support) OR housing) OR financ*) OR 'family support') OR support) OR 'legal support') OR 'primary health care') OR 'education support') OR education) OR mental)))	1,478
#28	Search ((((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic alcohol use) OR ((alcohol use disorder) OR 'AUD')) OR (mental AND (disorder OR difficult*)))) AND ((((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery))) AND ((((((((((((((social OR 'social services')) OR (human OR 'human services')) OR (intersector* OR 'inter-sector')) OR (multisector* OR 'multi-sector')) OR 'holistic service') OR social support) OR housing) OR financ*) OR 'family support') OR support) OR 'legal support') OR 'primary health care') OR 'education support') OR education) OR mental))	11,451
#27	Search (((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery))) AND ((((((((((((((social OR 'social services')) OR (human OR 'human services')) OR (intersector* OR 'inter-sector')) OR (multisector* OR 'multi-sector')) OR 'holistic service') OR social support) OR housing) OR financ*) OR 'family support') OR support) OR 'legal support') OR 'primary health care') OR 'education support') OR education) OR mental)	61,556
#26	Search ((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic alcohol use) OR ((alcohol use disorder) OR 'AUD')) OR (mental AND (disorder OR difficult*))	1,515,517
#25	Search ((((((((((((((social OR 'social services')) OR (human OR 'human services')) OR (intersector* OR 'inter-sector')) OR (multisector* OR 'multi-sector')) OR 'holistic service') OR social support) OR housing) OR financ*) OR 'family support') OR support) OR 'legal support') OR 'primary health care') OR 'education support') OR education) OR mental	20,995,188
#24	Search (((remote) OR rural) OR country) OR (region* OR regional)	1,870,464
#23	Search (((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery)	70,163

Search	Query	Items found
#22	Search (((((rural) OR remote)) OR country)) AND (((((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse))) AND (((((((((service) OR services) OR delivery)) OR care) AND full text[sb] AND Humans[Mesh])) AND ((((integration) OR integrated) OR integrate) AND full text[sb] AND Humans[Mesh])) AND full text[sb] AND Humans[Mesh])) AND full text[sb] AND Humans[Mesh]) Filters: Full text; Humans	465
#21	Search (((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse))) AND (((((((((service) OR services) OR delivery)) OR care) AND full text[sb] AND Humans[Mesh])) AND ((((integration) OR integrated) OR integrate) AND full text[sb] AND Humans[Mesh])) AND full text[sb] AND Humans[Mesh]) Filters: Full text; Humans	8,427
#20	Search (((((((service) OR services) OR delivery)) OR care) AND full text[sb] AND Humans[Mesh])) AND ((((integration) OR integrated) OR integrate) AND full text[sb] AND Humans[Mesh]) Filters: Full text; Humans	46,142
#19	Search ((((service) OR services) OR delivery)) OR care Filters: Full text; Humans	1,615,735
#18	Search ((integration) OR integrated) OR integrate Filters: Full text; Humans	148,553
#17	Search ((((((intergration) OR integrated)) AND integrate) AND full text[sb] AND Humans[Mesh])) AND ((((((((service) OR services) OR delivery)) AND ((intergration) OR integrated))) AND ((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse))) AND full text[sb] AND Humans[Mesh]) Filters: Full text; Humans	161
#16	Search (((intergration) OR integrated)) AND integrate Filters: Full text; Humans	2,312
#15	Search ((((((service) OR services) OR delivery)) AND ((intergration) OR integrated))) AND ((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse)) Filters: Full text; Humans	3,963
#14	Search ((((((service) OR services) OR delivery)) AND ((intergration) OR integrated))) AND ((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse)) Filters: Full text	4,887
#10	Search ((((((service) OR services) OR delivery)) AND ((intergration) OR integrated))) AND ((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse))	5,949
#13	Search (((((((service) OR services) OR delivery)) AND ((intergration) OR integrated))) AND ((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse)))) AND ((((rural) OR remote)) OR country)	368
#12	Search (((rural) OR remote)) OR country	297,243
#11	Search ((((((((service) OR services) OR delivery)) AND ((intergration) OR integrated))) AND ((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR	266

Search	Query	Items found
	psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse)))) AND ((rural) OR remote)	
#9	Search (((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse)	1,478,586
#8	Search (((psychiatric) AND health)) OR ((mental) AND health)	369,227
#7	Search (psychiatric) AND health	216,103
#6	Search (mental) AND health	269,793
#5	Search ((((service) OR services) OR delivery)) AND ((intergration) OR integrated)	36,564
#4	Search ((service) OR services) OR delivery	1,604,978
#3	Search (intergration) OR integrated	208,941
#2	Search (rural) OR remote	202,578
#1	Search (((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse	1,466,798

Table 5:PsychINFO search strategies

Search	Query	Items found
#1	(((Any Field:(((((service)) OR Any Field:(services)) OR Any Field:(delivery))) OR Any Field:(care)) AND (Any Field:(((integration)) OR Any Field:(integrated)) OR Any Field:(integrate))) AND (((Any Field:(Any Field:((((psychiatric)) AND Any Field:(health))) OR Any Field: (((mental)) AND Any Field:(health))))) OR ((Any Field: ((((((mental)) OR Any Field:(psychiatr*)) OR Any Field:(depression)) OR Any Field:(anxiety)) OR Any Field:(substance abuse)) OR Any Field:(drug abuse))))) AND ((Any Field:((((rural)) OR Any Field: (remote))) OR Any Field:(country)))	1,114
#2	((Any Field:(((((service)) OR Any Field:(services)) OR Any Field:(delivery))) OR Any Field:(care)) AND (Any Field:(((integration)) OR Any Field:(integrated)) OR Any Field:(integrate))) AND (((Any Field:(Any Field:((((psychiatric)) AND Any Field:(health))) OR Any Field: (((mental)) AND Any Field:(health))))) OR ((Any Field: ((((((mental)) OR Any Field:(psychiatr*)) OR Any Field:(depression)) OR Any Field:(anxiety)) OR Any Field:(substance abuse)) OR Any Field:(drug abuse))))	22,227
#3	Any Field: (((rural) OR Any Field: remote)) OR Any Field: country	89,887
#4	Any Field: ((((service) OR Any Field: services) OR Any Field: delivery)) OR Any Field: care AND Any Field: ((integration) OR Any Field: integrated) OR Any Field: integrate	39,547
#5	((Any Field:(Any Field:((((psychiatric)) AND Any Field: (health))) OR Any Field:(((mental)) AND Any Field: (health))))) OR ((Any Field:((((((mental)) OR Any Field:(psychiatr*)) OR Any Field:(depression)) OR Any Field:(anxiety)) OR Any Field:(substance abuse)) OR Any Field:(drug abuse)))	1,430,789
#6	Any Field: (((psychiatric) AND Any Field: health)) OR Any Field: ((mental) AND Any Field: health)	642,310
#7	Any Field: (((((mental) OR Any Field: psychiatr*) OR Any Field: depression) OR Any Field: anxiety) OR Any Field: substance abuse) OR Any Field: drug abuse	1,430,789

Table 6: Scopus search strategies

Search	Query	Items found
#14	TITLE-ABS-KEY ((((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery)) AND (((((((((((((social OR 'social AND services')) OR (human OR 'human AND services')) OR (intersector* OR 'inter-sector')) OR (multisector* OR 'multi-sector')) OR 'holistic AND service') OR social AND support) OR housing) OR financ*) OR 'family AND support') OR support) OR 'legal AND support') OR 'primary AND health AND care') OR 'education AND support') OR education) OR mental)) AND ((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR (((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance AND abuse) OR drug AND abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic AND alcohol AND use) OR ((alcohol AND use AND disorder) OR 'aud')) OR (mental AND (disorder OR difficult*)))) AND ((((remote) OR rural) OR country) OR (region* OR regional))) AND (LIMIT-TO (SUBJAREA , "MEDI ") OR LIMIT-TO (SUBJAREA , " PSYC ") OR LIMIT-TO (SUBJAREA , " SOCI ") OR LIMIT-TO (SUBJAREA , " NURS ") OR LIMIT-TO (SUBJAREA , " ARTS ") OR LIMIT-TO (SUBJAREA , " HEAL ") OR LIMIT-TO (SUBJAREA , " BUSI ") OR LIMIT-TO (SUBJAREA , " ECON ") OR LIMIT-TO (SUBJAREA , " DENT ") OR LIMIT-TO (SUBJAREA , " MULT ")) AND (LIMIT-TO (DOCTYPE , "ar ") OR LIMIT-TO (DOCTYPE , " re ") OR LIMIT-TO (DOCTYPE , " ch ") OR LIMIT-TO (DOCTYPE , " ip ")) AND (LIMIT-TO (PUBYEAR , 2017) OR LIMIT-TO (PUBYEAR , 2016) OR LIMIT-TO (PUBYEAR , 2015) OR LIMIT-TO (PUBYEAR , 2014) OR LIMIT-TO (PUBYEAR , 2013) OR LIMIT-TO (PUBYEAR , 2012) OR LIMIT-TO (PUBYEAR , 2011) OR LIMIT-TO (PUBYEAR , 2010) OR LIMIT-TO (PUBYEAR , 2009) OR LIMIT-TO (PUBYEAR , 2008) OR LIMIT-TO (PUBYEAR , 2007) OR LIMIT-TO (PUBYEAR , 2006) OR LIMIT-TO (PUBYEAR , 2005) OR LIMIT-TO (PUBYEAR , 2004) OR LIMIT-TO (PUBYEAR , 2003) OR LIMIT-TO (PUBYEAR , 2002) OR LIMIT-TO (PUBYEAR , 2001) OR LIMIT-TO (PUBYEAR , 2000))	624
#13	TITLE-ABS-KEY (#12)	2,613,892
#12	((((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery)) AND (((((((((((((social OR 'social AND services')) OR (human OR 'human AND services')) OR (intersector* OR 'inter-sector')) OR (multisector* OR 'multi-sector')) OR 'holistic AND service') OR social AND support) OR housing) OR financ*) OR 'family AND support') OR support) OR 'legal AND support') OR 'primary AND health AND care') OR 'education AND support') OR education) OR mental)) AND ((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR (((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance AND abuse) OR drug AND abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic AND alcohol AND use) OR ((alcohol AND use AND disorder) OR 'aud')) OR (mental AND (disorder OR difficult*)))) AND ((((remote) OR rural) OR country) OR (region* OR regional)) AND (LIMIT-TO (PUBYEAR , 2017) OR LIMIT-TO (PUBYEAR , 2016) OR LIMIT-TO (PUBYEAR , 2015) OR LIMIT-TO (PUBYEAR , 2014) OR LIMIT-TO (PUBYEAR , 2013) OR LIMIT-TO (PUBYEAR , 2012) OR LIMIT-	31,912

Search	Query	Items found
	TO (PUBYEAR , 2011) OR LIMIT-TO (PUBYEAR , 2010) OR LIMIT-TO (PUBYEAR , 2009) OR LIMIT-TO (PUBYEAR , 2008) OR LIMIT-TO (PUBYEAR , 2007) OR LIMIT-TO (PUBYEAR , 2006) OR LIMIT-TO (PUBYEAR , 2005) OR LIMIT-TO (PUBYEAR , 2004) OR LIMIT-TO (PUBYEAR , 2003) OR LIMIT-TO (PUBYEAR , 2002) OR LIMIT-TO (PUBYEAR , 2001) OR LIMIT-TO (PUBYEAR , 2000)) AND (LIMIT-TO (SUBJAREA , "MEDI") OR LIMIT-TO (SUBJAREA , "PSYC") OR LIMIT-TO (SUBJAREA , "SOCI") OR LIMIT-TO (SUBJAREA , "NURS") OR LIMIT-TO (SUBJAREA , "ARTS") OR LIMIT-TO (SUBJAREA , "HEAL") OR LIMIT-TO (SUBJAREA , "BUSI") OR LIMIT-TO (SUBJAREA , "ECON") OR LIMIT-TO (SUBJAREA , "DENT") OR LIMIT-TO (SUBJAREA , "MULT")) AND (LIMIT-TO (DOCTYPE , "ar") OR LIMIT-TO (DOCTYPE , "re") OR LIMIT-TO (DOCTYPE , "ch") OR LIMIT-TO (DOCTYPE , "ip"))	
#11	((((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery)) AND (((((((((((((social OR 'social AND services')) OR (human OR 'human AND services')) OR (intersector* OR 'inter-sector')) OR (multisector* OR 'multi-sector')) OR 'holistic AND service') OR social AND support) OR housing) OR financ*) OR 'family AND support') OR support) OR 'legal AND support') OR 'primary AND health AND care') OR 'education AND support') OR education) OR mental)) AND ((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance AND abuse) OR drug AND abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic AND alcohol AND use) OR ((alcohol AND use AND disorder) OR 'aud')) OR (mental AND (disorder OR difficult*))))) AND ((((remote) OR rural) OR country) OR (region* OR regional)) AND (LIMIT-TO (PUBYEAR , 2017) OR LIMIT-TO (PUBYEAR , 2016) OR LIMIT-TO (PUBYEAR , 2015) OR LIMIT-TO (PUBYEAR , 2014) OR LIMIT-TO (PUBYEAR , 2013) OR LIMIT-TO (PUBYEAR , 2012) OR LIMIT-TO (PUBYEAR , 2011) OR LIMIT-TO (PUBYEAR , 2010) OR LIMIT-TO (PUBYEAR , 2009) OR LIMIT-TO (PUBYEAR , 2008) OR LIMIT-TO (PUBYEAR , 2007) OR LIMIT-TO (PUBYEAR , 2006) OR LIMIT-TO (PUBYEAR , 2005) OR LIMIT-TO (PUBYEAR , 2004) OR LIMIT-TO (PUBYEAR , 2003) OR LIMIT-TO (PUBYEAR , 2002) OR LIMIT-TO (PUBYEAR , 2001) OR LIMIT-TO (PUBYEAR , 2000)) AND (LIMIT-TO (SUBJAREA , "MEDI") OR LIMIT-TO (SUBJAREA , "PSYC") OR LIMIT-TO (SUBJAREA , "SOCI") OR LIMIT-TO (SUBJAREA , "NURS") OR LIMIT-TO (SUBJAREA , "ARTS") OR LIMIT-TO (SUBJAREA , "HEAL") OR LIMIT-TO (SUBJAREA , "BUSI") OR LIMIT-TO (SUBJAREA , "ECON") OR LIMIT-TO (SUBJAREA , "DENT") OR LIMIT-TO (SUBJAREA , "MULT")) AND (LIMIT-TO (DOCTYPE , "ar") OR LIMIT-TO (DOCTYPE , "re") OR LIMIT-TO (DOCTYPE , "ch") OR LIMIT-TO (DOCTYPE , "ip"))	31,912
#10	((((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery)) AND (((((((((((((social OR 'social AND services')) OR (human OR 'human AND services')) OR (intersector* OR 'inter-sector')) OR (multisector* OR 'multi-sector')) OR 'holistic AND service') OR social AND support) OR housing) OR financ*) OR 'family AND support') OR support) OR 'legal AND support') OR 'primary AND health AND care') OR 'education AND support') O	35,811

Search	Query	Items found
	R education) OR mental)) AND ((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR (((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance AND abuse) OR drug AND abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic AND alcohol AND use) OR ((alcohol AND use AND disorder) OR 'aud')) OR (mental AND (disorder OR difficult*)))) AND ((((remote) OR rural) OR country) OR (region* OR regional)) AND (LIMIT-TO (PUBYEAR , 2017) OR LIMIT-TO (PUBYEAR , 2016) OR LIMIT-TO (PUBYEAR , 2015) OR LIMIT-TO (PUBYEAR , 2014) OR LIMIT-TO (PUBYEAR , 2013) OR LIMIT-TO (PUBYEAR , 2012) OR LIMIT-TO (PUBYEAR , 2011) OR LIMIT-TO (PUBYEAR , 2010) OR LIMIT-TO (PUBYEAR , 2009) OR LIMIT-TO (PUBYEAR , 2008) OR LIMIT-TO (PUBYEAR , 2007) OR LIMIT-TO (PUBYEAR , 2006) OR LIMIT-TO (PUBYEAR , 2005) OR LIMIT-TO (PUBYEAR , 2004) OR LIMIT-TO (PUBYEAR , 2003) OR LIMIT-TO (PUBYEAR , 2002) OR LIMIT-TO (PUBYEAR , 2001) OR LIMIT-TO (PUBYEAR , 2000)) AND (LIMIT-TO (SUBJAREA , "MEDI") OR LIMIT-TO (SUBJAREA , "PSYC") OR LIMIT-TO (SUBJAREA , "SOCI") OR LIMIT-TO (SUBJAREA , "NURS") OR LIMIT-TO (SUBJAREA , "ARTS") OR LIMIT-TO (SUBJAREA , "HEAL") OR LIMIT-TO (SUBJAREA , "BUSI") OR LIMIT-TO (SUBJAREA , "ECON") OR LIMIT-TO (SUBJAREA , "DENT") OR LIMIT-TO (SUBJAREA , "MULT"))	
#9	((((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery)) AND ((((((((((((social OR 'social AND services')) OR (human OR 'human AND services')) OR (intersector* OR 'inter-sector')) OR (multisector* OR 'multi-sector')) OR 'holistic AND service') OR social AND support) OR housing) OR financ*) OR 'family AND support') OR support) OR 'legal AND support') OR 'primary AND health AND care') OR 'education AND support') OR education) OR mental)) AND ((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR (((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance AND abuse) OR drug AND abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic AND alcohol AND use) OR ((alcohol AND use AND disorder) OR 'aud')) OR (mental AND (disorder OR difficult*)))) AND ((((remote) OR rural) OR country) OR (region* OR regional)) AND (LIMIT-TO (PUBYEAR , 2017) OR LIMIT-TO (PUBYEAR , 2016) OR LIMIT-TO (PUBYEAR , 2015) OR LIMIT-TO (PUBYEAR , 2014) OR LIMIT-TO (PUBYEAR , 2013) OR LIMIT-TO (PUBYEAR , 2012) OR LIMIT-TO (PUBYEAR , 2011) OR LIMIT-TO (PUBYEAR , 2010) OR LIMIT-TO (PUBYEAR , 2009) OR LIMIT-TO (PUBYEAR , 2008) OR LIMIT-TO (PUBYEAR , 2007) OR LIMIT-TO (PUBYEAR , 2006) OR LIMIT-TO (PUBYEAR , 2005) OR LIMIT-TO (PUBYEAR , 2004) OR LIMIT-TO (PUBYEAR , 2003) OR LIMIT-TO (PUBYEAR , 2002) OR LIMIT-TO (PUBYEAR , 2001) OR LIMIT-TO (PUBYEAR , 2000)) AND (LIMIT-TO (SUBJAREA , "MEDI") OR LIMIT-TO (SUBJAREA , "PSYC") OR LIMIT-TO (SUBJAREA , "SOCI") OR LIMIT-TO (SUBJAREA , "NURS") OR LIMIT-TO (SUBJAREA , "ARTS") OR LIMIT-TO (SUBJAREA , "HEAL") OR LIMIT-TO (SUBJAREA , "BUSI") OR LIMIT-TO (SUBJAREA , "ECON") OR LIMIT-TO (SUBJAREA , "DENT") OR LIMIT-TO (SUBJAREA , "MULT"))	35,811
#8	((((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery)) AND ((((((((((((social OR 'social AND services')) OR (human OR 'human AND services')) OR (interse	39,492

Search	Query	Items found
	ctor* OR 'inter-sector')) OR (multisector* OR 'multi-sector')) OR 'holistic AND service') OR social AND support) OR housing) OR financ*) OR 'family AND support') OR support) OR 'legal AND support') OR 'primary AND health AND care') OR 'education AND support') OR education) OR mental)) AND ((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR (((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance AND abuse) OR drug AND abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic AND alcohol AND use) OR ((alcohol AND use AND disorder) OR 'aud')) OR (mental AND (disorder OR difficult*)))) AND ((((remote) OR rural) OR country) OR (region* OR regional)) AND (LIMIT-TO (PUBYEAR , 2017) OR LIMIT-TO (PUBYEAR , 2016) OR LIMIT-TO (PUBYEAR , 2015) OR LIMIT-TO (PUBYEAR , 2014) OR LIMIT-TO (PUBYEAR , 2013) OR LIMIT-TO (PUBYEAR , 2012) OR LIMIT-TO (PUBYEAR , 2011) OR LIMIT-TO (PUBYEAR , 2010) OR LIMIT-TO (PUBYEAR , 2009) OR LIMIT-TO (PUBYEAR , 2008) OR LIMIT-TO (PUBYEAR , 2007) OR LIMIT-TO (PUBYEAR , 2006) OR LIMIT-TO (PUBYEAR , 2005) OR LIMIT-TO (PUBYEAR , 2004) OR LIMIT-TO (PUBYEAR , 2003) OR LIMIT-TO (PUBYEAR , 2002) OR LIMIT-TO (PUBYEAR , 2001) OR LIMIT-TO (PUBYEAR , 2000))	
#7	(((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery)) AND (((((((((((((social OR 'social AND services')) OR (human OR 'human AND services')) OR (intersector* OR 'inter-sector')) OR (multisector* OR 'multi-sector')) OR 'holistic AND service') OR social AND support) OR housing) OR financ*) OR 'family AND support') OR support) OR 'legal AND support') OR 'primary AND health AND care') OR 'education AND support') OR education) OR mental)) AND ((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR (((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance AND abuse) OR drug AND abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic AND alcohol AND use) OR ((alcohol AND use AND disorder) OR 'aud')) OR (mental AND (disorder OR difficult*)))) AND ((((remote) OR rural) OR country) OR (region* OR regional))	41,596
#6	(((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery)) AND (((((((((((((social OR 'social AND services')) OR (human OR 'human AND services')) OR (intersector* OR 'inter-sector')) OR (multisector* OR 'multi-sector')) OR 'holistic AND service') OR social AND support) OR housing) OR financ*) OR 'family AND support') OR support) OR 'legal AND support') OR 'primary AND health AND care') OR 'education AND support') OR education) OR mental)) AND ((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR (((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance AND abuse) OR drug AND abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic AND alcohol AND use) OR ((alcohol AND use AND disorder) OR 'aud')) OR (mental AND (disorder OR difficult*)))	108,798
#5	((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery)) AND (((((((((((((social OR 'social AND services')) OR (human OR 'human AND services')) OR (intersector* OR 'inter-sector')) OR (multisector* OR 'multi-	403,204

Search	Query	Items found
	sector')) OR 'holistic AND service') OR social AND support) OR housing) OR financ*) OR 'family AND support') OR support) OR 'legal AND support') OR 'primary AND health AND care') OR 'education AND support') OR education) OR mental)	
#4	((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance AND abuse) OR drug AND abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic AND alcohol AND use) OR ((alcohol AND use AND disorder) OR 'aud')) OR (mental AND (disorder OR difficult*))	1,373,774
#3	((((((((((((((social OR 'social AND services')) OR (human OR 'human AND services')) OR (intersector* OR 'inter- sector')) OR (multisector* OR 'multi- sector')) OR 'holistic AND service') OR social AND support) OR housing) OR financ*) OR 'family AND support') OR support) OR 'legal AND support') OR 'primary AND health AND care') OR 'education AND support') OR education) OR mental	5,761,605
#2	(((remote) OR rural) OR country) OR (region* OR regional)	10,496,237
#1	(((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery)	1,304,422

Table 7: ScienceDirect search strategies

Search	Query	Items found
#1	((TITLE-ABSTR-KEY(((((remote) OR rural) OR country) OR (region* OR regional))) AND ((((((((((((psychiatric) AND health)) OR ((mental) AND health))) OR ((((((mental) OR psychiatr*) OR depression) OR anxiety) OR substance abuse) OR drug abuse))) OR ((substance OR drug) AND (misuse OR abuse))) OR problematic alcohol use) OR ((alcohol use disorder) OR 'AUD')) OR (mental AND (disorder OR difficult*)))) AND ((((((integration) OR integrated OR integrat* OR holistic)) AND (((service) OR services) OR delivery))) AND ((((((((((((((social OR 'social services')) OR (human OR 'human services')) OR (intersector* OR 'inter-sector')) OR (multisector* OR 'multi-sector')) OR 'holistic service') OR social support) OR housing) OR financ*) OR 'family support') OR support) OR 'legal support') OR 'primary health care') OR 'education support') OR education) OR mental))) AND LIMIT-TO(cids, "271821,271074,271761,277811,271200,271035,271857,271785,272152,271845,271958,271276,271176,271253,271070,272854,271127","Social Science & Medicine,The Lancet,Health Policy,Procedia - Social and Behavioral Sciences,Biological Psychiatry,Journal of Affective Disorders,Children and Youth Services Review,Journal of Rural Studies,European Psychiatry,Health & Place,International Journal of Drug Policy,Drug and Alcohol Dependence,Schizophrenia Research,International Journal of Nursing Studies,Neuropsychologia,Public Health,Neuroscience & Biobehavioral Reviews"))) AND service integration.	730

Appendix 2: List of studies from developing countries

Abera, M., et al. (2014). "Perceived challenges and opportunities arising from integration of mental health into primary care: a cross-sectional survey of primary health care workers in south-west Ethiopia." BMC Health Serv Res 14: 113.

Acharya, B., et al. (2016). "Recommendations from primary care providers for integrating mental health in a primary care system in rural Nepal." BMC Health Serv Res 16: 492.

Araya, R., et al. (2003). "Treating depression in primary care in low-income women in Santiago, Chile: a randomised controlled trial." Lancet 361(9362): 995-1000.

Baron, E. C., et al. (2016). "Maternal mental health in primary care in five low- and middle-income countries: a situational analysis." BMC Health Serv Res 16: 53.

Chisholm, D., et al. (2000). "Integration of mental health care into primary care: Demonstration cost–outcome study in India and Pakistan." Br J Psychiatry 176: 581-588.

Farooq, S. (2013). "Collaborative care for depression: a literature review and a model for implementation in developing countries." Int Health 5(1): 24-28.

Fekadu, A., et al. (2016). "Development of a scalable mental healthcare plan for a rural district in Ethiopia." Br J Psychiatry 208 Suppl 56: s4-12.

Jayaram, G., et al. (2011). "Overcoming cultural barriers to deliver comprehensive rural community mental health care in Southern India." Asian J Psychiatr 4(4): 261-265.

Joyner, K. and B. Mash (2012). "A comprehensive model for intimate partner violence in South African primary care: action research." BMC Health Serv Res 12: 399.

Khenti, A., et al. (2012). "Strengthening efforts to integrate mental health into primary health care in Chile: Lessons from an international collaboration process." International Journal of Mental Health 41(1): 87-102.

Mueller, Y., et al. (2011). "Integrating mental health into primary care for displaced populations: The experience of Mindanao, Philippines." Conflict and Health 5(1).

Mugisha, J., et al. (2017). "Health systems context(s) for integrating mental health into primary health care in six Emerald countries: A situation analysis." Int J Mental Health Sys 11.

Ngo, V. K., et al. (2014). "The Vietnam multicomponent collaborative care for depression program: Development of depression care for low-and middle-income nations." J Cogn Psychotherapy 28(3): 156-167.

Raja, S., et al. (2014). Integration of mental health services into primary care settings. Essentials of global mental health. New York, NY, US, Cambridge University Press: 126-134.

Ssebunnya, J., et al. (2010). "Integration of mental health into primary health care in a rural district in Uganda." Afr J Psychiatry (Johannesburg) 13(2): 128-131.

Tilahun, D., et al. (2017). "Training needs and perspectives of community health workers in relation to integrating child mental health care into primary health care in a rural setting in sub-Saharan Africa: A mixed methods study." Int J Mental Health Syst 11.

Appendix 3: Overview of integration programs

Table 8: Integration program descriptions

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
Australian Integration Programs					
Allan (2010)	Australia (Rural and Remote)	Murdi Paaki Region (Western New South Wales) >8700 Indigenous people	**Aboriginal Community Controlled Health Services (ACCHS)** The program delivers services through primary health care workers (PHCW). The services included counselling services and information sessions. They also aimed to collaborate between mental health and substance and alcohol services. PCHW also helped in making referrals and assisting in addressing the needs of clients (e.g. court cases, child protection issues, debt and unstable housing).	Using a sociological action research approach, 47 participants were interviewed about their roles, clients' needs, and practice recommendations. Participants were also asked about their understanding of problematic drug and alcohol use, typical interventions, and service delivery gaps. Responses were analysed according to themes: service delivery, local perspectives from workers who deliver visiting services and outsider perspectives from workers who deliver services other than drug and alcohol.	The participants consisted of20 drug and alcohol workers, 12 workers in towns with visiting services, and 15 workers who delivered specialist services other than drug and alcohol. Researchers found: -Drug and alcohol teams failed to collaborate with other specialists -Inappropriate referral by the legal system despite the non-existence of the problem. -Lack of trust among the workers -Limited understanding of outside worker in terms of the role and function of PHCW Because of these findings, ACCHS planned to (1) increase the capacity of designated PHCW through training and support and (2) encourage PHCW to increase their expertise in primary health care.

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
Barraclough, et al. (2015)	Australia (Rural)	Rural New South Wales	**Nurse Practitioner-Led Primary Healthcare Mental Health Service** This program was based in a multi-function non-health NGO which hired a mental health nurse to deliver close, street-based contact with the community. Clients were seen every 3 to 6 months, with a maximum of 4 hours per appointment. The nurse usually referred clients and received referrals from other services (e.g. family services, police, GPs, and women's health services).	A mixed-method approach was used to evaluate the program from 2011 to 2012. Individual and group interviews as well as records review were undertaken among stakeholders, particularly in rural areas. Participants included nurses, managers, mental health workers, community health workers, GPs and a police superintendent, recruited through snowball sampling. Findings from records review were validated during interviews.	Apart from health workers, four participants in the study were from other agencies such as the police service and NGOs. Interviews revealed that since the program started, there had been fewer cases of violence in the area. Two years after the program implementation, there had been a reduction in the number of emergency cases as well. The program also enabled the nurses to gain the trust and respect of the community. There had been collaboration between health services and housing, transport, and employment agencies before the service was implemented. Mental health and drug and alcohol services on the other hand had problematic collaboration particularly in diagnosing patients.
Perkins, et al. (2010); Fitzpatrick, et al. (2017)	A rural New South Wales community, Australia	Primary health care clients in a rural community. These patients are assessed for psychotic disorders, mood disorders, personality disorders, substance	**GP Clinic** This is run by local community mental teams and GPs. The CMHT organised client appointments to a GP, who operated a monthly clinic. CMHT were present during consultations.	A mixed-methods approach was used for a records review (June 2007-December 2009) of 120 service clients and interviews with 15 service providers. Chi-square analysis and thematic analysis was applied respectively.	Around 50% had an appointment in the GP clinic within the first 12 months of implementation. 37.5% uptake were CMHT's first clients while 42.2% were their clients for 1-4 years. A fourth of the clients were still using the GP clinic at the evaluation period. Clients were usually referred to a psychiatrist, special medical services and government/legal services after attending the GP clinic.

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
		abuse, and other mental health problems.			Service providers perceived the GP clinic as a simplified strategy to integrate in the general practice mental health services. CMHT mentioned that the clinic was widely acceptable among their patients. The project also enabled a significant perceived decrease in the number of admissions in a mental health inpatient unit due the clear delineation of roles of GP and specialist providers. Overall, the clinic successfully operated since the start of its implementation having 16 clients every month. However, its long-term effect in terms of reducing mental health problems in the community is not yet evaluated.
Haswell-Elkins, et al. (2005)	Top End Northern Territory and Far North Queensland, Australia	Indigenous peoples in rural communities	**Australian Mental Health Initiative** This project aimed to establish pathways to meet the needs of Indigenous people with mental health illness in remote communities and assess its impact on mental health outcomes. The six main areas were: -Strengthening families and communities; -Improving clinical service delivery; -Assisting in the implementation of reliable and valid mental health outcomes measures; -Facilitating better information management for decision-making and monitoring; -Enhancing mental health literacy and health promotion; and -Contributing to effective workforce development.	N/A	N/A

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
			In 2005, the progress of this integration initiative comprised: -Addition of mental health screening tools on general adult health checks at the primary care level -Draft of clinical protocols and care planning tools to be used in the primary care setting -Preparation of the mental health database which will be available for primary care workers to enable a recall mechanism for physical and mental health care needs; and -Trial of audit and self-assessment tools for service providers.		
Judd, et. Al (2004)	Rural Victoria, Australia	Residents of Loddon Campaspe Southern Mallee region	**Rural Integrated Primary Care Psychiatry Programme** The program was established in 2001 and comprised three initiatives: Rural Depression Anxiety Research and Treatment Programme (DAR), Primary Mental Health and Early Intervention Programme (PMHI) and Eating Disorder Service (EDS). DAR aimed to provide specialist care to people with anxiety and depression, PMHI aimed to detect and treat mental health problems through education, training and consultation services, and EDS aimed to provide services to individuals with eating disorders in a primary care setting. All three initiatives were driven by training/education and supportive supervision of service providers (i.e. GPs and community workers) through workshops providing basic training (i.e. assessment, care planning and evaluation) through to advanced training (i.e. pharmacological and psychological treatment). The integration involves a stepped collaborative approach through a shared language (i.e. clinical guidelines and approach).	N/A	No evaluation was done yet

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
			The stepped collaborative care model involves 4 levels: -Screening, diagnosis, patient education, monitor outcomes (L1) -Diagnosis and treatment in primary care setting (L2) -Secondary consultation and limited shared care arrangements (L3) -Primary consultation and limited direct care (L4) Generally, GPs delivered care for mild cases at L1 and L2 while their collaboration through a consultation between primary care and specialist at L3. L4 involved care for patients with severe and complex disorders. PMHI provided services at L3 while DAR and EDS at L4.		
Killackey and Waghorn (2008)	Melbourne, Australia	Young people in West and Northwest regions of Melbourne	**ORYGEN Youth Health (OYH)** Established in December 2005 to provide specialist youth services, specifically treatment and care for youth with first episode of psychosis. Patients generally received assistance for 18 months, followed by a referral to adult mental health services if necessary. This project integrated employment services through direct communication with an employment specialist without constraint by income support requirements, job capacity assessments, and the availability of suitable case-based funding places in the local area. The project also conducted a supported education program which motivated clients' career aspirations, and continued their secondary or vocational education.	The Supported Employment Fidelity Scale-Implementation Questions was used to evaluate the quality of the employment services integrated with mental health services.	An evaluation of the demonstration site showed a successful integration is feasible within 6 months through an attainment of high-fidelity to the Integrated Placement Approach model. Integration of a vocational staff in the clinical team was rated 4/5. Rating for follow-up supports was 3/5 due to time constraints for funding while rating for the employment consultant was 1/5 due to lack of staff.

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
Kowanko, et al. (2009)	South Australia, Australia	This project helped the Eyre Peninsula region of South Australia.	**Coordinated Aboriginal Mental Health Care Project** This project was a product of a trial, in 2004, of systems for chronic disease management. Various services were integrated such as social, emotional, alcohol/drugs and other mental health services which enabled patients to receive services in a holistic manner. Some of the activities were: -Interagency meetings to address the wellbeing of the patients (i.e. comorbidity, emergency mental health and safety); -Case management for people with substance abuse -Informing the reviews of South Australian mental health law.	N/A	Not yet evaluated
Perkins, et al. (2006)	Far West Area Health Service (remote New South Wales) Australia	Those who have mental health needs usually those who have affective disorders, personality disorders, psychosis, cognitive impairment and substance abuse.	**Far West Mental Health Integration Project** This project aimed to ensure that mental health services are an integral part of primary health care. In this model, psychiatrists usually made regular visits to a designated facility. They provided patient consultations and also secondary activities (i.e. mentoring, caseload review, education to local staff). Local staff organised the planned care visits and follow-up (sometimes via phone). They usually referred clients identified by the community mental health teams (CMHTs). The elements of the model are (extracted from Figure 2 of the paper): *Primary care strategy* – primary care services are provided by local generalist staff supported by specialists from hubs and visiting psychiatrists from metropolitan centres *Hub structure* – CMHTs support general health staff and provide specialist services to patients *Funding mechanism* – The Area Health Service was given the funds it would receive if it had the national average number of private psychiatrists working	Records were reviewed from July 2000 to June 2003, and interviews were conducted to evaluate the project.	Nearly 50% (380) of the new referrals were seen by the visiting psychiatrists from 2002–03 while 3,908 were seen by CMHTs from 2000–02. Overall, collaboration with GPs was not improved due to short-staff, increased workload, and fast turnover which affected their relationship with the psychiatrists.

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
			across the area and received an equitable share of State mental health funds. *Management process* – Local mental health services are provided by a CMHT working with GPs, generalist health staff and others managed by a team leader who reports to the Director of Mental Health and Counselling. *Visiting Patterns* – An increase in the number of visiting psychiatrists was achieved. Psychiatrists were strongly encouraged to stay for one or more nights in the communities they visited. *VMO roles* – Specialist psychiatrists were appointed as Visiting Medical Officers and encouraged to undertake a mix of primary and secondary activities to meet the needs of the teams and the communities serviced and to contribute to the wider service. *Governance mechanism* – The project was treated as core business, covered the whole mental health and counselling services and was subject to the normal governance mechanisms.		
Canadian Integration Programs					
Kates, et al. (1997); Kates, Nick (2008); Kates, et al. (2011)	Ontario, Canada	Children and adult in Ontario visiting family physicians/GPs. Patients seen by the counsellors and psychiatrists often had depression, anxiety, marital and family problems,	**Hamilton Family Health Team Mental Health Program** (*also known as Hamilton HSO Mental Health Program*) This program was started in 1994 by Ontario Ministry of Health, aiming to link health counsellors and psychiatrists. Ultimately, enhancing the mental health services offered in primary care by strengthening the relationship of family physicians and psychiatrists. Initially, the program involved 45 GPs from 13 different practices. Now, the program has 149 GPs from 80 different practices covering 340,000 population.	Evaluation of the program involved use of a comprehensive database (1994–2006) which contained the demographics, treatment and outcome data of every patient referred. Satisfaction surveys were also undertaken among service providers and clients.	Currently, the program has enabled over 7,000 referral every year with 54 referrals per GP. Compared with GPs in non-program sites, GPs in the project had less referrals to outpatient services and patients had shorter lengths of stay when admitted. The program was also assessed using outcome measures such as Centre for Epidemiological Studies Depression Scale (CES-D), the Short Form 12 (SF12), Short Form 8 (SF8)

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
		dysthymia, adjustment disorders, affective disorders, substance abuse, etc.	Each GP practice has mental health counsellors to cover 8,000 patients while psychiatrists visit every 1–3 weeks. These two providers work together with GPs collaboratively instead of having parallel practices. *Role of Counsellors* These are usually registered nurses or social workers based in GPs' offices. Counsellors provide assessments and treatments as referred by the GP. In cases needing specialised services, the counsellor referred the client to a suitable mental health clinic. They are usually available on a regular basis, 24–48 hours after the diagnosis. *Role of Psychiatrists* They assist each GP half a day per month, assisting GPs and counsellors. Instead of being a supervisor, they work collaboratively with other providers. Psychiatrists sometimes perform patient care but are often involved in case reviews and discussions, through patient assessment. Similarly, with the counsellors, they usually examine the patient before developing a care plan then hand over the patient to the physician. *Role of GP* Receives all referrals and assess all patients and primarily assist in changing patients' lifestyle with the help of CMHT. The physician uses their discretion re the treatment that the patient needs, without the opinion of counsellors and psychiatrists. They are trained to manage mental health problem through informal education and patient-centred educational experiences. **New components in the program include handling children's mental health problems, management of individuals with addictions, and evidence-based practice to improve the management of depression*		and the General Health Questionnaire (GHQ). All these outcomes showed improvement over 70% by one standard deviation. However, this was compared to control sites since these areas don't have data for these indicators. Over 90% of the patients were satisfied after being examined by a service provider. 86% of the GPs in the practice were satisfied with the mental health services available in the community compared to 56% in the non-project sites. Qualitative assessments also showed increased access among ethno-cultural groups, reduced waiting times for an initial assessment, earlier detection of mental health problems, less attached stigma to patients seeking treatment, and efficient and well-coordinated care from primary to tertiary levels.

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
			such as peer support interventions, self-management and monitoring post-treatment. Additional 2 addiction specialists and 3 child/youth mental health specialists were hired.		
Maar, et al. (2009)	Northern Ontario, Canada	Residents of the Manitoulin Island specifically Aboriginals	**The Knaw Chi Ge Win Service system** This integration program is run by service providers in the field of psychology, social work and traditional medicine. Services are provided through referral or self-referral. On the other hand, specialist services through a psychiatrist or a traditional healer can be accessed using a referral form given by the core providers (i.e. program manager, psychologist, mental health workers/clinicians, and nurse/case managers). Services by psychiatrists are offered on a monthly basis. Care plans done by the psychiatrist are shared with the rest of the team for continuity of care. GPs and case managers collaborate to provide treatment and counselling to clients. Case managers also work with paraprofessionals to facilitate discrimination prevention, monitoring, and provision of other services such as housing and employment.	This study used a participatory action approach, document reviews, interviews and focus groups to obtain the various essential components and outcomes of the Knaw Chi Ge Win service system model. The study team consulted the core mental health team in the community to provide technical advice on the study objective and data collection tool development. Regarding document review, they collected data from reports from 2004–07. Interviews and from focus groups among service providers (e.g. consultants, therapists, social workers and community workers). Ethnographic interviews were undertaken among Aboriginal patients, with administrative staff assisting with recruitment. Reponses were transcribed, analysed, and triangulated using NVivo.	Overall the evaluation showed improved disease management, efficiency, cultural safety and reduction of professional isolation. Number of patients referred for admission was reduced from 3-4 to 0-1 per year. Providers mentioned that these patients become more stable and manageable at the local level. Clients mentioned that the service gave them the right to choose clinical or Aboriginal approaches instead of being forced to receive a particular treatment. Waiting times for urgent cases was reduced to less than a week and less urgent cases to 3–4 weeks. Providers felt well supported by the entire team making their working environment resulting iP better work performance.
Oyewumi and Savage (2009)	Ontario, Canada	Residents of Southeastern Ontario District	**Kingston Psychosis Prevention and Treatment (KPPAT)** This program aimed to deliver services to patients with symptoms of psychosis by adhering to the seven elements of its program logic model. This includes facilitating access, early identification,	Not mentioned	There was an increase in the annual number of referrals from 2001 (when the program commenced) to 2007 mostly around schizophrenia-spectrum. During this time period, it was

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
			comprehensive assessment, treatment, psychosocial support, family education and support, research and public education.		observed that the referral sources shifted from hospital to community particularly from GP, outpatient psychiatry services and families. Challenges in implementation were also noted. There was a delay in hiring staff and other infrastructure for data collection and expansion to other remote areas due to the bureaucratic system of the sponsoring institution. Until the date of evaluation, there was still lack of psychiatrists in the community to facilitate implementation of treatment plan.
USA and UK-based Integration Programs					
Balasubramanian, et al. (2015)	Colorado, USA	Patients at least 18 years old as well as those who are pregnant	**Advancing Care Together (ACT)** The program is composed of 11 practices that integrated behavioural health with primary care, integrating mental health, substance abuse and primary care services. The integration programs are outlined in Table 2 of their manuscript. Most of the programs were implemented through a psychologist providing traditional mental health services with collaborative care and other brief interventions. One of the 11 interventions had a primary care team which included a care coordinator and a substance use counsellor. Other than counselling, the program also enabled referral to other services within and outside the field of practice.	Data collection started upon program commencement. Assessment involved a mixed-method approach. Quantitative evaluation includes collection of practice-related indicators using Patient Health Questionnaires, body mass index, anxiety using Generalised Anxiety Disorder 7, and alcohol use using Alcohol Use Disorders Identification Test. Proportion of patients who received integrated care was also measured using a patient tracking sheet done quarterly. Linear regression was conducted to evaluate the program statistically. Qualitative assessment was done through observation and interview among patient in each facility. Data were	REACH is described in this paper as the extent in which of an intervention or program delivered services to their target population. Out of 11 practices, 8 were able to provide integrated care services to their target population. Higher referrals were among those that used clinicians' discretion to identify patients needing integrated care compared with those which used a more systematic method.

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
				analysed using a grounded theory approach.	
Bauer, et al. (2005)	Pennsylvania, USA	The program was conducted in the rural and economically depressed region in Greene County Pennsylvania.	**Rural Care Program** As a part of the Masters in Social Work Program, two licensed social workers with five nurses, supported staff delivering integrated services. The services included referral, case management, advocacy, crisis intervention, education, support, counselling and meetings with a multidisciplinary team. The social workers also conducted home visits as necessary. The program followed a process during its implementation. -Defining direct behavioural health services -Planning and mobilising support -Staff education and training -Interagency and community involvement -Program evaluation -Financial sustainability measures	A computerised system was developed to track the patients referred to and receiving services. Data was collected during patient visits. Satisfaction surveys were also undertaken with service providers and patients annually for two years.	The results of the evaluation were not yet presented.
Bunik, et al. (2013)	Colorado, USA	Paediatric patients in rural, urban and suburban communities with mental health disorders such as ADHD, depression and substance abuse.	**Integrated or Collaborative Care** This study defined integration as collaboration of health providers with specialists during patient consultations which enabled the non-obligatory return visit of atients	A survey among 53 continuity clinic directors was conducted while assessing the models and characteristics of mental health services being conducted, demographics, and the comfort of managing mental health issues in the facility. The study used non- parametric tests to test the difference between integrated and non-integrated sites in terms of access, screening, management of disorders, and referral pattern.	It was found that integrated sites had higher access to psychologists (75% vs 30%; p = 0 .001), psychiatrists (55% vs 19%; p = 0 .006), but not to social workers/paediatricians. Directors of the integrated program perceived that they identified mental health problems more frequently (100% vs 76%; p <0 .05). On the other hand, they, unlike the non-integrated sites, also perceived that they are not

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
					responsible to assess and educate these patients (25% vs 56%; p <0 .05). As to referral practices, no differences were found between the two sites.
Dea, Robin (2000)	California Kaiser-Permanente, USA	Adults in the Northern California Region	**Adult Primary Care Model** This program aimed to maximise patient visits while minimising return appointments and re-work. It also aimed to implement competent clinical treatment process to minimise delay in referral to the appropriate level of care. The program used practice guidelines to enable tracking and prevent relapse of care. These Safety Interface Guidelines required service agreements between the primary care providers and specialists in terms of expected type of care to be provided, and health issues to be addressed. It was mentioned in this guideline that behavioural specialists will not only treat disorders but also assist in patient education and monitoring of patients' general health. In the patient register system, specialists can access information about medical issues such as hypertension, high cholesterol levels, vaccine schedules, and other laboratory results. Apart from mental disorders and general health issues, the program also caters for special conditions (e.g. somatisation, chronic illnesses and pain) through health education classes. The group of service providers involved in this program had access to patients' information through a centralised clinical database which permitted efficient communication among multiple providers about the status of the patient.	N/A	Not yet evaluated
Kilbourne, et al. (2008)	USA	Nearly half of the practice	The study identified 20 projects integrating general medical and mental health practices, disease		

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
		caters patients from the rural areas.	management of diabetes and cardiovascular diseases, and dental care. The study identified three practices: -**Alaska Central Peninsula** was implemented in Central Kenai Peninsula integrating services through co-locate services in one clinic. -**California: Tides Center** is a 4-year project integrating mental health services within community-based general medical clinics. -**Michigan: Washtenaw Community Health Organisation** implemented a four-quadrant model as follows: Quadrant (I) caters patients low mental and physical health care needs, Quadrant (II) serves high mental health care needs and low physical health care needs while Quadrant (III) for low mental health care needs and high physical health care needs. Lastly, Quadrant (IV) caters high mental health and high physical health care needs. Through co-located services, general medical services are being delivered by nurse practitioners and care managers for serious illnesses and by mental health social workers and psychiatrists for less serious mental disorders within primary mental health clinics.		
Kirchner, et al. (2004)	Virginia, USA	Veterans with mental health disorders and substance abuse in rural Virginia	**PRISM-E Study** The integration program was developed at two intervention community-based outpatient clinics. A full-time trained advanced practice nurse was placed within the clinic to provide services (e.g. cognitive therapy, alcohol intervention, and pharmacotherapy) with patients with depression, anxiety and alcohol use disorders.	In this model, patients were referred to a medical centre 70-85 miles away from the clinic. The evaluation revolved around a naturalistic approach via semi-structured interviews from June to July 2001, a year after program implementation. Service providers were interviewed including primary care providers, support staff, administrative personnel, and advanced practice nurses.	The results described implementation factors which are generally about the consistency of the model with the staff attitudes and belief and the culture of the clinic as an organisation, influence of the community, and the leadership changes. Interestingly, it was found that nurse's position to enable the integration was retained after the study period

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
					which may indicate a success of for the program.
McGough, et al. (2016)	Washington, USA	Primary care patients from nine University of Washington Neighborhood Clinics. This program targets those with depressive or anxiety disorders who are not receiving specialty mental health services.	**The Behavioral Health Integration Program (BHIP)** This program implemented collaborative care with a stepped approach to treat common mental health disorders (e.g. depression and anxiety). The BHIP was managed through a patient registry system which enabled tracking of patient visits and outcomes. Services in this program were provided by a team based in primary care clinics, composed of a primary care provider (PCP), care manager (who can be a nurse, social worker or psychologist), and a psychiatrist. *Primary care providers* They are initial contact points for patients and diagnose the patient. PCPs also oversee all the care provided to the patients. *Care managers* They collaboratively work with PCPs while performing mental health assessments, providing services such as education and behavioural interventions, following up patients while monitoring treatment response using standardized tools, conducting case reviews and communicates patients' condition with the psychiatrists and the rest of the rest of the team, and lastly referrals with external services and agencies (e.g. social, legal). Case managers had an average load of 150 every year. They either followed up with patients directly or by phone, depending on the severity of the condition of the patients. *Psychiatrists* They provided direct patient consultations as referred by case managers. They referred patients back to case managers until the patients showed improvements based on a targeted clinical outcome.	The study evaluated BHIP using a registry system which tracks proportion of patients with improved patient engagement, clinic outcomes and patient access. The program used PHQ-9 and GAD-7 to assess patients' symptoms of depression and anxiety respectively. Indicators measured were: -Total number of patients enrolled -Mean carer manager caseload -5-point improvement in either anxiety or depression -50% improvement with depression (score under 10) after at least 10 weeks of treatment -50% improvement with anxiety (score under 10) after at least 10 weeks of treatment -Cost savings	After 18 months of implementation, the BHIP catered to 1256 patients with 52:1 manager caseload ratio. 57.3% of the patients with mental disorders have at least 5-pt score improvement for either depression or anxiety. Specifically, 70% has improved score on depression and 64% on anxiety. The program had a savings of approximately $750,000 after an annual evaluation. In total, the program has 348 currently enrolled patients and has discharged 788 patients which achieved treatment goals.

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
Nover, Cynthia (2014)	California, USA	Residents of rural Auburn, California with mental health and cardiovascular disorders and diabetes	**CalMEND Pilot Collaborative to Integrate Primary Care and Mental Health (CPCI)** This program facilitated the partnership between mental health and primary care providers to improve service delivery among patients with mental illness and chronic diseases. The program hired a clinical social worker to conduct assessments and design treatment plans and a designated registered nurse to conduct medical assessments and teaching. These two professionals worked together with the in-house psychiatrist and physicians. The treatment team also worked with family members, care home staff, and other social workers for educational support and external services. After the treatment team identified patients who needed psychosocial services, their details were registered into the system for follow-up and succeeding treatments. The team requested the patients to visit the clinic weekly or monthly, depending on the severity of the case. Treatment given to patients during visits included meal and fitness planning, weight loss programs, smoking cessation, diabetes management and counselling. Social workers performed detailed psychosocial assessments and provided counselling as recommended by the psychiatrist.	The treatment team collected and stored all patient data for analysis from initial enrolment. Data also includes progress notes from social workers documented during counselling sessions. From the data collected, the team monitored monthly data: number of patients receiving partnered, mental health and primary care services, number of patients screened for and having cardio-metabolic risk factors, number of patients taking psychotic drugs; number of patients who are screened for and use tobacco, alcohol, and other drugs, and number of patients who have documented mental health and primary care treatment goals. A total of 100 patients were included in the program and monitored.	Outcomes not yet evaluated but behavioural and primary care workers successfully worked together to deliver mental and chronic health services effectively.
Rees, et al. (2004)	Scotland, UK	Residents of Dumfries and Galloway in South-west Scotland	**Integrated Care Pathways (ICP)** This was a strategy to facilitate integration of mental health services. It is a tool which outlines the series of routine tasks to be performed in order.	This reports the perceptions of health professionals on integration of community mental health teams in the implementation of integrated care pathways.	The members of CMHT recognised the importance of joint working through ICP by sharing roles and data among team members. This approach facilitated a single-point

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
			Community mental health teams (CMHT) were supervised by a team leader experienced at talking to adults with mental health problems. To facilitate the practice of CMHT, ICP was developed to standardise healthcare and social services.	Group discussions were conducted among CMHTs consisting of nurses, social workers and occupational therapists. Individual interviews were done among team leaders and service development managers.	access among clients. It also facilitates a supportive working environment among staff. However, interviews revealed that the implementation of ICP still has several aspects to be improved. There were tensions among members' current roles in the facility and their roles as CMHT members. It also failed to incorporate reviews of social services received by the client during team meeting. At the management level, it was also found that there were no integration team leaders as they have various expectations on how ICP would work. Overall, the teams were not fully implementing ICP protocol which have resulted into lack of integration among workers at management level affecting ICP's full implementation, especially on social services.
Taxman and Bouffard (2003)	Louisiana, Oklahoma and California, USA	Offenders attending drug courts in rural and urban areas	**Drug Treatment Courts** Courts in rural areas had a post-plea structure and used the existing facility to implement the services. Treatment services were either delivered by local or specialist providers during the full drug court period. Treatment providers were usually from community-	Using a mixed methods approach, the study explored the operations of drug treatment facilities and courts. Interviews were done among key players of drug court operations (i.e. judge, probation officers, defence attorneys,	Re-arrest rates during the program were 14% and 42% among those who completed and terminated the program respectively. During the post-program period, rearrest rates were down to 9% and 41%. It

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
			based organisations (either public or private). Treatment included cognitive-behavioural therapy, educational and aftercare services, and involvement in therapeutic communities. Counsellors had at least a bachelor's degree and 4-year work experience. They generally worked 30–40 hours a week, providing individual and group counselling.	prosecutors, treatment administrators and providers). Survey was done among counselling staff in treatment agencies. An observation was also conducted in 124 treatment sessions. Survey was also done among 2,357 drug court participants using a data collection in a retrospective approach regarding the impact of treatment participation. Information about behaviour and program participation were collected during facility visit while rearrest data were gathered within 12 months after their program enrolment.	took an average of 6.6 months until rearrest under a new type of offense among those who completed the programs while 4.5 months for the drop-outs. Observation during service provision showed that cognitive-behavioural and safety and self-exploration interventions were done in approximately 20% of treatment meetings observed in rural areas; while less than 10% in terms of education and implementation of therapeutic groups.
Valleley, et al. (2007); Valleley, et al. (2008)	Rural Nebraska, USA	Children and adolescents in primary care clinics	**Integrated Behavioral Health Clinics (BHCs)** There was a total of 3 BHC facilities in rural Nebraska. In each facility there were primary care and behavioural health services. Physicians or nurse practitioners usually referred paediatric patients to BHC providers (or behavioural health specialists) in the facility. Primary care and BHC were integrated by being in the same facility. Referral from primary care to BHC occurred through progress notes, informal conversations, or formal introduction by the physician to the specialists.	The study used referral data between 2002 and mid-2005. The primary outcome of interest during the evaluation was the percentage of referred children who attended initial appointments with BHC providers. Other measures included length of time between referral and getting an appointment, number of attempts to contact a family, and physician rating. Chi-square analysis was conducted to determine the factors associated with patient attendance. Treatment integrity was also collected among participants. This variable was defined as the level of clients' adherence to the treatment recommendations. This was recorded by the BHC providers during each session. It was rated as poor, moderate or good derived from a numerical scheme. Alongside this	Patients catered are commonly with ADHD (23.6%), oppositional defiant disorder (23.1%), behaviour problems (22.8%) and aggression (13.2%). 80% of the referred children attended their initial appointment. An association was found between the longer waiting period for an appointment and the likelihood to attend. Families who waited for 44 days were less likely to attend compared to those who waited 24 days in average. Analysis also showed that children with more referral reasons and as more impaired as diagnosed were more likely to attend appointments. A third of those who returned between 76-100% of the session was rated with good treatment

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
				measure was the percentage of session in which the client returned upon BHC providers' request. Goal attainment perception was also measured using a Goal Attainment Scale, a 5-point Likert Scale.	integrity by their physicians. At least 60% of those with moderate or poor integrity were from those which only attended 0-25% of the session. Regarding goal attainment, more than half (55.5%) of the clients met the treatment goal set during the initial session.
Veysey, et al. (2005)	Franklin County, USA	Women with alcohol and drug problems (AOD) and mental health disorders.	**Franklin County Women and Violence Project (FCWVP)** This project consisted of peer-delivered services in three drop-in centres. Each facility provided four core services offered sequentially: physically safe space, peer connection through a trauma group, peer resource advocates (PCA) who would help women identify their needs and establish connections with the community, and identify opportunities for valued roles to increase self-worth and self-efficacy. *Safe space*-This was a women-only space providing alcohol anonymous meetings, art classes, resources from a small library, free child care, and other facilities to make clients comfortable when they visited the facility. This was managed by paid staff and volunteers. *Trauma services*-This was a recovery program through a bio-psychosocial group intervention which helped trauma survivors meet their needs, establish relationships, and grain coping skills. The program was facilitated by a psychologist. *PRAs*-These advocates had similar mental health, trauma and AOD experience and were successful in their ongoing treatment and motivated to help women with similar needs recover, identify their needs and goals, and access community resources.	The project hired consumer/survivor/recovering (CSR) women to evaluate the project. They conducted focus group discussions to identify the strengths and gaps of the integration in terms of accessibility, availability, and trauma sensitivity.	The project enabled the clients to pursue recovery. PSAs helped alleviate sense of loneliness among clients, created healthy environments for the clients to express themselves, facilitated access to needed services in the community. PSAs also led to role modelling among the clients which urged recovering clients to help others who are still in the initial stages of recovery. Despite this effective system enabling women, the communities still have scarce treatment services which halted the entire cycle of the integration process. The evaluation also suggests that clinical integration should be implemented with broader professional scope with other agencies through cross-sectoral collaborations, shared assessment, collaborative treatment planning and efficient trauma assistance.

Study	Country	Target Population	Description	Methods (and Analysis)	Evaluation
			PRAs were all volunteers who were willing to meet their clients at any suitable location. *Valued social roles*-Once stable, clients were given opportunities to volunteer or work as paid staff for this project.		

Appendix 4: Integration terms

Continuum of integration, from table on p. 4
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Autonomy: Agencies act without reference to each other, although the actions of one may affect the other(s).

Cooperation: Agencies establish ongoing ties and provide limited support to an activity undertaken by the other agency. Communication and sharing information is emphasised. Requires a willingness to work together for common goals, goodwill and some mutual understanding.

Examples include learning and information sharing networks and open access to each other's facilities and services.

Coordination: Separate partners plan the alignment of their activities. Duplication of activities and resources is minimised. Requires agreed plans and protocols or the appointment of a coordinator or manager.

Examples include the appointment of a hub coordinator to provide strong links between existing child care services, or developing joint funding proposals for new coordinated programs.

Collaboration: Partners put their resources into a pool for a common purpose, but remain separate. Responsibility for using the pooled resources is shared by each of them. Requires: common goals and philosophy, agreed plans and governance, and agreed administrative arrangements.

Examples include the establishment of shared service centres or developing joint management structures.

Integration: Links between separate agencies draw them into a single system. Boundaries between the agencies dissolve as they merge some or all of their activities, processes or assets.

Examples include preventative or community-based place management programs. It can also involve the merger of similar agencies to form a single larger organisation.

Appendix 5: Recruitment of CALD participants

When the interviewer established contact with relevant service providers and provided them with project information before entering the field, she indicated that people with CALD backgrounds were one of three participant groups being targeted. As the interviewing progressed in the first region (South West), the interviewer specifically sought to recruit CALD participants. However, none of the service providers, including the managers of the community/neighbourhood centres, were able to identify CALD people who met the eligibility criteria.

The next field trip was to the North West region, with Mount Isa as the hub. This region was identified as the region most likely to have eligible CALD people, and the interviewer impressed on service providers who were assisting with recruitment that recruiting such people was a priority. The interviewer was referred to the coordinator of the Community Action for a Multicultural Society (CAMS) program who invited her to attend a social event for CALD mothers and children. She attended the event and spoke to those attending but none were eligible or knew of anyone who would be eligible/willing to participate. Quite a few of the attendees pointed out that people with mental health problems would be cared for within the family.

On the third field trip (Central West region), the interviewer again stressed that she was seeking CALD participants but was unable to recruit any.

Additional attempts to recruit CALD participants

After returning from the field, the interviewer discussed ways to recruit CALD participants with members of the project team. They agreed that she should concentrate on trying to recruit CALD participants in Mount Isa as it had the largest proportion of overseas borne residents.

- One of the contact people (a service provider and academic at James Cook University) had offered to assist. She suggested that *headspace* in Mount Isa would be an appropriate organisation to work with as young CALD people may be less inhibited by cultural restraints to participate and that their participation may lead to recruitment among older people (snowballing). The JCU contact introduced the interviewer to relevant *headspace* personnel (clinical team leader and community engagement officer) via email. Both the team leader and the engagement officer made efforts to identify potential CALD participants (e.g. facebook posts, staff email, talking with their clients, networking meeting/group email). Their efforts were unsuccessful.

- ISSR's Prof Karen Thorpe had work contacts in Mount Isa from many years of linking with colleagues there and she asked her liaison officer in Mount Isa to assist; however, the liaison officer was unable to identify potential CALD participants or ways to recruit CALD participants.

- The interviewer also informed her contacts in Mount Isa that if she could identify at least two or three potential CALD participants, she would return to Mount Isa to interview them. The manager of the Neighbourhood Centre was a board member of the Mount Isa Community Development Association (MICDA) and she put the interviewer in contact with the relevant person at MICDA. This person explained to the interviewer that she would not be able to assist with recruiting of CALD participants because her

clients would not be willing to participate due to cultural constraints (e.g. stigma of having poor mental health, need for husband's approval).

None of the other contact people (including the coordinator of CAMS) were able to identify potential CALD participants or recommend ways to recruit CALD participants.

Conclusions

Potential CALD participants were most likely to be in Mount Isa but additional targeted attempts at recruitment there were unsuccessful. Cultural constraints were a likely barrier to help seeking at services and, consequently, to participation as interviewees.

Not recruiting via Queensland Health services (as requested by QMHC) may also have hindered our ability to recruit CALD participants.