



Improving the integration of mental health services in primary health care at the macro level

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Acronyms and abbreviations

AHMAC	Australian Health Ministers Advisory Council
AIHW	Australian Institute of Health and Welfare
AOD	alcohol and other drug(s)
ATAPS	Access to Allied Psychological Services
Better Access	Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule
Better Outcomes	Better Outcomes in Mental Health Care
CDHAC	Commonwealth Department of Health and Aged Care
CDHFS	Commonwealth Department of Health and Family Services
CGF	Calouste Gulbenkian Foundation
CHD	Coronary Heart Disease
COAG	Council of Australian Governments
COC	continuity of care
GP	general practitioner
HASI	NSW Housing and Accommodation Support Initiative
HASP	Housing and Support Programme
HITH	Hospital In The Home
IPS	Individual Placement and Support
IT	Information technology
MHH@H	Mental Health Hospital @ Home
MHIS	Mental Health Information System
NDIS	National Disability Insurance Scheme
NHS	National Health Service (incorporating NHS England, NHS Northern Ireland, NHS Scotland, and NHS Wales)
NMHSPF	National Mental Health Service Planning Framework
NSMHW	National Survey of Mental Health and Wellbeing
NSW	New South Wales
NZ	New Zealand
PACER	Police, Ambulance and Crisis Assessment Team Early Response
PAR	population attributable risk
PHAMs	Personal Helpers and Mentors programme
PHC	primary health care

PIR	Partners in Recovery
PMHT	Police Mental Health Intervention Team
Qld	Queensland
SA	South Australia
SAAP	Supported Accommodation Assistance Programme
SES	socioeconomic status
SHIP	Survey of High Impact Psychosis
SMR	standardised mortality ratio
US	United States
WA	Western Australia
WHO	World Health Organization
WONCA	World Organization of Family Doctors

Executive summary

Policy context

Mental disorders are highly prevalent in Australia. The most frequently diagnosed conditions are anxiety, affective and substance use disorders. Comorbidities are common, both in terms of concurrent mental health conditions and concurrent physical and mental health conditions. Many individuals with lived experience of mental illness also face a range of non-medical issues (e.g. housing, employment and education needs). Typically, individuals requiring mental health care for most moderate/mild cases are supported in primary health care (PHC), though specialist care in secondary and tertiary settings is required for more severe conditions. Given the multifaceted nature of mental health conditions, support for individuals experiencing such diagnoses also needs to be multidisciplinary and collaborative. PHC mental health services encompass a range of services, including counselling, pharmacological treatments, referrals and follow-up care, provided by health professionals in PHC settings (e.g. general practice) to treat or prevent mental health problems.

Internationally, the focus of health systems is shifting from hospitals towards PHC, and integrated care is a key priority. While definitions vary, integration typically refers to bringing together people and organisations that represent different sectors to align relevant practice and policy and to improve access and quality of health care. At the macro (systems) level, integration involves coherence across policies and legislation; development of cross-sectoral partnerships, collaborations and agreements; and joint administrative, planning and funding arrangements.

The potential benefits of integrated mental health care are widespread, including not only improving the quality of care individuals receive but also reducing costs for health systems. The task, however, is not simple. Integrating mental health care is complex due to the interaction between different systems. This report considers the structure of international health systems and highlights the macro level strategies relevant across four different levels of integration, namely:

- Horizontal integration of mental health care within PHC
- Vertical integration within the mental health system (i.e. between primary, secondary and tertiary mental health services)
- Vertical integration within the broader health system (i.e. between primary mental health services and secondary and tertiary physical health services)
- Horizontal and vertical integration with the non-health sector (particularly housing, employment, education).

Key findings

The structures of mental health systems were compared across Australia, Canada, England, the Netherlands and New Zealand (NZ). There are similarities across international health systems in terms of priorities, but there are also infrastructure differences. For example, there are variations in governments' levels of responsibility, local service coordination bodies, funding approaches, enrolled populations, key stakeholders, and responses regarding stigma, social inclusion and recovery.

Consistent evidence in this review highlighted the importance of primary and secondary sector mental health care services working together. This relates to a stepped care approach which encourages continuity of care (COC), enabled by efficient referral processes, shared electronic health records and inter-professional education. Different service providers need to respect each other's roles, and work in a complementary way to support people with lived experience of mental illness, particularly those with more severe conditions.

Given the rising prevalence of multimorbidity, addressing comorbid conditions is an increasingly common challenge for health professionals. Financial incentives have been useful in linking primary mental and physical health services through programmes such as Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule, and the Access to Allied Psychological Services initiatives.

Mental health and wellbeing influences, and is influenced by, a range of non-health and social issues; thus, well integrated care for those with lived experience of mental illness needs to extend beyond health boundaries. In particular, housing, education and employment services should be incorporated in integrated models of care. Initiatives such as the Partners in Recovery programme seek to address these needs in a collaborative fashion among vulnerable populations.

Integrating mental health care requires consideration of the following factors. If not addressed adequately these issues can be barriers; yet if considered fully they can enable effective integration:

- Taking into account local context
- Engaging key stakeholders in informal or formal partnerships
- Articulating governance procedures and identifying leaders
- Financing reforms in a sustainable fashion
- Establishing appropriate infrastructure and resources (including considering co-location of services)
- Accounting for organisational culture
- Encouraging respectful communication
- Providing inter-professional education
- Reducing stigmatisation and discrimination
- Collecting adequate data that assesses quality of care.

In terms of limitations of the review, although information was available about specific macro level policies for integration, there was limited detail as to how these policies have been operationalised and the impact they have had. Instead the focus in the literature was primarily on micro level integrated mental health care. Further, where data were available there were some concerns about the generalisability of findings. Often quantitative studies focused on specific populations, typically groups with low-prevalence, severe mental health conditions, yet expressed findings as if they represented the whole population. Similar patterns were found in the limited cost-effectiveness research. That is, costs for subpopulations were assumed to parallel costs for broader groups. In addition, the research that explored multifaceted approaches to addressing integrated mental health care did not determine whether they were effective only if implemented as a whole, or whether core elements could be applied in other situations.

Policy considerations

Based on the findings of this report, the following factors may be considered for action:

Policy

- Embrace a ‘no wrong door’ approach in which different services are capable of advising individuals with mental health issues of how to get the support they require.
- Develop waiting time targets for community mental health services (similar to those for emergency departments).
- Enable support/access for less severe, high-prevalence conditions through the National Disability Insurance Scheme (NDIS).

Governance

- Involve people with lived experience of mental illness and communities in planning and implementing integrated care, reflecting the practices in Aboriginal and Torres Strait Islander communities where Aboriginal Community Controlled Health Services have had considerable success.

Funding and financing

- Consider incentives to encourage stepped care (e.g. continued support for Better Access and Access to Allied Psychological Services initiatives as coordinated by primary health networks).
- Offer financial support for pharmacies and emergency services to be engaged in mental health teams.
- Provide funding and infrastructure for inter-professional education and training workshops.
- Plan and fund strategies to better connect the public and private sectors.

Infrastructure

- Develop technologies which enable effective referrals and shared health records not only across the PHC sector but that are compatible with secondary and tertiary sector technologies.
- Continue to encourage co-location and funding of wrap-around services which enable joint planning of care (e.g. co-locating mental health and social services within homeless centres, employment services, alcohol and drug services, legal services).
- Include PHC in cross-sectoral partnership arrangements with mental health and non-health services
- Encourage collection of up-to-date data – the most recent national survey was conducted in 2007; given the changes to PHC that occurred as a result of the 2010 National Primary Health Care Strategy, it would be prudent to re-examine the prevalence and experience of mental health conditions in Australia.
- Train police and other emergency services to identify individuals with mental health issues and to develop de-escalation techniques to avoid crises.

Models of care

- Some current models and policies show promise, but they need to be evaluated, with findings made publicly available.
- Evaluations should incorporate both quantitative and qualitative components, including health economic analyses, and should evaluate both process and outcomes, including effectiveness and cost-effectiveness.
- Support more explicit research focusing on cross-sectoral comorbidity as this issue becomes increasingly important with rising rates of multimorbidity.

Learn from international practices

- Additional policy recommendations include investigating the translation of World Health Organization (WHO) and Calouste Gulbenkian Foundation (CGF) (2014a) recommendations around governing principles to an Australian context:

- Public health approaches – taking into account life course approaches; increasing public awareness (e.g. continue to support *beyondblue*); involving people with lived experience of mental illness at all levels of planning; developing care pathways for continuity of care; supporting case management.
- Systems level approaches – ensuring consistency with international practices; planning for long-term future; designing inter-professional education models and encouraging stepped care; increasing availability of medications for those who require them; employing national surveillance agencies to measure key mental health indicators for quality improvement when assessing general health system performance.
- Whole-of-government approaches – involving not only end users but also all relevant organisations in planning, funding and delivering services (i.e. developing and maintaining relationships with the social sector); coordinating multi-sectoral leadership for shared goals and shared decision making.

Methods

A rapid review was conducted to explore the effectiveness of macro level strategies to improve integration of mental health services in PHC. This pragmatic review involved a search and synthesis of relevant peer reviewed and grey literature, generally restricted to the period from 2009 to 2014. Although the emphasis was on Australian evidence, international examples were included where appropriate, predominantly from countries with comparable systems and priorities to Australia (i.e. Canada, England, NZ, and the Netherlands).

Context

Mental disorders were the fourth highest contributors to the burden of disease in Australia in 2010 (13%), behind cancer (16%), musculoskeletal disorders (15%) and cardiovascular disease (14%) (AIHW, 2014). The economic cost to the health system in 2008-09 was \$6.4 billion (8.6% of the total disease expenditure). However, the burden extends far beyond health system costs alone, imposing substantial economic and social costs on families and the wider community. Mental disorders are complex and multifactorial; requiring a collaborative, multi-sectoral, integrated care approach. Australia has had a national mental health policy – the National Mental Health Strategy – for more than 20 years. The original policy (Australian Health Ministers, 1992b) recognised that primary health care (PHC) service providers, particularly general practitioners (GPs), are often the first point of contact for people with lived experience of mental illness. It argued for greater mainstreaming and integration of mental health services. Further key policy initiatives relevant to primary mental health care are listed in Table 5 (Appendix C).

Integrated health care is consistently cited in policy documents as a priority for international health systems (Oliver-Baxter et al., 2013d). In particular, there is a need for integrated mental health care as individuals with poor mental health represent a vulnerable population group who are at risk of falling through the gaps in services (Commonwealth of Australia, 2009). At the same time, there has been a global shift away from acute care as the centre of the health system, to a much greater focus on the role and impact of PHC (Standing Council on Health, 2013b). Thus, in order to provide more effective and efficient mental health care, it is important to improve integration between the primary, secondary and tertiary sectors, and across mental, physical, and social services.

PHC in Australia is currently provided by a complex mix of agencies, which includes State and Territory government-managed community health services, publicly and privately funded providers, and government and non-government agencies. The PHC sector operates at a number of levels in the context of Australia's system of government and the broader health system (for more details, see Oliver-Baxter et al., 2013a). Broadly these levels can be grouped into three categories (Australian Medicare Local Alliance, 2012):

- **Macro** (system) level governments and agencies are responsible for national and/or State level policy, funding strategy and enabling infrastructure. In addition to the Commonwealth, State and Territory Governments, examples include the National Mental Health Commission, the Royal Australian and New Zealand College of Psychiatrists, and the National Aboriginal Community Controlled Health Organisation. Many social services organisations, which play a role in the lives of those with mental illness, also operate at the systems level (e.g. Centrelink).
- **Meso** (middle) level agencies are positioned between the macro and micro levels, often have a regional role and may act as commissioning, linking, enabling agencies for the local and regional PHC sector, such as PHC organisations (including Medicare Locals or the proposed new Primary Health Networks, and Local Hospital Networks).
- **Micro** (practice) level includes agencies and individuals who provide direct PHC to people with lived experience of mental illness such as general practice, community health services, private nursing or allied health providers; and social services providers (e.g. employment services).

Integration of PHC and mental health services is influenced by a range of issues at the macro level of systems and policies, which may impact on delivery of integrated care at the micro level of health care services. These include infrastructure, financing, governance, partnerships and collaborations across organisations and sectors. This report reviews macro level factors influencing the integration of PHC mental health services with secondary and tertiary mental health services; PHC physical health services; secondary and tertiary physical health services; and non-health services.

Background

Mental health

Mental disorders are common, and mental health is a key social and public health issue. Furthermore, the costs of mental health are high and are likely to be underestimated. These costs relate not only to public funding systems and treatment costs, but also to specific costs related to lost productivity, disability, justice and educational systems, and caregiving (Commonwealth of Australia, 2009, Mental Health Commission of Canada, 2012).

It is widely accepted that multiple factors contribute to poor mental health, including biological, psychological, and environmental factors. Although most research has focused on biological factors, there is strong evidence of social determinants of mental disorders, including economic adversity and social inequity (Allen et al., 2014). According to the World Health Organization and Calouste Gulbenkian Foundation (WHO and CGF, 2014b, p 8):

- Mental health and many common mental disorders are shaped to a great extent by the social, economic, and physical environments in which people live.
- Social inequalities are associated with increased risk of many common mental disorders.

As many of these factors are external to an individual's sphere of control, they need to be addressed at a systems (macro) level. According to Fisher and Baum (2010), higher rates of mental health problems are associated with social conditions including low income, inadequate housing, lack of education, unemployment, insecure employment, high-demand or low-control work, child neglect/abuse, gendered violence, unsafe neighbourhood conditions, and social isolation. Given this complexity, there is a strong need for a multifaceted approach acting across a range of health and non-health sectors to meet the needs of those with poor mental health.

Prevalence of mental disorders in Australia

There are relatively good sources of information about the prevalence of mental disorders in Australia. In particular, several rigorous national studies have been conducted in recent decades. The 2007 National Survey of Mental Health and Wellbeing (NSMHW), which investigated the prevalence of common mental disorders in the Australian population (Slade et al., 2009a), found that one in five Australians aged 16-85 years had a mental disorder at some time during 2007 (12-month prevalence)¹. The most common conditions were anxiety disorders (14.4%), followed by affective disorders (6.2%) and substance use disorders (5.1%) (Slade et al., 2009a). Of those with a disorder, nearly half (46.3%) had mild, one-third (33.2%) had moderate, and one-fifth (20.5%) had severe disorders.

Lifetime prevalence is higher, because many people recover from mental disorders, particularly depression and anxiety disorders. In many cases, symptoms resolve naturally or with minimal intervention (Lee et al., 2012, Sareen et al., 2013, Whiteford et al., 2013). The UK National Institute for Health and Clinical Excellence (NICE) (2009) guidelines for treatment of depression in primary and secondary health care settings recommended active monitoring (often referred to as 'watchful waiting') or low-intensity psychosocial interventions for many patients with mild depression (pp 19-20). Whiteford et al. (2013) endorsed watchful waiting on the basis of evidence from wait-list controlled trials and observational cohort studies. For more severe and persistent cases, NICE recommends more intensive interventions, such as cognitive-behavioural therapy and/or antidepressants (pp 22-23), usually for several months (pp 28-29). Untreated mental illness can be problematic, leading to social problems (e.g. job loss, relationship breakdown, loss of reputation) and

¹ This survey data report needs updating as there have been many changes in mental health care since the time of collection.

suicide, as can treated mental illness in some cases (Lourey et al., 2012, Lourey et al., 2013, Chesney et al., 2014).

A smaller proportion of people have severe and persistent disorders that profoundly affect their lives (Lee et al., 2012) and necessitate long-term, more intensive treatment involving specialists, often including some episodes of hospitalisation. According to the Fourth National Mental Health Plan (Commonwealth of Australia, 2009), approximately three per cent of Australian adults have severe mental disorders; and many such people also have comorbid physical disorders (e.g. cardiovascular disease and/or diabetes).

A useful distinction has been made in Australia between high-prevalence (common) and low-prevalence mental disorders (Jablensky et al., 1999). The latter tend to be more severe and chronic, and therefore impose a substantial burden despite being much less common. High-prevalence disorders include anxiety disorders, affective (mood) disorders (e.g. depression), and alcohol and other drug (AOD) problems (the three conditions included in the NSMHW); whereas low-prevalence, but generally more serious, disorders include schizophrenia and related disorders, bipolar disorder, depression with psychotic features, delusional disorders, and acute transient psychotic disorders (Jablensky et al., 1999). Most of those with low-prevalence disorders experience “profound and widespread disability, decreased quality of life, persistent and distressing symptoms, and frequent side-effects of medication” (Jablensky et al., 1999, p xii, Jablensky et al., 2000). The 2010 Survey of High Impact Psychosis (SHIP) estimated that nearly 64,000 people (4.5 people per 1,000) aged 18-64 years had a psychotic illness and were in contact with specialised public mental health services in the previous year (Morgan et al., 2011). Other mental disorders that are generally not considered to be in either category include eating disorders and personality disorders.

Comorbidity

Comorbidity (co-occurrence) of disorders is common, both with other mental disorders and with physical disorders, which can complicate management. The 2007 NSMHW reported that 25.4 per cent of people with a mental disorder had more than one mental disorder (Slade et al., 2009b); and more than half (54%) of those with multiple mental disorders had severe impairment.

Comorbid physical disorders also add significant complexity in terms of care provision. People with lived experience of common mental disorders (e.g. depression/anxiety/substance use disorders) were no more likely than the general population to have physical disorders (Slade et al., 2009b). However, these mental disorders were more common among people with chronic physical conditions (28.0%) than among people without such conditions (17.6%). Moreover, there is a strong association between rates of multimorbidity and areas of social deprivation. For example, an analysis of data from Scotland’s national database of registered practices (2007) reported earlier onset of multimorbidity including mental health disorders in the most deprived areas of Scotland (Barnett et al., 2012).

According to the Australian Institute of Health and Welfare (AIHW) (2012), approximately one in nine Australians aged 16-85 years in 2007 had a mental disorder (most commonly an anxiety disorder) and a physical disorder at the same time. There was an inverse relationship between comorbidity and socioeconomic status (SES), with people living in the most disadvantaged areas being 65 per cent more likely than people in the least disadvantaged areas to have comorbid disorders.

For low-prevalence but serious conditions, data from the 2010 SHIP indicated high rates of chronic diseases, including diabetes, asthma, arthritis and cardiometabolic risk factors (Morgan et al., 2011, p 42):

- 82.1% met at-risk criteria for abdominal obesity
- 28.1% had elevated blood glucose, which is associated with diabetes
- 49.9% met criteria for metabolic syndrome.

Treatment of mental disorders typically involves use of psychiatric drugs, including antipsychotics and antidepressants, which commonly have adverse effects, both physical and psychological. They may also increase the risk of chronic diseases including diabetes and cardiovascular disorders (De Hert et al., 2012). This is particularly the case with atypical (newer) antipsychotics. Despite being at higher risk for these disorders, people with severe mental illnesses are less likely to be screened and monitored (De Hert et al., 2012). People with serious mental disorders also commonly have oral/dental health problems (Kisely et al., 2011).

Disability

In the NSMHW, disability associated with mental illness was explored by examining the extent to which it interfered with day-to-day activities, household maintenance, work or study, close relationships and social life (Slade et al., 2009b). The NSMHW reported that people with depressive episodes and dysthymia had the greatest levels of interference in their lives, particularly their social lives. On average, individuals with mental disorders reported that they had been unable to conduct their usual activities for four out of the last 30 days, compared with 1.4 days in those without a diagnosed mental disorder; and this rate increased to an average of six days for people with affective disorders.

Schizophrenia and bipolar disorder are among the top 20 causes of years of life lived with disability (Vos et al., 2012). The 2010 SHIP data reinforced that psychosis is associated with both substantial and persistent disability; almost a quarter of people were assessed as significantly or extremely/totally disabled, meaning that they were unable to function independently (Morgan et al., 2011). Further, 63 per cent reported dysfunction in overall socialising.

Mortality

Mental disorders are associated with increased risk of premature death, including suicide (Doessel et al., 2010); and, like mental disorders, suicide rates tend to be higher in times of economic crisis (Reeves et al., 2014). However, more people with severe mental disorders die prematurely from causes other than suicide (Lawrence et al., 2013, Tidemalm et al., 2008) and the relationship between mental disorders and mortality is partly mediated by social factors (Lazzarino et al., 2013).

Furthermore, the methodology used to determine mortality in mental health studies may be problematic. Many studies tend to overestimate mortality (Chesney et al., 2014), particularly if they focus on inpatient samples (Crump et al., 2013). Some highly cited statistics are based on samples of people with severe chronic disorders but are inappropriately generalised to the broader population of people with mental disorders, including high-prevalence disorders (Hickie et al., 2014, Lawrence et al., 2013). For example, Lee et al. (2010) reported that “death rates for people with any mental illness are 2.5 times higher than for the general population” [italics added] (p 16). However, these data were based on research on individuals with serious mental disorders who were registered on the Mental Health Information System (MHIS) (Coghlan et al., 2001). As the MHIS only tracks people with lived experience of mental illness who have had contact with mental health services (not GPs or

private practice specialists), or been a psychiatric inpatient in Western Australia, the findings only illustrate that the death rate is higher among those people in contact with mental health services.

Treatment

Although many people with mental disorders recover naturally or with minimal intervention (Lee et al., 2012, Sareen et al., 2013, Whiteford et al., 2013), this is not the case for all people with serious mental disorders, which are often chronic and debilitating.

In Australia, most mental health care is provided in PHC, primarily by GPs (AIHW, 2013b). Treatment by GPs is appropriate for many people with mild or moderate disorders; and 78 per cent of people who sought help for depression contacted a GP (Slade et al., 2009a). In 2011-12, 12.1 per cent of GP consultations were for mental health-related problems (AIHW, 2013a), most commonly anxiety, depression and sleep disorders.

GPs are most likely to prescribe, supply, or recommend medications for mental health problems, most commonly antidepressants, anxiolytics, hypnotics, and sedatives. However, they also provide psychological counselling, advice, and other treatments (AIHW, 2013a); and refer to other health professionals, particularly psychologists and psychiatrists (AIHW, 2010). Often there is poor communication and collaboration between these mental health care providers (Craven and Bland, 2006, Fletcher et al., 2014, Gask, 2005). In addition, many people with serious mental illness have comorbid physical disorders (e.g. cardiovascular disease and/or diabetes), their care and treatment is poorly integrated, and frequently they have multiple complex needs related to non-health issues such as housing, vocational support and legal issues.

Integration and integrated care

There is a range of definitions available for integration and integrated care; some focus on the organisation of services across different sectors while others focus on interactions among providers within a sector. However, the underlying principle is that integration refers to bringing together individuals and organisations representing different sectors/fields to align practices and policies and to enhance access to quality health care (Oliver-Baxter et al., 2013a). For a detailed discussion on integration, see previous reports produced by PHCRIS (Oliver-Baxter et al., 2013b, Oliver-Baxter et al., 2013a, Oliver-Baxter et al., 2013c, Oliver-Baxter et al., 2013d, Raven et al., 2014).

Briefly, the term integration is often used synonymously with cooperation, collaboration and coordination. However, these concepts differ. Konrad (1996) described a continuum of intensity of integration. At the simplest, least formal end of the scale lies information sharing and communication, which involves systems that “operate autonomously in a parallel fashion” (p 9). At each step, collaborative strategies gain intensity and increase the formality of their arrangements, with integration at the other end of the continuum. Table 6 and Table 7 (Appendix D) provide detail on Konrad’s different levels of intensity of integration.

For the purposes of this report, macro or systems-level integration relates to “purpose-built, top-level down coordination of services under designated cross-sectoral programs” (Flatau et al., 2010, p 7). Specifically, this includes integration across systems and organisations and may include: coherence of policies and legislation; cross-sectoral partnerships and agreements; and joint administrative, planning and funding arrangements. Various forms of integration are required for mental health care: vertical integration in which primary and secondary mental and physical health services are connected; and horizontal integration where the PHC sector acts in collaboration with the social care and community sectors.

Although multidisciplinary teams are commonly proposed in PHC and this frequently entails a sense of collaboration, it is only since the National Primary Health Care Strategy was introduced that the policy focus has been on integration (Commonwealth of Australia, 2010).

In relation to mental health specifically, integration issues include:

- Horizontal integration within PHC (i.e. between physical and mental health services)
- Vertical integration within the mental health system (i.e. between primary, secondary and tertiary mental health services)
- Vertical integration within the broader health system (i.e. between primary mental health services and secondary and tertiary physical health services)
- Horizontal and vertical integration with the non-health sector (particularly housing, employment, education).

Aim and research questions

The main aim of this rapid review (from here on referred to as a Policy Issue Review) is to identify and evaluate the effectiveness of macro level strategies to improve integration of mental health services in PHC.

The *Policy Issue Review* addresses the following research questions:

- How do different countries structure their mental health systems (focusing on mental health care delivered in PHC settings)?
- What macro level factors influence integration of PHC mental health services with secondary and tertiary mental health services (including hospitals and community-based services)?
- What macro level factors influence integration of PHC mental health services with PHC physical health services?
- What macro level factors influence integration of PHC mental health services with secondary and tertiary physical health services?
- What macro level factors influence integration of PHC mental health services with (non-health) support services such as housing, AOD services and vocational services?

This *Policy Issue Review* focuses on factors influencing integration of PHC mental health services (with secondary/tertiary mental health services, PHC/secondary/tertiary physical health services, and social/welfare support services), including infrastructure (e.g. co-location), governance and partnerships in the Australian setting. Relevant information from international settings (England, NZ, Canada and the Netherlands) will be included where relevant. Although additional factors, such as workforce issues, funding models and economic analyses may also influence integration across these sectors, they are out of scope for the current review; and the search strategy thus does not include these terms.

Methods

This *Policy Issue Review* follows a 'rapid review' format. Rapid reviews are short literature reviews that focus on research evidence, with a view to facilitating evidence-based policy development (Grant and Booth, 2009). Due to the limited timeframe for this review (8 weeks), searches and critical appraisal of the literature were pragmatic rather than systematic. In order to obtain the most relevant material quickly, search terms varied across different databases. Consequently, replication of this review may result in a different literature base.

A selection of relevant academic databases was searched: PubMed, the Cochrane Library, the *Informit* databases, and Google Scholar. Search terms are detailed in Appendix A.

In order to obtain evidence from the most recent examples of integration efforts, literature searches were generally restricted to the period from 2009 to 2014. Earlier publications were included where there were relevant key reports/articles or a scarcity of more recent information. A snowballing technique was also used to identify additional relevant literature from reference lists of papers identified through database searches. Although the emphasis was on Australian literature, international literature was included, where appropriate, focusing predominantly on countries with comparable systems and priorities to Australia, specifically Canada, NZ, the Netherlands, and England. Only English language sources were included. Searches were restricted to adult populations; childhood disorders were not included, nor was dementia, because it is not within the ambit of national mental health policy (Australian Health Ministers, 2003).

The specified disorders were the high-prevalence disorders (i.e. anxiety, affective, and substance use disorders) included in the 2007 NSMHW (Slade et al., 2009b) and the lower prevalence (psychotic) disorders included in the 2010 SHIP (Morgan et al., 2011).

Limitations of the review

The literature search was challenged by lack of specificity. Searches for 'integration' and similar terms (e.g. 'collaboration', 'multidisciplinary', and 'inter-professional') located large numbers of sources that mentioned those terms but often did not provide any relevant information. The lack of consensus in definitions of integration and heterogeneity among models presented a challenge. For example, terms such as 'collaborative' often refer to components of integration, such as communication and liaison between GPs and medical specialists, rather than multidimensional concepts, such as teamwork that includes other health and welfare service providers.

The literature related to integration and integrated care is plagued with inconsistent use of terms and a high degree of heterogeneity in the use of models and mechanisms (Whiteford et al., 2014); a range of synonyms or methods of operationalising integration have been applied throughout the literature (Oliver-Baxter et al., 2013a). For example, one of the challenges in the literature is when the term integration is used to explain basic working relationships between parties such as the police and social services (Forti et al., 2014); it is necessary to consider the extent to which key stakeholders' practices are fully integrated and under which circumstances the practices are merely 'coordinated' (Konrad, 1996).

Similarly, an additional limitation relates to the inconsistencies in definitions of PHC that occur in the literature. When exploring mental health services, sources may refer to examples such as community mental health, mental health services provided by allied health professionals, physician services,

psychology services, or mental health services generally. In other cases these variations are subsumed under a more comprehensive definition of PHC mental health services. As searches were restricted to 'primary health care' and synonyms, it is possible that material on some of these services which do not refer to themselves as PHC, may have been missed.

Additionally, there were relationships explored in this review for which appropriate search terms were challenging to define. For example, research alluded to integration across primary mental and secondary and tertiary physical care sectors but rarely mentioned these specific terms.

There is a blurring between macro, meso and micro levels throughout both the available literature and the synthesis in this review. This is partly due to definitional differences, but also because many policies, organisations and stakeholders operate across multiple levels of integration. For example, organisations that deliver services directly to clients operate at the micro level; however, several examples have been included in this report as macro level policies refer to their establishment, or they represent integrated partnerships or other arrangements.

While a number of policy documents described the need for integration, in some cases it was difficult to be explicit about the relationship between these policies and practice; and difficult to articulate the differences the policies have made in terms of outcomes. In these situations it was necessary to instead focus on whether policies have provided a more enabling environment which allows integration to occur.

The ability to present an exhaustive review was limited by the short time period and availability of evidence. For example, there was a lack of evaluation of a number of key policies and programmes; and this report has focused on those that have been evaluated where possible.

Findings

The findings from this review have been organised into the following sections:

- Integration in mental health: this section describes the rationale for integrating mental health care with other sectors that impact on a person's health and wellbeing
- Mental health systems: this section provides a brief overview of Australian and some international health systems and how they approach integration with mental health
- Integration of PHC mental health services with secondary and tertiary mental health services: this section examines **vertical** integration between different levels of the mental health system
- Integration of PHC mental health services with PHC physical health services: this section examines **horizontal** integration between mental health services and PHC services
- Integration of PHC mental health services with secondary and tertiary physical health services: this section examines **vertical** integration between mental health and hospitals
- Integration of PHC mental health services with non-health services: this section describes the different factors that impact on mental health and examines both **vertical** and **horizontal** integration with non-health sectors
- Barriers and facilitators: this section summarises the main barriers and facilitators to macro level integration that have been identified in the literature.

As stated in the limitations, the terms 'primary health care', 'primary care' or 'general practice' are not always explicitly stated in the literature, yet at times it is evident that PHC plays a role in integration with mental health.

Although policy documents consistently recognise the need to develop and sustain an integrated, cross-sectoral approach that incorporates social, physical and mental health needs, there is little available information on the extent to which this has occurred (Lourey et al., 2012), or the impact this has had more broadly. For the most part, the available literature on macro level integration is purely descriptive, outlining the intention of particular policies, strategies and expected outcomes, but providing little detail on how the different sectors or organisations should work together, or how to evaluate the effectiveness of this approach. Evaluations of macro level policies and initiatives are scarce; and results of evaluations have been provided, where possible.

Integration in mental health

Mental health issues are often complex and multifactorial, thus requiring multifaceted support. Internationally, integrated care is emerging as a priority in mental health care, with a shift away from institutionalisation towards community-based care services. The National Mental Health Commission (Lourey et al., 2012) emphasised the need for "co-ordinated and integrated support for people with severe and persistent mental illness and complex care needs, who need stable homes and support to keep well, avoid homelessness, and break the hospital cycle" (p 63). In developing their mental health outcomes strategy, *No Health Without Mental Health*, the English Department of Health noted how "the Government can achieve more in partnership with others than it can alone... services can achieve more through integrated, pathway working than they can from working in isolation from one another" (HM Government, 2011, p 11). It has been suggested that integrated care also benefits families and carers who are recipients of services; and enables more effective and efficient use of a nation's services (Commonwealth of Australia, 2009).

Although PHC is fundamental for mental health care, it needs to be complemented by other levels of care, as illustrated in the WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health (Figure 1), which proposes the integration of mental health services with general health care (WHO, 2009). The key point illustrated in this pyramid is the relationship between the

frequency of need and costs across different levels of care. For example, informal community care and self-care services are highest in terms of quantity and frequency, but lowest in cost; whereas more formal specialist psychiatric services are lower in quantity and frequency, but much higher in costs. To reduce costs, optimal care is provided through less formal services where possible. An additional dimension depicting the need for social care services is missing from this pyramid.

In a recent review (WHO and CGF, 2014a), three macro level governing principles for integrating the response to mental disorders were developed (Table 1), reflecting public health, systems and whole-of-government approaches. The actions included in Table 1 illustrate the complexity of the mental health area.

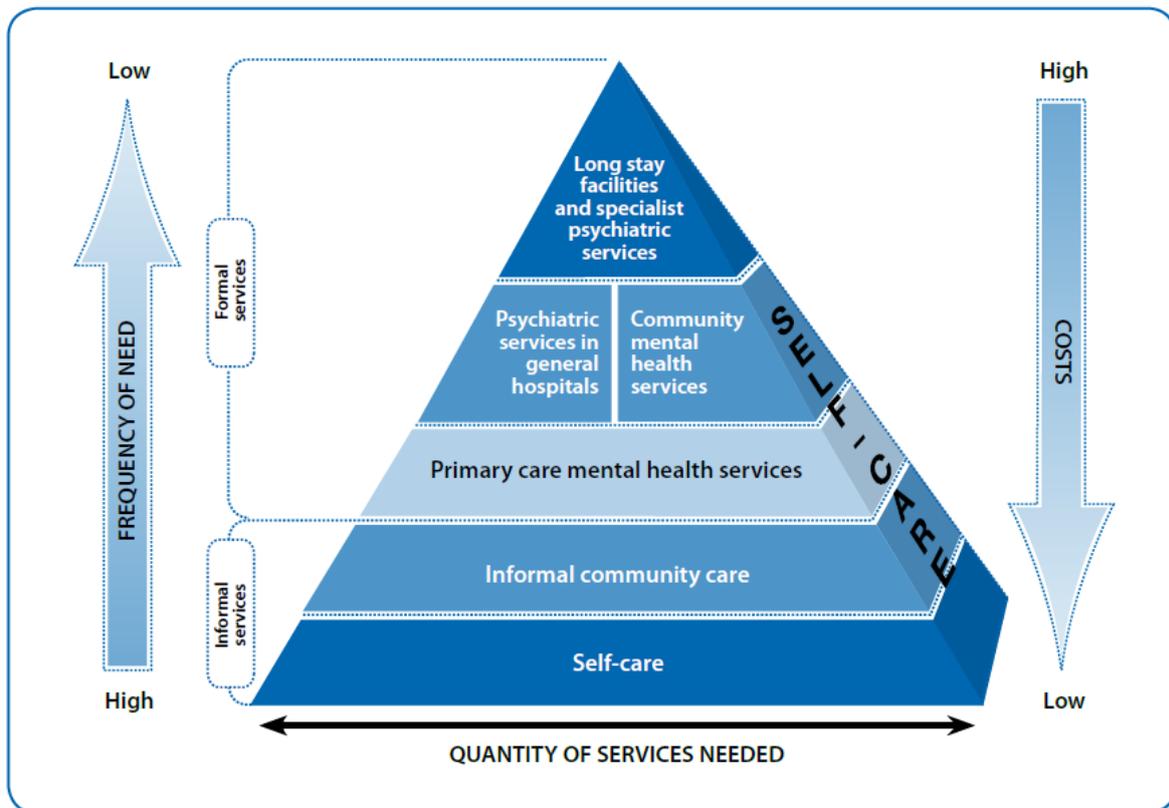


Figure 1 WHO Service Organization Pyramid

Table 1 Principles and actions for integrating the response to mental disorders

Overarching approach	Key principles or functions	Practical steps that can be taken
Public health approach	<i>Life course approach</i>	(Re)design policies and plans to address the health and social needs of people at all stage of life, including infancy, childhood, adolescence, adulthood and old age.
	<i>Healthy living/behaviours</i>	Promote mental and physical health and wellbeing through public awareness campaigns and targeted programmes.
	<i>Person-centred, holistic care</i>	Involve people with lived experience of mental illness in the planning of their care; provide self-management support; promote and adopt a recovery approach to care and rehabilitation.
	<i>Coordinated care</i>	Provide training in chronic disease management and prevention; strengthen clinical and health management information systems; develop integrated care pathways.
	<i>Continuity of care/follow up</i>	Develop or enhance case management mechanisms.
Systems approach	<i>Governance and leadership</i>	Ensure health policies, plans, and laws are updated to be consistent with international human rights standards and conventions.
	<i>Financing</i>	Identify and plan for future resource needs; extend financial protection to the poor, the sick and the vulnerable; ensure mental health parity.
	<i>Human resources</i>	Train and retain non-specialist health workers to provide essential health care and support for mental disorders and other chronic diseases.
	<i>Essential medicines</i>	Ensure the availability of essential medicines at all levels of the health system (and allow trained, non-specialist providers to prescribe them).
	<i>Information</i>	Establish and embed health indicators for mental disorders and other chronic diseases within national health information and surveillance systems.

Table 1 (cont) Principles and actions for integrating the response to mental disorders

Overarching approach	Key principles or functions	Practical steps that can be taken
Whole-of-government approach	<i>Stakeholder engagement</i>	Support and involve organisations of people with mental disorders and/or other chronic conditions.
	<i>Multisectoral collaboration</i>	Establish a multisectoral working group to identify synergies and opportunities for integrated care and support.

(Reproduced from WHO and CGF, 2014a, p 12).

Mental health systems

Across international mental health systems, policies and practices, there are some striking similarities and discernible differences. The following sections compare the common priorities and differences found in mental health systems and processes in Australia, Canada, England, the Netherlands and NZ.

As seen in Table 8 (Appendix E), mental health systems across countries were similar in terms of contribution of disorders to global burden of disease, and mental health expenditure; and suicide rates were in a similar range, although rates were lower in Europe (WHO, 2011). In most countries there is a similar mixture of public and private funding; typically, inpatient and PHC visits are covered through public funding (Thomson et al., 2013). One of the key differences relates to complex jurisdictional issues affecting who has primary responsibility for mental health care (e.g. as a result of Federal/State government mix, or appointment of local service coordination bodies).

In each location, GPs are primarily responsible for the care of individuals with mild to moderate mental health conditions. They are frequently the first point of contact in the health system, and they often play a gatekeeper role, providing a key link between primary and secondary care, especially for more complex mental health cases. There has been increasing reliance on community-based services as health systems have shifted away from an acute secondary sector focus (Thomson et al., 2013). Nevertheless, reliance on the hospital sector remains important for treatment of serious mental health concerns, particularly in Europe where mental hospital expenditures represent high percentages of the total mental health budget (WHO, 2011).

Common priorities across international mental health systems

Consistencies across international mental health systems reflect the following priorities (Table 8, Appendix E):

- Integration
- Redistributing current funding and using available resources more effectively
- Supporting universal health coverage for hospital and physician services
- Communities rather than hospitals: focus on primary care and community services
- Developing and maintaining relationships with the social sector (e.g. in relation to education, employment, income, criminal justice) including cross-sector planning, funding and service delivery
- Building strong infrastructure
- Mobilising government leadership and supplying leadership roles for people with lived experience of mental illness
- Closing the gap between Indigenous and non-Indigenous populations
- Quality improvement through data collection

- Improving access to mental health care
- Monitoring and setting/reducing waiting times in both community and specialist settings
- Capacity building and inter-professional education for primary care providers
- Empowering people with lived experience of mental illness to have a role not only in their own care but also in informing policy
- Emphasis on importance of technology for sharing records and improving access
- Provision of culturally appropriate care
- Implementing stepped care or multi-stage approaches involving primary care as initial site of care for diagnosis and/or treatment of less complex cases and a shift to secondary sector for more complex problems
- Development of multidisciplinary guidelines for collaborative practice.

Funding and financing

Across countries there is substantial variability in the way mental health is structured and funded (McDaid et al., 2007). For example, the Netherlands has a market-based system of “regulated competition for healthcare, in which health insurers and service providers have to negotiate on costs as well as quality of care (outcomes, client opinion, patient safety)” (Nas and van Geldrop, 2013, p 1). This is an activity- and quality-based payment system for mental health care. The Dutch Healthcare Authority determines the maximum fees for diagnosis treatment combinations (Westerdijk et al., 2012), of which there are 140 for treatment and seven for accommodation. Patient-reported outcomes, which are assessed by the Consumer Quality Index and integrated into the outcome measurement system, are considered pivotal to assessing quality of care (Nas and van Geldrop, 2013).

Although most countries fund a proportion of mental health care through general taxation and social insurance, many services are excluded and there is strong reliance on families to provide support both financially (out-of-pocket costs) and for various aspects of care and support. Some countries also apply means testing for publicly-funded mental health services, often using the principle of subsidiarity, whereby personal income, savings, capital and assets are applied to costs before eligibility for public assistance (McDaid et al., 2007).

In some cases, the funding models reflect patient registration models. In the Netherlands, England and parts of NZ, patients are required to be registered with a general practice (Thomson et al., 2013). This not only relates to capitation payments but also enables a smooth transition between primary and secondary care with the GP in a gatekeeper role. In Canada and Australia, there is still a gatekeeper role for GPs but the lack of patient enrolment makes both funding and COC more complex.

Key stakeholders

Typically, there is a mix of public and private health care providers responsible for mental health care service provision across the different countries, and a diversity of organisations and stakeholders involved in integrated mental health care. For example, in Australia, influential non-government organisations provide information, treatment and advocacy services (Commonwealth of Australia, 2009). In Canada and England, voluntary organisations form an important part of the mental health systems (Boyle, 2011, Mental Health Commission of Canada, 2012); these are organisations for service providers, families, specific conditions and health professional groups. One example is the Canadian Mental Health Association, a voluntary organisation which provides services to more than 100,000 Canadians; promotes mental health; supports resilience and recovery; and offers advocacy, education, research and service provision (Canadian Mental Health Association, 2014).

In the Netherlands, 85 per cent of all mental health care services are delivered by 31 regional integrated mental health care organisations. These are specialist mental health services acting at secondary and tertiary care levels, connecting a range of different types of service providers across ambulatory specialist care, acute inpatient care, Flexible Assertive Community Treatment teams, housing services, addiction support and forensic care (Forti et al., 2014). Local Health and Wellbeing Boards in England address social determinants of health and consequences of mental health problems, reflecting a high-level strategy which incorporates the National Health Service (NHS), public health and social care. They connect elected members of local authorities, Clinical Commissioning Groups, public health representatives and social services representatives (from both adult and children's sectors) and offer an opportunity for joint commissioning and pooled budgets (HM Government, 2011).

There are also differences in terms of members of primary mental health care teams. In some countries, there is a greater role for health psychologists who have the potential to act as brokers across physical and mental health domains (Netherlands Government, 2012). Similarly, nurse specialists² in mental health are more prevalent in European primary care than in Australasia. Further, the composition of mental health care teams depends on what is included in the 'mental health' portfolio. For example, addiction care is quite separate in the Dutch system, with integrated providers combining mental and physical health care (Forti et al., 2014).

Priorities

International mental health systems have different methods for addressing some of the key priorities for mental health care. In England, there is an underlying focus on **quality improvement**, with key performance indicators in place for measurement of practices and processes (Centre for Mental Health et al., 2012). That is, "we want to increase the impact of mental health services by changing how we track success in mental health services, so we measure the things that matter most to the people using them" (Department of Health, 2014c). Australia is enacting a similar plan to improve quality and innovation by monitoring change through a set of key performance indicators that cover both social and clinical domains (Commonwealth of Australia, 2009).

There is also a focus on building capacity within the **workforce** to increase the impact of mental health services. For example, Health Workforce New Zealand funds a national infrastructure to develop the skills of those working in mental health and addictions (Ministry of Health, 2014b). In a similar vein, Australia has placed emphasis on the importance of the **research** workforce including driving the research agenda and coordinating research activity to inform evidence-based care and health system reform (Commonwealth of Australia, 2009).

The different systems each offer initiatives across the care spectrum. For example, some English processes place value on **health promotion and prevention**, and the role of early identification (HM Government, 2011) such as the Early Intervention in Psychosis Services provided for young people (though this latter model, while shown to be beneficial, is currently facing funding cuts) (Rethink Mental Illness, 2014). In NZ, the Mental Health Recovery Service (MASH Trust, 2010) provides an example of assisting **recovery** in order to encourage informed decisions and client-centred practices (Ministry of Health, 2014a). Australia's *Fourth Mental Health Plan* (Commonwealth of Australia, 2009) also mentions the importance of a recovery focus, not only in terms of reducing symptoms but

² Nurse specialists include those trained as psychiatric nurses.

in regard to facilitating community participation. One example of this is the *Partners in Recovery* initiative funded by the Australian government (see p 39 for more details).

One of the major priorities in mental health care is reducing **stigma** (Nas and van Geldrop, 2013). For example, Dutch policies encourage client organisations, insurers and providers to work together and jointly prepare an anti-stigma campaign (Forti et al., 2014). In England, there are also prominent anti-stigma initiatives such as *time2change*, a campaign established in 2007, which aims to empower individuals with lived experience of mental illness to feel confident to discuss issues without discrimination (Time to Change, 2008). This builds on the work in the *Like Minds, Like Mine* project initiated in NZ in 1997. This is a public education programme funded by the Ministry of Health which aims to reduce stigma around mental illness and facilitate social inclusion (Mental Health Foundation of New Zealand, n.d.). **Social inclusion** is also a particular focus, as illustrated in the Australian system with South Australia's *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform*. The emphasis in this plan is on engagement with, and involvement in, society (South Australian Social Inclusion Board, n.d.). One method of achieving this is through **wrap-around** service provision which addresses all of an individual's health and social needs (Commonwealth of Australia, 2009). See page 54 for more details on wrap-around services.

Countries also differ in how they engage with **technology**. This may stem from the view that younger people rely strongly on the internet, social media and electronic devices, hence the future of their health care will be strongly centred on these technologies (Mental Health Commission of Canada, 2012). eHealth models have the potential to improve access to services for those facing challenges due to rural location, experiences of isolation, a desire to seek help anonymously, or a dislike for traditional clinical services (Commonwealth of Australia, 2009). Each of the mental health systems emphasises the value of technology. In the Netherlands, eHealth practices have been fully embraced (Forti et al., 2014), reflected in the current government's investment in online mental health support approaches. Since 2014, people in the Netherlands with mild to moderate mental health problems have been offered support from a primary mental health care provider (e.g. counselling from a psychologist, psychotherapist or psychiatrist); online mental health support; or a combination of these (Netherlands Government, 2012). Online treatments and supervisory processes either add to or replace off-line care in this model (Forti et al., 2014). This is supported by widespread access to mobile broadband; an important consideration for translating such approaches into other countries (e.g. Australia). Nevertheless, Australia is prioritising the need for an e-mental health strategy, with the development of an e-mental health portal ([mindhealthconnect](#)) that provides a gateway for the general population as well as people with lived experience of mental illness and their families/caregivers to gain access to both quality services and information (Department of Health and Ageing, 2012).

Integration of PHC mental health services with secondary and tertiary mental health services

Rationale for integrating PHC mental health services with secondary and tertiary mental health services

The current intention of mental health care policy reflects a model that combines PHC and community-based services, complemented by specialist and/or inpatient care for those individuals who require it (Boyle, 2011). The focus aims to support less severe conditions in PHC, with GPs providing referral to secondary or tertiary care settings for support of more complex disorders (e.g. Netherlands Government, 2012). Integration of PHC mental health services with secondary mental health services (particularly psychiatrists in the community) and tertiary mental health services (particularly hospitals, including both inpatient units and outpatient clinics) is a form of vertical integration within the mental health system. As is the case with physical disorders, which may require episodic specialist treatment and/or hospitalisation, vertical integration is important to ensure continuity of safe, high-quality care.

Kelly et al. (2011) reviewed shared care models of ambulatory mental health care, focusing on their effectiveness and on key ingredients of effective models. They defined shared care as:

A structured system for achieving integration of care across multiple autonomous providers and services with both primary and secondary care practitioners contributing to elements of a patient's overall package of care (p 2).

Drawing on Fuller et al.'s (2009) review of service linkages in primary mental health care, they found that there was reasonable evidence to support shared care of depression and anxiety disorders, but limited evidence for shared care for psychosis.

Kelly et al. (2011) identified the following macro level factors as important:

- Purposively designed care delivery systems, including interventions tailored to local contexts
- Leadership and governance, including shared governance arrangements between primary care and specialist services, and formal service agreements
- Funding, including reimbursement for activities such as joint care planning by multiple service providers
- Physical infrastructure, including co-location.

The National Mental Health Service Planning Framework (NMHSPF) is an important current initiative of the *Fourth National Mental Health Plan*, specifically addressing one of the actions related to *Priority Area 3. Service access, coordination and continuity of care*: “the development of a national service planning framework that establishes targets for the mix and level of the full range of mental health services, backed by innovative funding models”. Its anticipated outcome is “to achieve a population-based planning model for mental health that will better identify service demand and care packages across the sector in both inpatient and community environments” (Department of Health and Ageing, 2013b). However, publicly available information about the NMHSPF is scarce. In June 2014, it was reported that it had not yet been submitted to the Council of Australian Governments (COAG) Health Council (Halton, 2014).

It seems likely that the NMHSPF will facilitate vertical integration in mental health services. However, it does not seem likely that it will address other types of integration, as it focuses specifically on mental health services.

Based on experiences of variable integration, NZ's *Rising to the Challenge Mental Health and Addiction Service Development Plan* (Ministry of Health, 2012) emphasised the need for enhanced integration of mental health services. In particular, this plan highlights the value in better linkages between primary and secondary services, with primary and specialist services required to collectively agree on "how they will work together and support one another to provide seamless, effective services" (p 18). The key mechanism for connecting primary and secondary or tertiary services is through referral processes. Despite limited evidence of uptake and value, international policies indicate that there are official two-way referral processes in place for transitions between these levels, except in the Netherlands where there are no processes for referral from tertiary/secondary care back to primary care (WHO, 2011).

COC is also important when considering integrated mental health care. This reflects the need for improved connections between the primary and secondary care sectors and the value of a care coordinator to ensure that a person with lived experience of mental illness has continuity over time with a care provider (WHO and WONCA, 2008). Continuity also relates to the method of 'stepped care' commonly proposed in many international mental health systems. This model acknowledges the variability in needs, whereby some people will only require PHC support while others will need more integrated support from across sectors (Commonwealth of Australia, 2009). As described in a NZ policy, the stepped care approach has the potential for "services [to] intervene in the least intrusive way, from self-care, right across the primary, non-government organisation and district health board continuum, in order to get the best possible outcomes, enabling entry and exit at any point depending on the level of need" (Ministry of Health, 2012, p 47). The opportunity to seamlessly integrate mental health care across community services and primary and secondary care sectors also offers a chance to integrate services that provide care across the spectrum from prevention through to recovery. This is particularly important in the context of mental illness where recurrence or persistent problems can be common (Commonwealth of Australia, 2009).

The Australian Government has introduced a number of programmes in recent years to improve access to mental health treatment and connections across primary, secondary and tertiary sectors. These include *Better Access to Psychiatrists, Psychologists and General Practitioners* through the Medicare Benefits Schedule programme and a number of youth mental health initiatives, including *headspace*.

Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access)

The *Better Access* initiative commenced in November 2006. It is funded by the Commonwealth Government as part of the COAG mental health package. Its primary aim is to use best evidence to treat individuals with lived experience of mental illness and improve health outcomes.

The *Better Access* initiative complements the *Better Outcomes in Mental Health Care (Better Outcomes)* initiative (Fletcher et al., 2009), which commenced in 2001 and is described in further detail on page 29. Both programmes include mechanisms enabling GPs to refer patients to psychologists and other health professionals for approved non-pharmacological treatments. People with lived experience of mental illness are referred for up to ten sessions, with the potential for six additional sessions after GP review (Fletcher et al., 2008). Whereas *Better Outcomes* does this

through Access to Allied Psychological Services (ATAPS) projects currently run by the Medicare Locals, the *Better Access* initiative operationalises it through Medicare rebates (Bassilios et al., 2009).

The *Better Access* initiative involves establishing a GP mental health treatment plan which enables the assessment, management and provision of care to individuals with mental illness by GPs, psychologists, social workers and occupational therapists (General Practice Mental Health Standards Collaboration, 2013). GPs are incentivised not only to develop these plans, but also to undertake mental health training. It has been suggested that *Better Access* enables more effective referral processes for GPs, offers flexibility for allied health professionals and provides a funding system that is able to operate concurrently with the private specialist system (Fletcher et al., 2008).

The *Better Access* initiative prioritises a multidisciplinary approach to care. This macro level funding model encourages integrated care by incentivising connections across providers. Establishing the initiative involved the introduction of new item numbers on the Medicare Benefits Schedule, offering a rebate for services from particular providers (i.e. GPs, psychiatrists, psychologists, social workers and occupational therapists) (Pirkis et al., 2011).

Private practice psychologists are the main allied health service providers involved with the *Better Access* initiative (King et al., 2010). In 2011-12, the largest proportion (41%) of mental health related Medicare costs was for services provided by psychologists, followed by psychiatrists (33%) and GPs (23%) (AIHW, 2013b). The number of psychologists providing *Better Access* services increased rapidly from 3,688 in December 2006 to 8,088 in December 2008 (King et al., 2010). The number of social workers and occupational therapists (the smallest group of allied health professionals) involved also increased over the same period from 126 to 646 and from 23 to 172 respectively (p. xiv).

Evaluation of the initiative suggests that *Better Access* has been able to improve multidisciplinary micro level collaboration among the diverse mental health care providers (Pirkis et al., 2011). A number of psychologists, GPs, social workers and occupational therapists participating in the evaluation noted how working together had led to a greater appreciation of different professions' roles. This was reinforced by participation in the Mental Health Professionals Network (described below), a component of the initiative that runs multidisciplinary workshops and provides education and training resources. However, there have been concerns regarding communication in the initiative with inadequate referral information from GPs and insufficient feedback from allied health professionals. This may in part be a result of the large reliance of the *Better Access* initiative on private service providers, many of whom lack the networks and infrastructure to facilitate effective integration.

Findings from Pirkis et al.'s evaluation of the *Better Access* initiative suggest that the initiative has been able to improve access to mental health care for individuals with high-prevalence mental disorders, and improve overall engagement with mental health services, including among individuals in vulnerable populations. Consumer feedback and outcomes have been positive though these outcomes predominantly relate to clinical rather than social factors. Preliminary cost effectiveness analysis has illustrated good value for money.

Mental Health Professionals Network

The *Mental Health Professionals Network* was funded by the Australian Government "to bring together different primary care mental health professionals with the aim of fostering interdisciplinary networking, collaboration and ultimately improved consumer outcomes" (Fletcher et al., 2014, p 30). It has successfully done so in three interrelated areas: education (interdisciplinary

workshops supported by education and training materials); networking (fostering ongoing, self-sustained clinical networks among GPs, psychologists, social workers, occupational therapists, mental health nurses, paediatricians and psychiatrists); and informational support for the workshops (a website, web portal (MHPN Online) and a toll-free telephone information line). According to Eagar et al. (2005), it is “an example of the much-needed systems and tools, and co-ordinated leadership and support that are necessary to overcome the barriers to collaboration in Australian primary care” (p 40).

Key lessons learned (p 39) included:

- A clear vision and plan to establish interdisciplinary collaboration is vital to creating momentum in developing interdisciplinary networks and motivating providers to participate in networks on an ongoing basis.
- Ongoing support and leadership, such as that provided by the network, is needed to further create and support opportunities for collaborative mental health care.
- Mental health professionals’ interest in engaging in ongoing networks was influenced by their local environment as well as their professional group, with those in rural areas and newer to private practice more engaged than those in urban areas and more established professionals.

headspace

Under the *Youth Mental Health Initiative (2005-06)*, *headspace* was established to support young people with mild to moderate mental health problems (Banfield et al., 2012). *headspace* aims to provide integrated primary and mental health care, AOD services, and vocational and other social services support. The *headspace* strategic plan recognises that:

to build an integrated service system for youth mental health, you need good systems and processes. You need a solid workforce, sustained community awareness and engagement, strong quality and performance monitoring systems, a strong evidence base and robust infrastructure and internal capability to drive growth (headspace, 2012, p 1)

National partnerships are an invaluable aspect of *headspace’s* practices. *headspace’s* consortium model specifies that, at minimum, there must be organisations representing each of the four core streams of service delivery, namely mental health, physical health, AOD and vocational support.

Key elements of the programme include the development of a National Friends and Family Advisory Committee to help in the design of the service delivery model, taking into account the importance of consumer-driven action (*headspace*, 2012). Additional factors affecting the sustainability of the programme relate to effective governance in developing policies, a wide variety of funding sources, adequate workforce, effective leadership, positive attitudes, shared infrastructure and a high number of service users (Muir et al., 2009). Nevertheless, there were also ongoing challenges identified, predominantly around effective communication, including meso level tensions between providers, and confidentiality and information-sharing problems, which impacted on referral pathways and coordination of services (Banfield et al., 2012).

Hospital-in-the-home

One strategy which bridges the gap between hospital and community care, and helps to avoid unnecessary hospitalisations is ‘hospital-in-the-home’ (*HITH*; or ‘hospital at home’) programmes (Oliver-Baxter et al., 2013c). *HITH* is a model in which acute care is provided to public hospital patients while they are in the comfort of their own home. Typically the care of these ‘inpatients’ is led by hospital doctors, though actual care may be delivered by nurses, doctors or allied health

professionals. Some research suggests that many patients prefer to receive treatment at home surrounded by their family; and this type of care setting both enables patients to resume normal routines quickly and demonstrates improved outcomes with fewer complications (Victorian Department of Health, 2014). Although this is not PHC-led, there is potentially a role for PHC, particularly where people have multimorbidity.

In South Australia, an innovative *HITH* initiative, the Mental Health Hospital @ Home (MHH@H) service, was established at Flinders Medical Centre to provide an alternative to inpatient treatment for people in crisis (Kalucy et al., 2004). This model takes into account the local context and is informed by evidence that outcomes improve when patients are treated at home. This service operates across several domains, including health/medical, carer support, and social services (e.g. AOD, Centrelink). One of the core strategies relates to referral pathways (Flinders Medical Centre, 2006). The primary aim of the model was to reduce pressure on the emergency department. However, once MHH@H was operating, it became apparent that it was also freeing up inpatient beds, allowing quicker admission of patients for whom inpatient treatment was necessary. Despite initial resistance on the part of staff, particularly psychiatrists, who doubted the effectiveness of home-based treatment, once the programme was implemented, approval was high. This demonstrates the importance of inter-professional education, in which health care providers learn of the roles and responsibilities of other providers, and discuss methods of working in a complementary fashion.

Mental Health Nurse Incentive Programme

The Commonwealth Government's *Mental Health Nurse Incentive Programme (MHNIP)*, which commenced in 2007, is intended to “ensure that patients with severe and persistent mental illness in the private health system receive adequate case management, outreach support and coordinated care” (Department of Human Services, 2014), and to:

- Improve levels of care for people with severe mental disorders
- Reduce the likelihood of unnecessary hospital admissions and readmissions for people with severe mental disorders
- Assist in keeping people with severe mental illnesses well, and feeling connected within the community
- Relieve workload pressure on GPs and psychiatrists, allowing them more time to spend on complex care.

Administered by the Department of Human Services on behalf of the Department of Health (Department of Health, 2014a), the *MHNIP* provides non-Medicare funding for GPs, private psychiatrists, PHC organisations, and Aboriginal and Torres Strait Islander PHC services to employ mental health nurses (MHNs) to assist with the provision of coordinated clinical care for people with severe mental disorders, providing services including:

- Periodic reviews of patients' mental states
- Medication monitoring and management
- Providing patients with information about physical health care
- Arranging access to services from other health professionals (e.g. psychologists) when required.

An evaluation of GPs' and patients' opinions of the *MHNIP* (Meehan and Robertson, 2013) found very strong support for it. Patients rated it as affordable, convenient, holistic, and less stigmatising than accessing designated mental health services. GPs valued the collaborative working arrangements and the MHNs' ability to provide a wide range of interventions. The nurses' skills, including taking

comprehensive mental and physical histories and providing holistic care, were considered integral to the success of the programme, as was their knowledge of local services.

A more comprehensive evaluation (Health Management Advisors, 2012) similarly revealed high levels of support on the part of doctors, patients, carers, and peak bodies. It also found evidence of effectiveness and efficiency. However, there was scope for improving the operation of the programme, particularly in relation to purchasing arrangements.

Summary

Most people with lived experience of mental illness receive mental health treatment from GPs, but many also require some specialist treatment and/or hospitalisation. Vertical integration is important to ensure continuity of safe, high-quality care.

Macro level factors that have been identified as important include shared governance arrangements, funding incentives, co-location, and tailoring to local contexts. Formal referral pathways and stepped care arrangements are also important.

Several Australian initiatives have facilitated this type of integration. The *Better Access* initiative enables GPs to refer patients to mental health specialists (a formal referral pathway). The youth mental health initiative *headspace* provides specialist mental health treatment in a PHC setting (co-location). The *MHNIP* enables GPs, psychiatrists, and other health services to employ mental health nurses, thereby blending primary and secondary healthcare (funding incentive and co-location).

Integration of PHC mental health services with PHC physical health services

Rationale for integrating PHC mental health services with PHC physical health services

In many cases, physical and mental health are inextricably linked (Commonwealth of Australia, 2009) and PHC is in a unique position to coordinate and integrate care for both (Mental Health Commission of Canada, 2012, WHO and WONCA, 2008). It has been consistently acknowledged that both mental and physical factors need to be considered to improve and maintain wellbeing. That is, “throughout the mental health care system, good relationships and cooperation with physical health care and non-medical professionals are essential to an integrated approach to recovery” (Netherlands Government, 2012). Integration of primary mental health care with physical PHC services, particularly GP services, is a form of horizontal integration.

People with mental disorders are subject to the same physical ailments (at least) as those without mental disorders, and therefore are likely to have contact with PHC services for physical health care treatment. Unfortunately, however, there is evidence that the physical health needs of people with mental disorders are not optimally managed (Lourey et al., 2012, Viron et al., 2014).

Mauer’s four-quadrant clinical integration model (Table 9, Appendix F) is a useful way to illustrate the relationship between the level of need (high/low) and the type of integration that is relevant to mental and physical health (Mauer, 2003).

Most Australians see a GP at least once a year (Commonwealth of Australia, 2008). Ideally, GPs would provide mental health care as well as physical health care, drawing on the expertise of colleagues of other professions (e.g. psychologists, counsellors, social workers and nurses) as appropriate. Although GPs or family doctors provide a large amount of care in PHC settings, there are also increasing numbers of primary care nurses, psychologists and social workers in PHC teams around the world (WHO and WONCA, 2008). Thus integration between physical and mental health services requires collaboration across general practice, allied health and social care providers.

There are two main ways to view integration between PHC and mental health. One is to introduce specific primary mental health initiatives within PHC and the other is to enhance greater mental health support in general PHC (Ministry of Health, 2012). As illustrated in Figure 1, the WHO has explored the ‘optimal mix of services’, proposing the integration of mental health services with more general health care as no one service will ever be able to meet all needs (WHO and WONCA, 2008). It has been suggested that integration of mental health and primary care is “characterised by shared care planning and decision making, charting in a common medical record, and collaborative activities, with care being shared according to the respective skills and availability of participants” (Kates et al., 2011, p 3).

In terms of integrating mental health and PHC generally, Table 2 lists ten key principles (WHO and WONCA, 2008). This WHO and WONCA report argues that “holistic care will never be achieved until mental health is integrated into primary care” (p 1), citing the importance of this process for closing the treatment gap and enabling the right services to be provided to the right people at the right location and the right time.

PHC services may be offered in a diverse range of settings. For example, in NZ, primary care providers may be based in general practices, schools, prisons, non-government organisations or community settings (Ministry of Health, 2012). Similarly, integrated mental health care incorporates not only hospital and community-based services but should also consider the influence of emergency and pharmacy services (Commonwealth of Australia, 2009). Further, integrating the public and private sectors would encourage more seamless service provision and efficient use of providers' skills and resources (Commonwealth of Australia, 2009).

It is important not only for PHC and specialist care to be well connected, but also for clinical and community support services to work in partnership. Globally, countries have shifted away from institutionalisation towards a greater emphasis on community-supported care provision. The first level of contact with health services is typically through either community services or PHC. Thus, recent mental health system policies have focused on provision of support in these settings, rather than hospital-based activity (Boyle, 2011, Mental Health Commission of Canada, 2012). In Australia, since 1992 there has been a shift in the State/Territory spending on mental health care from inpatient services (71% in 1992-93) to community settings (53% in 2006-07) (Commonwealth of Australia, 2009). However, disparities persist between jurisdictions regarding the mix and level of services provided for people with mental illness.

Table 2 Principles for integrating mental health into primary care

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, non-governmental organisations, village and community health workers, and volunteers is required
10	Financial and human resources are needed

Source: (WHO and WONCA, 2008, p 6-7)

Behavioural Health Homes

In the US, a key development in recent years in PHC has been the patient-centred medical home, a health care delivery site that provides comprehensive, integrated, and easily accessible health care, including a continuing relationship with a personal physician (Oliver-Baxter et al., 2013b, p 80). In Boston, this model was adapted by the Massachusetts Mental Health Center in 2013, with the goal of providing patients with “one stop shopping” for physical and behavioural health services (Viron et al., 2014):

Massachusetts Mental Health Center (MMHC) in Boston is a state-operated community mental health center that serves individuals with SMI, an estimated 60–80% of whom have at least one chronic medical condition. Historically, local primary care services have been difficult to access and poorly coordinated with mental health treatment, leading to significant deficits in

healthcare for these individuals. In 2013, to improve the general health and healthcare of its patients, MMHC began a process of transformation into a Behavioral Health Home with co-located and fully integrated wellness and primary care services through a partnership with a nearby private, not-for-profit academic medical center (Brigham and Women's Hospital), with the ultimate goal of providing patients "one stop shopping" for physical and behavioral health services.

Models such as this are beneficial for informing future practices with the NMHC (2012) endorsing the concept of the patient-centred medical home, recommending expansion of this approach in an Australian context.

Better Outcomes in Mental Health Care (Better Outcomes)

In July 2001, the Commonwealth Government launched the *Better Outcomes* initiative, which supports the role of GPs in mental health care. *Better Outcomes* has evolved since its inception. In 2009, it had five major components relating to training, systemic support and financial incentives (Fletcher et al., 2009, pp 30-31):

- 1 **Education and training for GPs:** training to familiarise GPs with the *Better Outcomes* programme including: level 1 training, focusing on use of mental health plans; and level 2 training, preparing GPs to deliver Focussed Psychological Strategies.
- 2 **The GP Mental Health Care Plan:** development of three new Medicare items for GP mental health care (preparation and subsequent review of a mental health care plan, and mental health consultations).
- 3 **Focussed Psychological Strategies:** Medicare rebates for psychological therapies delivered by GPs who have completed level 2 training.
- 4 **Access to Allied Psychological Services (ATAPS):** Focussed Psychological Strategies delivered by allied health professionals (primarily psychologists).
- 5 **Access to Psychiatrist Support:** Medicare rebates enabling psychiatrists to organise or participate in case conferences; and the GP Psych Support service, which allows GPs to consult psychiatrists via phone, fax, and email.

The first three components represented horizontal integration, in which GPs were upskilled and supported to provide better mental health care within their PHC-based practices. Currently the *Better Outcomes* initiative focuses on the ATAPS component, as discussed below.

Access to Allied Psychological Services (ATAPS)

The ATAPS initiative is the referral pathway component of the *Better Outcomes* programme (Bassilios et al., 2009). It is used to engage community-based service providers, including GPs, psychologists, social workers and occupational therapists, to assist people with mild to moderate mental illness. Currently this initiative is coordinated by Medicare Locals (processes may change following the transition to primary health networks in 2015).

Under this initiative, GPs may refer individuals with high-prevalence disorders to allied health professionals for up to 12 sessions in a year (Bassilios et al., 2010). According to the Australian National Audit Office (2011), it is the Commonwealth Government's primary mechanism for improving access to mental health care for groups with historically limited access, such as those living in remote areas (including Indigenous communities), young people, and homeless people. For example, an examination of the impact of this initiative reported that "ATAPS projects have been

successfully providing equity of geographic and socioeconomic access for consumers most in need of subsidized psychological treatment” (Bassilios et al., 2010, p 997).

An earlier review of the *ATAPS* programme (Pirkis et al., 2006) demonstrated enhanced provision of affordable, evidence-based mental health care. Pirkis et al. also reported that many of the *ATAPS* projects have established contractual arrangements with allied health professionals (i.e. memoranda of understanding between parties rather than direct employment); many used direct referral rather than working through a broker, register or voucher system; co-location was common; and projects often reflected combination models that use a mixture of these strategies to suit their local context.

Summary

People with lived experience of mental illness have high rates of physical health problems, receive much of their mental health care from GPs, and often have limited access to specialist services. Consequently, it is crucial that they are able receive appropriate management of both mental and physical health from GPs and other PHC providers (horizontal integration).

Facilitators of integration of mental health care into PHC include policy support, advocacy, training of PHC workers, availability of specialist support, and intersectoral collaboration.

The *Better Outcomes* initiative initially focused on improving GPs' mental health skills and providing a referral pathway to community-based psychologists, social workers, and occupational therapists as well as a mechanism for support from psychiatrists.

Integration of PHC mental health services with secondary and tertiary physical health services

Rationale for integrating PHC mental health services with secondary and tertiary physical health services

People with lived experience of mental illness, particularly those with chronic mental illness, often experience significant physical health problems and comorbidity that may require specialist treatment, both in hospital and in the community (i.e. vertical and horizontal integration).

Despite known associations between the use of psychotropic drugs and cardiovascular disease and/or metabolic disorders, and the high prevalence of chronic illness in people with a mental illness, studies indicate that there is inadequate identification, monitoring and treatment of chronic conditions in this population (De Hert et al., 2012, Hippisley-Cox et al., 2007). Similarly, a Finnish linkage cohort study reported that people with a history of psychosis receive poorer, and less timely, health care for their physical conditions (Manderbacka et al., 2012). Manderbacka et al. (2012) recommended “targeted measures to address challenges in provision of somatic care among people with severe mental health problems, especially among people with psychoses and old people” (p 1).

At the micro level there are challenges for this type of vertical integration due to a limited understanding of who plays a gatekeeper role; limited recognition of physical illness symptoms among individuals with severe mental illness; inadequate care-seeking and low patient adherence; and misdiagnosis due to assumptions that physical symptoms represent medication side effects (Behan et al., 2014).

This form of integration requires effective communication enabled by adequate infrastructure. At a micro level, health care providers need to be able to communicate about comorbidities and shared treatment plans. This can be enabled by macro level infrastructure such as co-location of facilities or development of shared electronic health records (e.g. a current barrier is the inability of PHC software to connect with hospital technologies). Similarly, team care arrangements incentivised through Medicare would encourage integration at this level (Australian Government Department of Health, 2014b). Hospital-based psychologists can fill a gap with their inpatient and outpatient service provision; however, this micro level brokerage role needs more top-down support. In order for these activities to be achieved, inter-professional education is required to ensure that all key providers understand the roles and capabilities of their colleagues.

Though there is limited published information available, there is some evidence of hospital outpatient psychology clinics designed to simultaneously address individuals’ physical and mental health needs. It has been suggested that treating the mental health needs of individuals with serious physical health conditions including burns, cancer, cystic fibrosis and pain can improve overall health care costs and health outcomes (Azuero et al., 2014, Royal Adelaide Hospital, 2013). This approach not only improves individuals’ access to mental health services, but provides GPs with the collaboration they require to ensure their patients’ needs are met (Zeidler Schreiter et al., 2013).

From a top-down level, governance arrangements between Medicare Locals and Local Hospital Networks (or their equivalents in each State) have been proposed to encourage integration between the primary and secondary or tertiary sectors. Shared board membership has been achieved across these organisations in some parts of Australia, encouraging joint planning and improved

communication. In the Medicare Local review, Hovarth (2014) suggests that boundary alignment between PHC organisations and the hospital-level organisations are critical to this cross-sector engagement. It must be noted that this is an important consideration in the development of the primary health networks due to be established in 2015. While not specific to mental health care, the opportunity for integration enabled by the potential co-location, shared governance and infrastructure between these organisations is extremely valuable for the provision of high-quality care.

As discussed on page 21, although the NMHSPF is likely to facilitate vertical integration in mental health services, it may not address other types of integration. It seems unlikely that it would facilitate integration of PHC mental health services with secondary and tertiary physical health services, because it only addresses mental health services.

Summary

Integration of PHC mental health services with secondary and tertiary physical health services seems to be a particularly neglected issue in the available literature, despite high levels of chronic and serious physical problems among people with lived experience of mental illness. However, there are some potential facilitators, including appropriate infrastructure enabling shared electronic health records and shared governance arrangements.

Integration of PHC mental health with non-health services

Rationale for integrating PHC, mental health and non-health services

Health care for people with mild or moderate mental illness, which is provided predominantly in the PHC setting (AIHW, 2013a), is described as less stigmatising, more accessible and less costly compared with specialised mental health services (Fuller et al., 2009). However, people with lived experience of mental illness often have complex needs, many of which lay outside the health system in areas that impact on physical and mental health. Many people with chronic mental disorders suffer multiple disadvantages and require frequent access to a broad range of social services for their daily living requirements. Some receive support for themselves and their families/carers from non-government organisations and consumer organisations such as SANE Australia (Morgan et al., 2011). However, living with a mental illness means that it is harder to obtain and retain a job, which directly impacts on income; and it is harder to compete for adequate housing in the private rental market. Unemployment (or under-employment) also impacts on mental health (e.g. low self-esteem, lack of motivation/confidence, suicide) and may aggravate physical conditions and/or increase risk of other harms (e.g. AOD use, domestic violence, crime, homelessness). Furthermore, research suggests that physical and mental illness is often mediated or exacerbated by poverty, whereby the poor have a higher risk of developing a mental illness (vs not poor); and those with lived experience of mental illness are more likely to have lower socioeconomic status, comorbid AOD problems and/or chronic illnesses (Ngui et al., 2010).

To address the challenges of independent living, and to complement existing primary and mental health care services, people living with a mental illness may need income and vocational support, supported housing, carer support and assistance with education opportunities and social participation (Lee et al., 2010, Lee et al., 2012, Morgan et al., 2011, Whiteford and McKeon, 2012, Whiteford et al., 2014). Additionally, individuals with chronic mental health conditions commonly experience problems related to AOD use and are over-represented in the criminal justice system. Each of these areas requires the individual to make appointments and complete numerous forms, which is a substantial challenge for this vulnerable population.

Thus a holistic approach to health care entails addressing not only physical and mental health needs, but also social needs that impact on health – i.e. integrated health and social care. Community health services and non-government organisations have a large role to play in advocacy and mental health support; and a comprehensive integrated mental health care system needs to connect with non-health sectors. To do this, organisations and services need macro level policies that foster cross-sectoral collaborations and facilitate an integrated care system that incorporates all of the consumer's needs across their lifespan and through the course of their illness.

This section describes different macro level aspects of integration of mental health services with non-health services, including cross-sectoral policies and frameworks; financing and funding issues; and legal and ethical issues. The key non-health sectors that impact on health and wellbeing are outlined, with a focus on integrated services for people with mental illness. Finally, a brief discussion of the issues related to Indigenous peoples with mental illness is presented; and a summary of the role of PHC in integrating with non-health sectors to meet the needs of people with lived experience of mental illness.

Cross-sectoral policies and strategic frameworks

Connecting services across different sectors is a common priority in policy documents and strategic frameworks for most international mental health systems. In Australia and elsewhere, there have been many attempts to develop collaborations and partnerships across the health and social service sectors at the macro level of systems and policies.

Given the complexity of mental health problems and their potential impact on all facets of an individual and their family's lives, several countries have taken a "genuinely public health approach" (WHO and CGF, 2014a, p 11). For example, a core component of Canada's *Changing Directions, Changing Lives strategy* specifies that "a full range of services, treatments and supports includes primary health care, community-based and specialized mental health services, peer support, and supported housing, education and employment" (Ministry of Health, 2012, p 8). This strategy emphasises the need for mental health care to involve doctors, teachers, policy makers, long-term care providers in the community and public and privately funded mental health service providers. Similarly, the English *No Health Without Mental Health* strategy reflects this interaction between determinants and specifies that "objectives for employment, for education, for training, for safety and crime reduction, for reducing drug and alcohol dependence and homelessness cannot be achieved without improvements in mental health" (HM Government, 2011, p 5).

Population health and social needs and issues specific to each region are sometimes considered in cross-sectoral policies. For example, the Netherlands government has cooperated with the transport sector (i.e. the railways) and health professionals to develop a suicide prevention programme (Forti et al., 2014); and they developed covenants between employee insurance agencies and mental health providers; and between providers and police to create uniformity in care processes.

In Australia, the Commonwealth government supports **joint service development** and offers a "no wrong door" approach (Commonwealth of Australia, 2009, p 44). The underlying principle relates to social needs and social inclusion, enabling individuals with lived experience of mental illness to get the health and social supports they need to fully participate in society (Commonwealth of Australia, 2009).

As the balance of care moves towards greater community-based delivery of services, the key challenges for health and social services are:

- How to allocate resources across sectors that have different budgets, goals and structures
- How to provide equitable and affordable access to meet the needs of people with mental health problems without incurring substantial out-of-pocket costs
- How to streamline services and protect the rights and preferences of this vulnerable population, irrespective of which sector is responsible for the service delivery.

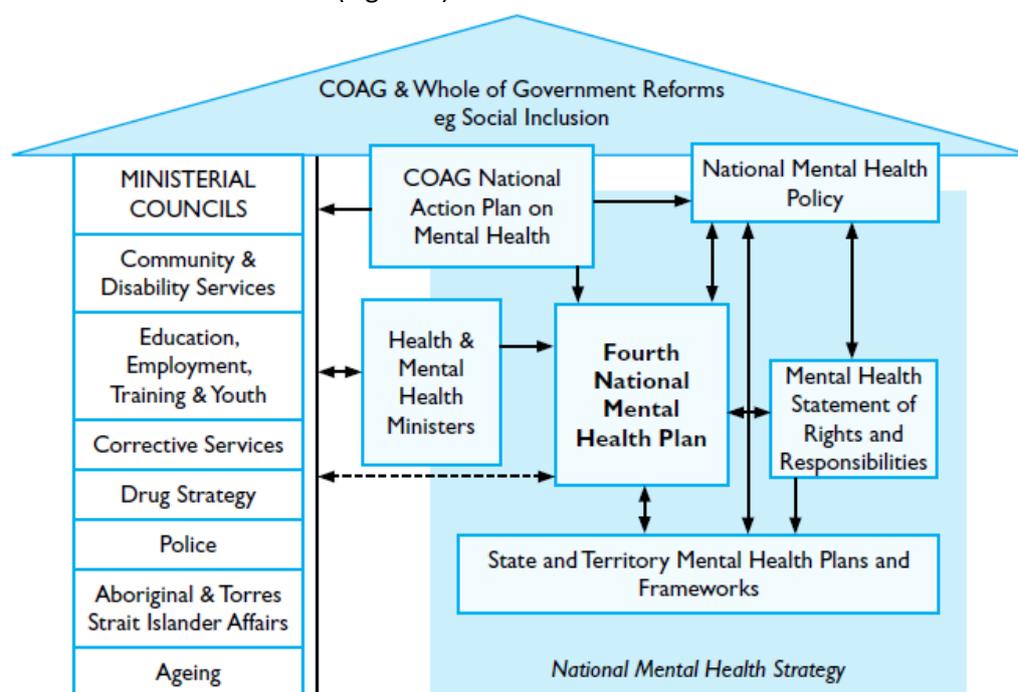
This section describes some of the relevant Australian policies and frameworks that specifically refer to integration across the mental health and social sectors. Evaluation results are provided where possible. However, despite frequent reference to integration with the non-health sector in policy directives, plans and initiatives, there is almost no information about how the three key challenges stated above will be addressed; and there are few examples of specific programmes, activities or initiatives that involve partnerships across the PHC, mental health and non-health sectors.

Fourth Mental Health Plan (2009-2014)

In the *Fourth National Mental Health Plan*, the Commonwealth Government set an agenda for collaborative government across the health and social care domains (Commonwealth of Australia,

2009). The first priority area was about social inclusion and recovery. Among the actions were a commitment to “develop integrated programs between mental health support services and housing agencies to provide tailored assistance to people with mental illness and mental health problems living in the community” and to “develop integrated approaches between housing, justice, community and aged care sectors to facilitate access to mental health programs for people at risk of homelessness and other forms of disadvantage” (p iv).

Using a population health framework, the plan recognises that there is a “complex interplay of biological, social, psychological, environmental and economic factors” (p 10) impacting on health and requiring a joint consideration of health and social needs. The plan also recognises that a **whole-of-government** approach is needed to achieve change and that reforms in the mental health sector are linked with policies in other government portfolios, including (but not limited to): housing, employment, education, aged care, corrective services, disability services, AOD, and Aboriginal and Torres Strait Islander affairs (Figure 2).



Source: (Commonwealth of Australia, 2009, p 11)

Figure 2 A whole-of-government approach to mental health

In 2010, several activities were undertaken in the key priority areas, including: flexible care funding through ATAPS; and introduction of new employment support services (Disability Employment Services, Local Connections to Work) to assist people with lived experience of mental illness to gain employment (Australian Health Ministers' Advisory Council, 2010). Other activities related to managing mental illness in PHC included: the *Better Access* initiative; guidelines on management of co-occurring AOD and mental health problems for AOD workers; and additional funding for the *MHNIP* to coordinate care across private psychiatry, general practice and other organisations as needed.

A report that monitored the progress and outcomes of the Plan (Department of Health and Ageing, 2013a) acknowledged that many problems persisted and “the considerable variation in funding between the states and territories that existed at the beginning of the Strategy is still evident 18 years later, mid-way through the *Fourth National Mental Health Plan*” (p 3).

In relation to social care needs, the report stated that, between 2007-08 and 2011-12, **employment participation** rates for people with mental illness decreased from 64 per cent to 62 per cent; **education participation** rates did not change; and the percentage of people with no significant **housing** problems also remained the same (78%) (Department of Health and Ageing, 2013a).

Although previous mental health plans, strategies and frameworks also recognised the importance of cross-sectoral collaboration to support mental health and wellbeing, evaluations agree that progress has been slow in this area (Banfield et al., 2012) and the focus needs to be more clearly defined. The reasons for limited progress are varied, including definitional inconsistencies and a focus on *access* to mental health services, which largely overlooks other aspects of living that impact on health and wellbeing. Table 3 illustrates examples of activities and programmes that cross multiple sectors relevant to mental illness, social services and PHC.

Table 3 Activities and programmes that cross multiple sectors

Service Type	Example
Early intervention services	KidsMatter: a suite of school-based programmes to support mental health promotion, prevention and early intervention
Family mental health support services	A range of tailored services that work together with existing family support services and focus on prevention and early intervention in vulnerable and at-risk populations
Services for people with AOD problems and mental illness	Capacity building grants for non-government AOD services and cross sectoral support and strategic partnership to AOD peak bodies to form partnerships and develop strategies for workforce development, training and service improvement.
Personal helpers and mentors	Personal Helpers and Mentors uses a strengths-based recovery approach to assist community-dwelling people with severe mental illness to manage daily activities and work with employment services
Employment support services	Job Services Australia and Disability Employment Services offer tailored, responsive services to assist job seekers with mental illness and employers. Initiatives also include: <ol style="list-style-type: none"> 1. Enhancing expertise in employment services staff to assist people with mental illness 2. Mental health professional advice for employers and employment services staff regarding employment of people with mental illness 3. Supported Wage System for job seekers with mental illness
Day-today living in the community support	A programme of structured and socially based activities to enhance confidence and social skills for optimal independent living
Helping young people stay in education	Youth Pathways/Youth Connections: tailored case management and support to build resilience, promote positive life choices and support young people in education and training.
Respite care for families and carers	Flexible respite and family support for carers of people with severe mental illness

Source: (Commonwealth of Australia, 2009)

National Mental Health Commission

Established in 2012 by the Commonwealth Government, the National Mental Health Commission (NMHC) has a leadership and advisory role, providing independent reports and advice about mental health, mental illness, and suicide. It is “committed to driving change that supports people’s ability to lead to a contributing life and maximise their potential”

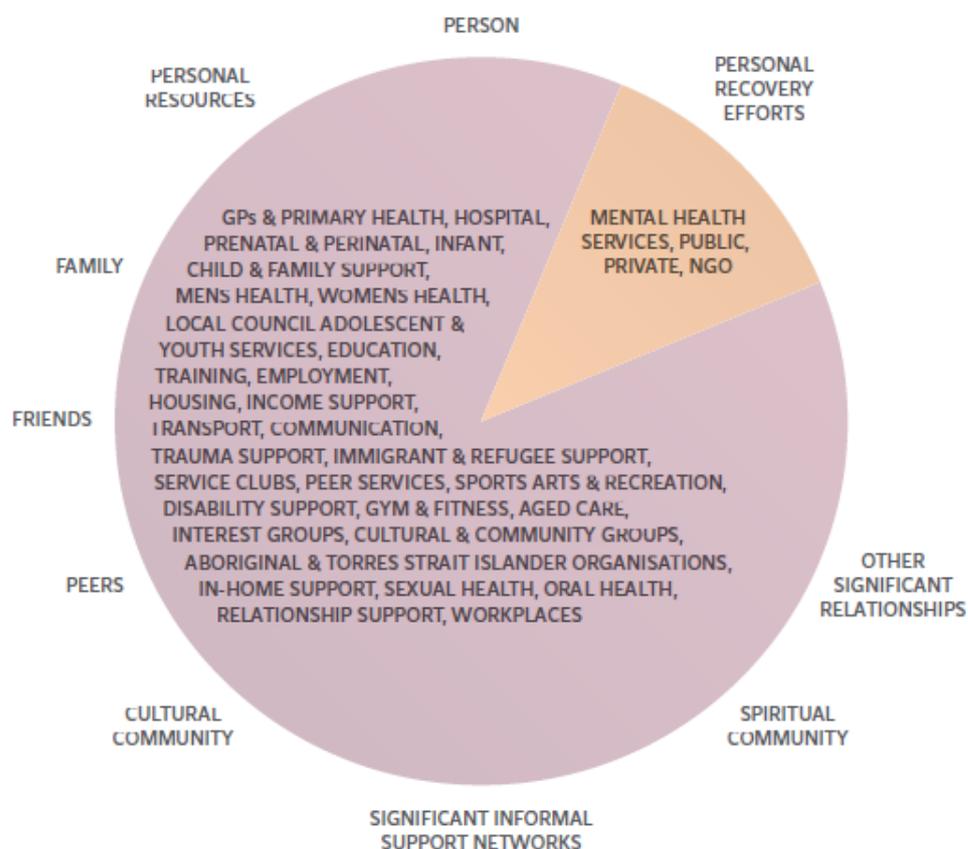
(<http://www.mentalhealthcommission.gov.au/about-us.aspx>).

One of the NMHC’s first priorities was to deliver the first annual National Report Card on Mental Health and Suicide Prevention. The 2012 Report Card (Lourey et al., 2012) identified poor integration of health and other services as a barrier to the wellbeing of people with lived experience of mental illness.

The 2012 Report Card made ten recommendations, to which the 2013 Report Card (Lourey et al., 2013) added a further eight. None of the recommendations explicitly mention integration or collaboration; however, it is implicit in a few of them, for example: “No one should be discharged from hospitals, custodial care, mental health or drug and alcohol related treatment services into homelessness” (Lourey et al., 2012); where alluding to integration, the recommendations reflect this notion of collaboration across health and non-health sectors.

National Framework for recovery-oriented mental health services (2013)

The *National Framework* recognises that a recovery-oriented focus in mental health includes a wide range of groups that impact on outcomes (AHMAC, 2013).



Source: (AHMAC, 2013)

Figure 3 Groups involved in a person’s recovery

Figure 3 shows that most of these groups exist outside the individual's own recovery efforts related to mental health services. In particular, connections with family, friends, neighbours, school, workplace and the community may be facilitated by services that take a recovery-oriented approach.

The recovery-oriented mental health approach outlined in the framework draws on a body of international research and human rights policies that support the 'social inclusion and recovery' priority area in the *Fourth Mental Health Plan* and the person-centred strategies outlined in the *Roadmap for National Mental Health Reform 2012-22* (COAG, 2012).

This approach recognises that biopsychosocial factors impact on health and that "recovery occurs within a web of relations" including various social determinants. Although a *National Contributing Life Pilot Online Survey* has been undertaken to explore people's experience of services for people living with mental illness (Lourey et al., 2013), no data were available on the macro level factors that were implemented in this project.

COAG National Action Plan on Mental Health 2006-2011

The *COAG National Action Plan on Mental Health 2006-2011* committed governments to a range of strategies, including more investment in non-health sector services for people living with mental illness (Commonwealth of Australia, 2009).

Policy directions outlined in the Action Plan were (Standing Council on Health, 2013a, p 8):

- 1 Enhance support services for people with mental illness to participate in the community, education and employment
- 2 Enable people with mental illness to have stable housing by linking them with other personal support services
- 3 Improve referral pathways and links between clinical, accommodation, personal and vocational support programmes
- 4 Expand support for families and carers including respite care.

The Government's two 'flagship' initiatives to coordinate care across health and community services for people with mental health problems were *Governments working together* and *Coordinating care* (Standing Council on Health, 2013a, p 10).

Governments working together

COAG convened Mental Health Groups to oversee planning and implementation of initiatives under the Action Plan (Standing Council on Health, 2013a). The groups comprised representatives from relevant government departments, non-government organisations, the private sector, consumers and carers. The groups met quarterly in 2008-09 to enable collaboration across portfolios and focus on implementation of initiatives. An evaluation of the *Fourth National Mental Health plan* reported some differences across jurisdictions, but there was no information relevant to the role of PHC (Department of Health and Ageing, 2013a).

Coordinating care

The focus of this initiative was to build on existing arrangements, using care coordinators supported by clinical providers to connect people with appropriate services for accommodation, employment, education, income, social and family support (Standing Council on Health, 2013a). Flexibility was built in to reflect jurisdictional differences. Care coordination models were implemented in most jurisdictions by 2011, when a major new initiative was announced – the *Partners in Recovery* programme (PIR), which aims to improve coordination and streamline access to clinical and community services.

Partners in Recovery (PIR)

The *PIR* programme was established to address challenges in care coordination for individuals with severe and persistent mental illness and complex needs, requiring multi-agency support. The aim is to provide more effective and efficient support to individuals, their carers and their families through coordinating care and facilitating access to clinical and community services. One of the important considerations of the *PIR* initiative is that instead of introducing new service providers, this model is expected to consider how existing services can work together more effectively (Morgan et al., 2011, Rosenberg and Hickie, 2013). *PIR* organisations, designed to be complementary, operate at a systems level; they work within specified regions to facilitate collaboration between sectors, services and supports to provide wrap-around care that meets people's needs (Standing Council on Health, 2013a). The initiative focuses on a holistic approach; and thus does not include direct clinical services funding, but instead considers the relationships across PHC providers, community services, emergency services and non-government organisations. This is one of the only initiatives identified that specifically aimed to bring together PHC, mental health and non-health services.

One key element of the initiative is 'support facilitation' (Brophy et al., 2014). Acting at the micro level and addressing service delivery gaps, support facilitators coordinate care in terms of conducting assessments, designing multisectoral action plans, coordinating supports and offering a single point of contact for individuals. At the meso level, the initiative aims to strengthen partnerships and links between clinical and community services which, in turn, aim to encourage more effective referral processes (Health Management Advisors, 2012). Support for these micro and meso level actions are underpinned at the macro level (i.e. Federal government funding and policy).

In exploring the impact of care coordination models on mental health service delivery in Australia, Brophy et al. (2014) outlined the need to consider macro level strategies in the implementation of the *PIR*. These included:

- Formal governance arrangements, which outline the roles and responsibilities of the different organisations involved in *PIR*
- Efficient referral processes, reflecting the need for effective communication across providers, both for intake of clients and for supporting clients in transition across services
- Appropriate training and competencies among support facilitators, which reflects a common macro level barrier in terms of supply, recruitment and retention of an appropriate workforce to enact integrated care models
- Boundary spanners who understand the different sectors, professional responsibilities and consumer needs and lead the way in building relationships across providers, connecting problems and solutions and mobilising resources
- Co-location as a potential enabler.

A national evaluation of the *PIR* initiative is expected to be completed in 2016 (Whiteford et al., 2014). The comprehensive evaluation aims to explore the extent to which the initiative has improved integration of services and subsequent patient outcomes. However, Whiteford et al. suggest that system-level integration information related to "what works, for whom, in what settings and why" may be limited. Part of the health reform proposal of the current government is to incorporate the *PIR* initiative into the NDIS though no formal details are currently available.

Mental Health Integration Programme

In 1999, the Australian government funded three demonstration projects to improve integration between public mental health services, private psychiatrists, private psychiatric hospitals, GPs, and non-government organisations (Eagar et al., 2005). Each project (Inner Urban East Melbourne, Illawarra, and Far West NSW) used a different model, and one (Illawarra) included additional subprojects that developed during the course of the project. A national evaluation framework underpinned local evaluations of the projects (Eagar et al., 2005). Key lessons from the projects (pp 198-199) were:

- Improving integration is hard but possible
- Improved integration can only occur in the context of structural and cultural change
- Integration needs to be planned at the local area level
- System-level integration is required within the specialist mental health sector and beyond
- The magnitude of change depends on the starting point
- No one model fits all
- Change requires leadership
- Fee-for-service arrangements are limited
- Money alone does not drive change
- Changes occur in a policy context.

Financing issues

Joint/pooled budgets

Coordination and integration of services across health and social care sectors could be facilitated by joint or pooled budgets. For example, Sweden has tried various permutations of pooled funds between health, social care and health insurance (McDaid et al., 2007). The Swedish *Socsam* scheme allows up to five per cent of social services and insurance budgets to be pooled with health services, which contribute a matched proportion. Limited evaluation of the scheme reported that, although there was improved coordination and more integrated services, it is unknown whether the scheme led to a reduction in support costs; and administrative costs probably offset any potential cost-effectiveness.

Incentives and disincentives for appropriate use of resources

In England, one approach to encouraging health and social services to work together is the use of penalties where there is an unreasonable delay (more than three days) before an individual's social care needs are assessed when discharged from hospital (McDaid et al., 2007). When this was introduced in 2003, there was a significant reduction in delayed discharges. However, prior to this initiative, the rate of delayed discharges dropped to a much larger extent following a substantial financial investment in social services. Thus, an injection of funds was more effective than penalties. McDaid et al. suggest that extending this (penalties) approach to mental health care raises some issues:

- Excluding people with mental health problems from the scheme may indicate that their social care needs are not a priority
- Penalties imposed on social care services for delays is not conducive to developing harmonious working partnerships across the sectors
- To avoid penalty, individuals may be placed in facilities that are not the most appropriate to their needs.

Direct payments for services

An alternative to allocating resources according to formulae based on demographic composition of the population and socioeconomic data, is to provide an allocation of funds to the individual to

purchase the most appropriate services (health, social, housing, education etc.) to meet their needs (McDaid et al., 2007). This approach is commonly implemented in the Netherlands, but also in Austria, Denmark, Germany, Finland, France, Luxembourg and Sweden, primarily for the elderly and those with physical or learning problems. It has also been used by people with mental illness in England and Scotland; but there are no rigorous evaluations of its effectiveness. A pilot study indicated some positive benefits of independent living for service users who used the funds to pay for personal assistants, transport, respite care and educational opportunities. However, eligibility criteria, restrictions on use of funds and other challenges have limited the uptake. In Australia, a similar process has been implemented in the form of the NDIS. This new national system is currently at trial stage and includes support for people with a psychosocial disability associated with a mental illness (Mental Illness Fellowship Victoria, 2011).

Legal and ethical issues

Macro level strategies relating to mental health also include the development and implementation of cross-sectoral, cross-country mental health-related legislation. Human rights are closely interrelated with legislation. In Australia, mental health legislation is the responsibility of the States and Territories (Whiteford and Buckingham, 2005). Each State and Territory has a mental health Act that regulates the “care, treatment, and protection of mentally ill persons” (Halsbury's Laws of Australia, 2004), including provision for involuntary detention and treatment. These Acts predominantly affect the small minority of people with severe, high-impact mental illnesses, particularly psychoses, and do not usually influence most people with lower impact, higher prevalence disorders. For example, only one per cent of depression-related mental health service contacts in Australia in 2001-2 were involuntary (AIHW, 2004); and most involuntary treatment is for psychotic disorders (AIHW, 2010).

The *National Mental Health Strategy* was developed with a strong human rights orientation (Wilson, 1999). However, Hazelton (2005) suggests there is little evidence that human rights protection has improved, and that there has been a paradoxical 'hardening' of institutional mental health services, possibly as a response to liberalising reforms. Two widely cited reports by the Mental Health Council of Australia (MHCA) have emphasised ongoing human rights violations in the Australian mental health system (Groom et al., 2003, Mental Health Council of Australia, 2005).

The MHCA's (2005) report, *Not for service: Experiences of injustice and despair in mental health care in Australia* concluded that “after 12 years of mental health reform in Australia, any person seeking mental health care runs the serious risk that his or her basic needs will be ignored, trivialised or neglected” (p 14). The AHMAC's (1997b) *National standards for mental health services* were used as a framework for organising a large amount of research data collected. However, the MHCA survey respondents were heavily weighted towards consumers of specialist mental health services, including many with psychoses; and some with dementia, which is outside the ambit of national mental health policy (Australian Health Ministers, 2003). Therefore, it is important not to over-generalise from institutional mental health services to the full spectrum of mental health services. Most people with lived experience of mental illness, including most depression sufferers, never have contact with institutional mental health services, and do not experience human rights violations reported in such services. The human rights agenda has traditionally focused on people with severe, high-impact mental illnesses who are much more likely than people with depression to be affected by mental health/illness legislation (particularly by being hospitalised involuntarily). Such people are also more likely to experience overt stigma and discrimination; and schizophrenia is much more stigmatised in the media than depression (SANE Australia, 2009).

Medico-legal partnerships

One area that is of growing interest and relevance to integration between mental health, PHC and non-health services relates to partnerships between health service organisations and legal services that deal with laws designed to address the social determinants of health (Sandel et al., 2010). In many cases, patients' legal needs may be barriers to accessing adequate health care services. For example, legal issues that may impact on physical and mental health include: social welfare benefits, housing (e.g. rental payments, unsanitary/unsafe conditions), employment (unfair dismissal, bullying), debt, criminal record, immigration, custody/guardianship, domestic violence and capacity/competency to manage own affairs. Medico-legal partnerships between PHC providers and lawyers could provide legal advice or assistance, identify ways to improve how systems are working for vulnerable populations, and identify inequitable policies. PHC providers that are trained to identify legal needs could facilitate referral to appropriate services. To date, there is little information to determine the effectiveness of these types of partnerships, or the extent to which they may facilitate integration across sectors. However, this may be a useful way of bringing together the different stakeholders to address unmet needs.

Non-health sectors

This section discusses the different non-health sectors, their impact on health and wellbeing, and the ways in which they are, or could be, integrated with PHC and mental health. Overall, there was some evidence of integration between mental health and individual services; but there were no published accounts of collaborations or partnerships that included PHC as a key partner in delivery of integrated care for people with lived experience of mental illness.

Alcohol and other drugs

Comorbidity of mental health problems and AOD use is common, often perceived as expected rather than the exception. Almost 25 per cent of people with a mental health disorder have a substance use disorder in their lifetime; alcohol use is the most common; and affects approximately twice as many males compared to females (Slade et al., 2009b). Over 70 per cent of those seen in mental health settings and up to 90 per cent of those seen in AOD treatment settings have comorbid mental health and substance use problems (Deady et al., 2013). People with dual mental health and substance use problems also have poorer treatment outcomes, more severe course of illness and reduced life expectancy; and are at greater risk of imprisonment, homelessness and suicide compared to those with a single diagnosis of either mental health or AOD problems (Cole, 2005).

Mental health presentations to emergency departments are frequently affected by AOD. For example, in a Melbourne hospital, approximately 39 per cent of emergency department presentations by people with lived experience of mental illness were related to intoxication or overdose (Shafiei et al., 2011). However, often medical staff are not adequately skilled to manage the combined effects of mental illness and substance use, which may present challenging behaviours and added burden on resources. This reflects the need for inter-professional education and advanced training where health care providers across sectors are trained in mental health care.

Simultaneously addressing mental health and AOD problems is generally accepted as a more effective approach as the relationship between mental health and AOD can be one of mutual influence. Several government initiatives have been implemented to improve the identification, coordination of services, capacity building and implementation of programmes for addressing comorbidity (Deady et al., 2013). These include:

- 1 National Comorbidity Project (1998-2003); National Comorbidity Initiative (2004-2008); and National Comorbidity Collaboration (2010-2011)
- 2 Improved Services Initiative (2006-2012)
- 3 Victorian Dual Diagnosis Initiative (2001-2010).

However, rigorous evaluations of comorbid treatment approaches are lacking. At the macro level of policies, system fragmentation still exists and Deady et al. (2013) suggest that strategies to address the structural, cultural and financial barriers to integrated services for comorbid mental health and AOD problems are essential.

In a US review, system level efforts to integrate agencies for homeless people with comorbid mental health and AOD problems reported improved access to more services, but little impact on quality of life (Fletcher et al., 2009). This was partly attributed to a lack of appropriate services that could be linked; and loss of connections once the five-year funded project was terminated. Such results suggest that increased, sustained investment is needed for partnerships between homelessness services and mental health services, including crisis accommodation (Wright-Howie, 2009).

There are few examples of integrated models that address AOD comorbidity with mental health; and there are reports of reluctance in PHC to treat these problems concurrently, even though an estimated two people per day attend their GP with comorbid AOD and mental illness (Lourey et al., 2013, Sacks et al., 2013).

Victorian Dual Diagnosis Initiative

Funded by a partnership between the Victorian Drugs Policy & Services Branch and the Victorian Mental Health Branch, the *Victorian Dual Diagnosis Initiative* employs a range of strategies to build capacity in mental health and AOD workforce to manage people with dual diagnosis (Croton, 2007, Lee et al., 2012). The Victorian government's *Dual diagnosis: Key directions and priorities for service development (2007)* policy stipulated a "no wrong door" service, mandating partnerships between mental health and AOD services to develop "integrated assessment, treatment and recovery" (Croton, 2007, p 8). The key characteristics of the initiative were to: develop partnerships across mental health and AOD services using formal and informal means; develop routine screening for dual diagnosis across both sectors, including appropriate training and guidelines; and enhance mutual understanding of integrated treatment, using mentoring and cross-sector rotations. An evaluation of the *Victorian Dual Diagnosis Initiative* was undertaken by Australian Health Care Associates in 2011³. Lee et al. (2012) reported significant improvements in knowledge and skills related to comorbidity, however, participation in the programme was poor (<50%). Furthermore, there were no specific details about system-level integration with PHC.

eHealth

eHealth initiatives are viewed as having the potential to deliver integrated services, particularly in terms of strengthening links between systems of care for AOD problems, mental health and the PHC setting (Deady et al., 2013). However, Deady et al. caution against "replicating the siloed approach to designing and delivering eHealth interventions that has been taken in mental health and substance use research and practice" (p 15), where there has been a tendency to develop and deliver eHealth components without considering comorbidity. Only one effective evidence-based programme used eHealth technology that considered comorbid mental health and substance use problems - *Self-Help for Alcohol/other drugs and Depression* (Deady et al., 2013).

³ The full report was not accessible.

Recommendations for practice

Lee et al. (2012, p 340) identified some key principles to improve treatment for people with mental illness and co-occurring drug and alcohol problems:

- 1 Collaboration should be led by the needs and goals of consumers and carers and be built on recognition that recovery is achievable.
- 2 Government, organisational, and clinical leadership is needed to promote and reward collaborative practice and establish incentives to facilitate integrated care.
- 3 Prior to commencing collaborative initiatives, the roles for staff of partner agencies and the mechanisms facilitating collaboration (e.g. expectations for communication and professional standards, expected partnership outcomes) must be agreed upon and documented (e.g. partnership agreement) to assist in holding partners accountable.
- 4 Governance structures must be established (e.g. project steering committees), independent of clinical partnership mechanisms, which regularly meet to review progress against project expectations and resolve any partnerships difficulties.
- 5 Collaboration should be built on respect, understanding of the complementary roles of partnering services, and shared knowledge for staff of the capacities and skill set of partnering services.
- 6 All staff should be trained on the impact of comorbidity, how to identify it, and how to engage staff from partnering services in supporting shared consumers.
- 7 Mechanisms to enhance communication and continuity of care between sectors (e.g. co-location, use of shared client record and care plans, joint assessments or case review meetings, secondary consultation on request, planned formalised education sessions, and zero-exclusion criteria for referrals) should be implemented.
- 8 Mechanisms to promote sustainability beyond existing staff (e.g. protocols outlining expectations regarding comorbidity and how to work with partner services, orientation to allow new staff to meet and learn how to work with collaborating services, shared opportunities for education or consultation) should be implemented.
- 9 Evaluation should accompany model implementation to demonstrate effectiveness and to serve a quality improvement role to identify whether aspects of the model are not working effectively.

Housing and homelessness

One of the biggest obstacles in the lives of people with a mental illness is the absence of adequate, affordable and secure accommodation. Living with a mental illness – or recovering from it – is difficult even in the best circumstances. Without a decent place to live it is virtually impossible (Burdekin report, cited in Mental Health Council of Australia, 2009, p 5).

Inadequate housing may lead to increased risks of deterioration in existing health conditions, mental health, strain on family relationships, suicide, involvement with the criminal justice system, inappropriate hospitalisation and longer hospital stays (Freeman et al., 2004). Data from the SHIP (Harvey et al., 2012, p 840) participants⁴ showed that:

- 48.6% were living in public or private rented housing
- 22.7% were waiting for public housing
- 13.1% were living in their own home
- 5.2% were currently homeless
- 12.8% had been homeless in the previous 12 months.

⁴ Participants had serious mental illness – high impact psychosis.

Housing is perceived as a stabilising force for people with mental illness. Informal community resources to support community housing have also been identified as enablers to recovery among young people with mental illness (Duff et al., 2013). Examples include access to local cafés, sports teams and social groups, which play a role in ‘anchoring’ young people in their community and enhancing social inclusion. Thus, the combined effects of housing stability and security, and support to facilitate links to informal local community resources are germane to young people’s recovery from mental illness.

There is a range of options for housing, with differing levels of support available, from high needs supported accommodation, with on-site support services, to independent living with home-based outreach support services. However, low income and the stigma of mental illness make it difficult for individuals to compete in the private rental market; and given the scarcity of socially-supported housing, people may end up in sub-standard housing (noisy, crowded, undesirable neighbourhood), on the street, or with escalated AOD problems (Kyle and Dunn, 2008). Furthermore, although obtaining model housing⁵ is beneficial (Leff et al., 2009), inappropriate, transient or inadequate housing may have negative effects (Battams and Baum, 2010).

The responsibility for funding and delivery of housing and related support services for people with mental illness is split between the Commonwealth and State/Territory governments through bilateral agreements (Battams and Baum, 2010). Most States and Territories recognise that planning for social housing needs to consider the requirements of those with mental illness (Commonwealth of Australia, 2009).

Homelessness and serious mental health problems are inextricably linked. Thus, co-management of the problem makes good sense. Separate, independent services are more likely to result in gaps in services; confusion in terms of conflicting advice, support and treatment options; and higher costs (transportation, transaction) for those who are homeless and with mental illness and/or substance use problems (Flatau et al., 2010).

Homelessness may be both a cause and an effect of mental illness and mental health problems (Commonwealth of Australia, 2009, p 72)

The National Mental Health Strategy relates to the *Homelessness White Paper* (Homelessness Taskforce, 2008), which outlines a national approach to reducing homelessness. Among the strategies in this paper was a recognition that people with mental illness are at risk of homelessness and that the ‘structural drivers of homelessness’ need to be tackled. Specifically, the report acknowledges the involvement of several different government portfolios and the need to work across these areas to reduce homelessness. In addition, prevention strategies have been proposed, including (p x):

- ‘No exits into homelessness’ from statutory, custodial care, health, mental health and drug and alcohol services
- Delivering community based mental health services under the *Personal Helpers and Mentors Programme (PHAMs)* to 1,000 difficult-to-reach Australians, including people who are homeless.

Despite a policy of ‘no exits into homelessness’ (Mental Health Council of Australia, 2009), this is a very complicated area of concern. Accommodation supply may be limited, the individual may refuse

⁵ In contrast, non-model housing, which is analogous to ‘usual care’, includes living on the street, using shelters or other transient, unsupported living arrangements.

an offer of accommodation, or people may fail/forget to pay their rent due to an acute mental health episode. The traditional view is a linear path from homelessness, to institutional living, to permanent supported housing. However, this view presupposes a need to demonstrate ‘housing readiness’ by being compliant (e.g. medications, sober, treatment etc.) (Kyle and Dunn, 2008).

Underpinned by legislation and quality standards, mainstream and specialist homelessness services are expected to work together, improve information technology systems across services, and develop “advanced practitioner positions in specialist homelessness services” to drive integration and enhance expertise (Homelessness Taskforce, 2008, p x). In terms of governance, a Council on Homelessness was appointed, comprising a diverse group of community leaders, to advise government on issues relevant to implementing the initiatives stated in the White paper.

Other related macro level partnerships that may also impact on homelessness among those with mental illness and AOD problems include (Homelessness Taskforce, 2008):

- *Household Organisation Management Expenses Advice* programme, which involves a partnership between Centrelink and non-government agencies to help resolve debt issues related to tenancies.
- *Housing and Accommodation Support Initiative (HASI)* in NSW, involves partnership between NSW Health, Housing NSW and non-government agencies, to provide support for accommodation, clinical care, rehabilitation and other personal support.
- *PHAMs* programme to assist those with mental illness to build social networks, get employment, resolve housing issues and develop skills for independent living.
- *Centrelink* also has a role to play in reducing and preventing homelessness. Centrelink has introduced a ‘vulnerability indicator flag’ to inform staff that a client may be homeless or at risk of homelessness and requires a tailored approach to meet their needs. A network of Community Engagement Officers, working through Centrelink, is expected to provide outreach services for people who are homeless.
- *Co-location* of State and Territory housing services in Centrelink offices (piloted in 2008, continuing in 2014).

Below are some of the models that aim to use an integrated approach to housing and mental health; and to identify where PHC may play a role in facilitating this approach to meet the needs of people with lived experience of mental illness. Where possible, the results of evaluations have been provided.

Supported housing

Previous inquiries recommended that an adequate number and variety of supported accommodation options should be available for community-dwelling people with mental health problems at different stages of their illness (Commonwealth of Australia, 2009); and that support should include clinical assessment/treatment, living skills and vocational support. Evidence suggests that co-existing clinical treatment and social support (stable housing, employment) are complementary and lead to better outcomes for clients, their families and carers (Commonwealth of Australia, 2009).

Under the *National Partnership on Homelessness*⁶, State and Territory governments agreed to develop “expanded tenancy support models to help people sustain their tenancies” (Homelessness

⁶ <http://www.dss.gov.au/our-responsibilities/housing-support/programs-services/homelessness/national-partnership-agreement-on-homelessness> This agreement expired on 30 June 2013.

Taskforce, 2008, p 25). Support included financial assistance (bond, rent) and non-financial support (guidance, referrals to other services).

The *Supported Accommodation Assistance Programme (SAAP)*, which is funded jointly by the Commonwealth and State/Territory governments, is a network of approximately 1,500 specialist homelessness services (Homelessness Taskforce, 2008). However, demand exceeds supply and it is recognised that specialist homelessness services cannot achieve optimal outcomes without better integration with mainstream services. Strong partnerships between SAAP services and mainstream housing, health and employment services are essential. The Homelessness Taskforce suggests “improving coordination and installing information technology systems that allow for real-time data exchange across specialist homelessness services will also improve utilisation of existing capacity *within* the specialist homeless services service system and enable better deployment of services to meet demand” (p 40).

An evaluation of the SAAP (termed the NESAAP report) acknowledges that there is little consensus on which indicators are appropriate to determine the effectiveness of this initiative and that the quality of the available data is problematic for drawing reliable conclusions (Erebus Consulting Partners, 2004). Given the diversity of clients’ needs, the report suggested that “some disaggregation of the client profile is required” (p 149) if their needs are to be met, particularly where integration with other services and systems is needed. Other issues that were raised in the submissions for this report were the tension between collaboration and competition for contracted services at the State level; and the potential for limited services in some locations where there is insufficient competition for contracts (e.g. rural and remote areas). To a large extent, the SAAP successfully resolves housing crises for many clients. However, it is not clear from the data how many of these people end up back in housing crisis at a later time. Therefore, a longer-term focus on sustainable housing may require better integration with other sectors, such as supported employment initiatives, police and justice systems, mental health, PHC and family support services.

To address one problem without addressing the others results in short-term solutions to long-term problems (p 155) (Erebus Consulting Partners, 2004)

At the local level, integration may involve memoranda of understanding or similar formal arrangements. Although the NESAAP reported increases in formalisation of activities between services; and enhanced commitment and collaborations at the senior management level, the authors reported that there was little evidence of any commonly agreed principles to guide integration efforts between the sectors and services.

Several factors were seen as barriers to integration across these services, including: lack of time and resources; lack of expertise; high staff turnover; and lack of trust in the skills of partnered agencies. Although there was a brief acknowledgment that people with lived experience of mental illness commonly have chronic conditions, there was no mention of a role for PHC or integration with mental health and other services.

Housing First models

Housing First is a housing policy model that was first introduced in the US to address chronic homelessness⁷ (Stanhope and Dunn, 2011). Evidence showed that ‘doing nothing’ generated extremely high costs associated with the chronically homeless due to repeated hospitalisations, arrests and alcohol and substance use problems. The cost of doing nothing was starkly illustrated in

⁷ In the US, chronic homelessness = those who are long-term homeless with mental health problems (Stanhope and Dunn 2011)

the US case of “Million Dollar Murray”, who cost taxpayers \$100,000 per year for multiple hospital visits due to his mental illness and alcohol addiction, leading a police officer to remark “it costs us one million dollars not to do something about Murray” (p 278).

The *Housing First* approach is in stark contrast to more restrictive, graduated housing models, which require residents to be sober and compliant with treatment before accessing housing or moving to more independent living, and puts them back on the streets when they fail to adhere to the strict regulations. *Pathways Housing First* reverses the order and puts stable housing as a priority; then the clinical, psychosocial, addiction, justice, employment and other daily living needs of chronically homeless are addressed. One of the key elements of success with this model was that it gave individuals the right to choose their level of participation in an array of services that incorporated a harm minimisation approach (Greenwood et al., 2013a). Most services can be accessed directly through a multidisciplinary Assertive Community Treatment team, which comprises expertise in mental health, substance use treatment, supported employment and peer counselling. Case managers conduct home visits weekly or fortnightly as needed. Despite scepticism about participants’ capacity to make appropriate choices, a growing body of evidence from rigorous study designs supports the efficacy and cost-effectiveness of the programme (Greenwood et al., 2013a). Compared to traditional more restrictive programmes, the main outcomes of the *Pathways Housing First model*, which have been replicated in other locations, were reduced homelessness, longer tenure in stable housing, greater choice of services for participants, less institutionalisation, and it was cheaper to administer.

The *Pathways Housing First* model used an evidence-based approach to develop the programme, which was first implemented in New York City and more recently has been adopted in Canada and several European⁸ countries (Greenwood et al., 2013b). The success of this approach generated a number of similar programmes that used the ‘Housing First’ label, but were not always faithful to the core elements that included research, integrated services and participant engagement in choices, thus undermining the validity of the original model.

In Australia, several models of collaborative care for people with mental health conditions adopt a ‘housing first’ approach (Lee et al., 2012), including:

- HASI (NSW)
- Platform 70 project (NSW)
- Project 300 (Qld)
- Independent living programme (WA)
- Housing and support programme (HASP) (Qld, Vic)
- Neami community housing programme (Vic)
- Returning home programme (SA).

An evaluation of HASP, which involves partnership between Queensland Health, Department of Communities and the non-government sector, reported that the programme exceeded its initial targets by achieving stable housing for over 240 people with mental illness (Standing Council on Health, 2013a).

The *Platform 70 project* is a joint initiative of Bridge Housing, St Vincent’s hospital and Neami National, which aimed to provide housing, health and mental health services for people who were sleeping rough in Sydney. The 2013 National report card (Lourey et al., 2013) reported on a small study of 70 people who participated in the *Platform 70 project*, and demonstrated positive

⁸ Portugal, France, Netherlands, Scotland, Finland, Ireland

outcomes, including starting work or further education, reconnecting with family and addressing AOD use. Although there was partnership with the hospital, there was no mention of a role for PHC.

HASI, which is jointly funded by NSW Health and NSW housing, has been the most rigorously evaluated among these initiatives (Muir et al., 2008). *HASI* provides permanent social housing, support on-site and from external agencies to assist in development of living skills and social participation skills in the community, and case management from the Area Mental Health Services. A two-year longitudinal evaluation of the first 100 *HASI* participants found substantial improvements in housing stability, community participation (43% worked or studied), family connectedness, social and living skills (Lee et al., 2012). In terms of costs, the findings showed cost savings in health (84% fewer psychiatric or emergency department admissions), a 78 per cent decrease in imprisonment, and an increase in participation in paid and voluntary work. Shared understanding and commitment to the partnership, clear roles and responsibilities, shared information system and engagement of *HASI* participants were identified as key elements of the model's success.

In a similar approach, the *Housing Mental Health Pathways Programme* in Melbourne is a co-location model, whereby housing service staff are co-located in mental health services (Lee et al., 2012). Clients with housing issues are identified and the housing worker coordinates assessment, practical support and referral to crisis, transitional, or long-term housing services. A 12-month review reported improved collaborative relationships between mental health and housing staff, but lack of stable housing precluded ongoing engagement with clients.

Most of the literature that mentioned connections with health was concerned with hospital and/or emergency department admissions. There was little information on collaborations with PHC.

Employment

A complex relationship exists between employment and mental health. Employment can both improve and worsen mental health and poor mental health can be both a cause and a consequence of unemployment. In Australia, LaMontagne et al. (2008) estimated that a substantial amount of the burden of depression was attributable to work stress. According to Butterworth et al. (2011), "the psychosocial quality of work determines whether employment has benefits for mental health" and "gaining employment may not necessarily lead to improvement in mental health and well-being if psychosocial job quality is not considered" (p 806).

The employment rates of people with mental illness are complex, and there are contradictory statistics. According to the Department of Health and Ageing (2013a), 62 per cent of Australians aged between 16-64 years with a self-reported mental illness were employed in 2011-12, compared to 80 per cent of the population without a mental illness. Data from the 2011-12 National Health Survey illustrated wide variation in employment rates for people with mental illness across the country (e.g. 52 per cent in Tasmania, 73 per cent in the Australian Capital Territory). Participation rates in education and employment for those aged 16-30 years were slightly higher.

According to the NSMHW, approximately 20 per cent of employed people reported a mental disorder in a 12 month period (Slade et al., 2009b). Data from 2007 indicated that unemployment among those with a mental illness was slightly higher compared to those without a mental illness (4% vs 2.7%) (Zhang et al., 2009).

Australian Bureau of Statistics (ABS) statistics (cited in Queensland government, 2011) suggest that, compared to people without mental and behavioural disabilities (aged 18-65), those experiencing

mental illness have lower workforce participation rates (54% vs 80%). Gaining employment is a key issue for those with low-prevalence conditions and participation rates vary according to illness severity. High levels of unemployment have been reported among those with a psychotic disorder (75%) or schizophrenia (81%), many of whom want to work (Lee et al., 2012). Productivity loss due to mental illness is substantial (almost \$6bn per year).

Some other widely quoted statistics on employment rates are problematic, because they are based on samples of people with severe chronic disabling disorders rather than the much broader group of people with mental disorders, particularly those identified in the NSMHW. For example, it is widely stated that about 28 per cent of Australians with a mental illness are employed (Rosenberg et al., 2009, Australian Government, 2009). The source is the ABS Survey of Disability, Ageing and Carers (ABS, 2004), which focused on people with a disability (defined as any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities). Consequently, it is more accurate to say that only about 28 per cent of people with a mental health-related *disability* were employed in 2003, but not that only 28 per cent of people with a mental illness were employed. Furthermore, this estimate is now a decade out of date, and employment rates are likely to have been affected by economic, demographic, and secular changes. In the 2010 SHIP, which focused on low-prevalence relatively serious conditions (mainly psychosis), Waghorn et al. (2012b) reported the following rates for people with low-prevalence psychoses (p 774):

- 22.4% of people were employed (full-time or part-time) in the previous month
- 32.7% were employed at some time in the previous month
- 63.9% of those in competitive employment worked part-time
- 23.4% worked 38 or more hours per week
- 31.9% had completed high school
- 18.4% reported difficulties with reading or writing
- the proportion currently employed has remained stable at 22% since the first survey in 1997.

It is often assumed that increasing access to treatment is the key strategy for increasing employment. However, the evidence on this is mixed. Some studies have found positive results (Rost et al., 2004, Wang et al., 2007), whereas others have found that treatment is associated with decreased productivity. For example, an Australian study (Waghorn and Chant, 2005) found that “receiving treatment was consistently associated with non-participation in the labour force” (p 415). It is likely that this reflects, in part, lack of availability of non-health services and supports. Integrating mental health services with supported employment services for those with chronic mental health conditions is essential. Research shows that people with a mental illness who stay in work or return to work have improved outcomes when they receive vocational support that is linked to treatment services including post-placement support and employment readiness support. A workplace that supports good mental health and wellbeing is critical not only to employees, but also to employers (absenteeism and productivity).

Government policies that promote inclusive practices in recruitment and retention are part of the *Fourth Mental Health Plan*. For example, Centrelink and job network agencies are required to facilitate and support employment and retention of people with mental health problems (Commonwealth of Australia, 2009). Using another approach, the *Mentally Healthy Workplace Alliance* (NMHC) brings together the National Mental Health Commission, mental health care organisations (e.g. Black Dog Institute) and business peak bodies with a view to developing good practice in the workplace and creating a mentally healthy work environment. They do this through research, collaboration and engagement with employers. This is a strategic alliance to address the employment needs of people with lived experience of mental illness. Currently, this alliance does not

have a direct connection with PHC. However, given the high prevalence of chronic illness amongst this population, including PHC in the alliance could improve the integration of services, provide early intervention and prevention when needed and potentially reduce absenteeism.

Supported employment programmes

Supported employment programmes have been developed to assist people with mental illness who want to work, but have difficulty competing for jobs against those without diagnosed mental illness (Lee et al., 2012). In addition to pre-vocational training models, which focus on getting people ready to work, supported employment models work with employers and mental health professionals to identify suitable employment, support both clients and employers and address multiple barriers to employment in this population. One of the key evidence-based principles for supported employment services emphasises the need for employment specialist and clinical teams not only to work together but also to be co-located.

Examples of supported employment programmes include the *Employment Specialist Initiative*, employment-based social enterprises and the *Individual Placement and Support (IPS)* programme. In Australia, the *Employment Specialist Initiative* involves establishing a formal partnership between services. Intensive and ongoing support is needed to meet individuals' and employers' needs (Waghorn et al., 2012a). Queensland's *Employment Specialist Initiative* incorporates a formal partnership between the State mental health services (Queensland Health) and the Commonwealth Government-funded employment specialists (e.g. Disability Employment Services). Typically, this involves co-locating an employment specialist within a community mental health service. Evidence suggests that the addition of vocational support significantly increased the likelihood of employment at six month follow-up compared to those who received usual mental health care only (Killackey et al., 2009 cited in Queensland government, 2011).

In another model, employment-based social enterprises specifically focus on creating jobs for people with disabilities, mental illness, Indigenous Australians, ex-offenders, homeless people and others who are often excluded from the labour market. Social enterprises create a low-stigma environment to support and encourage participation in meaningful work. For some, this is a first step and they may move from a social enterprise into mainstream employment. The *IPS* is an evidence-based employment support programme that was developed in the US. It has been rigorously evaluated and generated significantly better employment outcomes for people with serious mental illness (Waghorn et al., 2012b). The *IPS* model aligns closely with the *Fourth Mental Health Plan's* priority to establish formal partnerships between mental health services and employment services. Waghorn et al. (2011) suggest that where formal partnerships are difficult due to the traditional segregation of these sectors, adherence to the other evidence-based practices in this model may compensate to some extent for the lack of service integration at a local level. A weakness of the *IPS* model is that when mental health services are placed within employment services, there may be some reluctance to participate due to stigma of having specialist mental health support within the workplace. There is no formal collaboration with PHC in the supported employment programmes. However, PHC could have a role to play in referring people with lived experience of mental illness to supported employment and/or supporting those in the programme in relation to their physical health needs.

Criminal justice and forensic⁹ mental health services

People with mental health problems are over-represented in the criminal justice system. NSW surveys reported that 40-50 per cent of adult prisoners and 60 per cent of juvenile detainees had mental impairment (excluding AOD problems) (Baldry, 2013). For the police, corrections officers and legal officers/courts who encounter people with mental/cognitive impairment, there is often little training or understanding of how to deal with them, often resulting in repeated pathways to imprisonment. Moreover, mainstream approaches are less effective in dealing with their offender behaviour as well as their overall health and wellbeing (Australian Institute of Criminology, 2011).

As homeless people with mental health and addiction problems often live in public spaces, they have an increased likelihood of involvement with the criminal justice system in relation to 'public space offences' (begging, littering, not paying for public transport etc.) (Adams, 2014). As a result, they may accumulate thousands of dollars in fines. Ten recommendations from Adams' report were proposed to improve the response to their behaviour and avoid clogging up the courts and legal services about public space fines. Recommendations reflected a shift away from law enforcement and punishing people for being homeless towards acknowledging the reasons for homelessness, working with organisations and the community to resolve problems, challenging stereotypes through education and advocacy, and working with law enforcement officers to develop more appropriate procedures.

Lee et al. (2012) reported that police brought in almost 20 per cent of mental health presentations to a Sydney emergency department. Police officers with limited expertise in mental health problems are often, by default, gatekeepers to the mental health system; and strategies to enhance collaboration between police and mental health services are needed. Moreover, police involvement may lead to excessive criminalisation of people with serious mental illness, particularly for those living on the streets.

Below are examples of some initiatives that involve collaboration between the justice sector and mental health services. No studies or reports mentioned how PHC could contribute to these collaborative efforts. However, PHC professionals, including specialist nurses, could play a role in managing the general health, chronic conditions and the sequelae of AOD problems, which are common in this population.

Police and mental health services collaboration

The Victorian Police, Ambulance and Crisis Assessment Team Early Response (PACER) and NSW Police Mental Health Intervention Team (PMHT) models are designed to enhance collaboration between mental health services and the police (Lee et al., 2012).

PACER is an outreach model whereby a crisis assessment and treatment team works closely with police and is available by phone or on-site to respond to frontline officers' requests for assistance in dealing with someone experiencing an acute mental episode. An evaluation of the model reported a reduction in the need for transportation to a mental health facility and increased understanding of mental illness among police officers. However, the service was limited by availability of the PACER team in times of high demand.

PMHT, which involves a partnership between the NSW police and the NSW Department of Health, involves a mental health education package for police officers. The training led to more use of de-

⁹ The term 'forensic' is commonly used to denote "connections with or to the court or justice system in relation to a mental health condition or matter" (Lourey et al., 2013, p 71).

escalation techniques, better understanding and confidence in dealing with people with mental illness, and less time managing mental health events compared to police officers not trained in PMHT (Lee et al., 2012).

The 2013 National Mental Health Report Card suggests that there is a need for a more targeted approach to support the broad range of workers who frequently have contact with people with lived experience of mental illness, including health care professionals, police and others working in the justice sector (Lourey et al., 2013).

Court-based liaison and diversion programmes

The West Australian state-wide mental health court liaison service aims to divert people with mental illness away from court and facilitate access to mental health care (Lee et al., 2012). Specialist nurses perform or refer for assessments under the 1996 *West Australian Mental Health Act*. Educational sessions for court staff, police officers and lawyers are a key element of the service and data linkage enables better identification. The mental health court liaison service has improved identification of mental illness among offenders, with the goal of getting them appropriate care sooner. A videoconferencing service has been included to manage assessments for individuals in rural and remote areas.

An alternative approach is court-based diversion programmes and specialist mental health courts for people with mental illness or alcohol/drug dependency (Australian Institute of Criminology, 2011, Commonwealth of Australia, 2009). Table 4 presents the key principles applied in effective court-based mental health diversion programmes.

A review of the mental health courts (Sarteschi et al., 2011) reported that mental health courts are effective in connecting clients with appropriate mental health services, reducing re-offending rates in this population, and reducing costs. One factor that impacts on effectiveness includes the requirement for offenders to plead guilty. Having a criminal record has significant flow-on effects for gaining employment, rental accommodation or other social services. A best practice guide has been developed for implementing diversion programmes.

A broad range of models requiring cross-sectoral partnerships between mental health and social services (e.g. psychiatry, psychology, social work, AOD services) have been implemented in different jurisdictions. Examples include prison 'inreach' services to identify mental health issues among new prisoners; and transition services for those just released to the community. However, information about the macro level partnerships in these models is scarce and evaluations are lacking.

Table 4 Principles of effective court-based mental health diversion programmes

Principles of an effective court-based mental health diversion programme	
Integrated services	Multidisciplinary approach that integrates mental health and social services with the criminal justice system
Regular meetings of key agency representatives	Administrative meetings that deal with the operation of the programme and funding, and meetings between service providers and stakeholders about individualised treatment plans
Strong leadership	Programme director/co-ordinator who has excellent communication skills and an awareness and understanding of all elements of the mental health court or diversion programme
Clearly defined and realistic target population	Clear eligibility criterion that takes the treatment capacity of the community and offender circumstances into account
Clear terms of participation	The terms of programme participation are made clear to clients and individualised to suit the needs and circumstances of the offender
Participant informed consent	The decision to participate in a programme should be consensual and made only once the offender is fully informed about the process and the consequences of participation. This can be facilitated through rigorous legal representation specially trained case managers and/or the presence of an advocate
Client confidentiality	Although there are reporting requirements for case managers regarding client progress in treatment, confidentiality and privacy of clients must be preserved
Dedicated court team	Development of a team of court staff who are trained in the identification and management of a broad range of mental health issues
Early identification	The identification of suitable clients should be made as early as possible in their interactions with the criminal justice system
Judicial monitoring	Client programme engagement is closely monitored by the court and subject to sanctions and rewards
Sustainability	Formalisation and institutionalisation of the programme to ensure long-term sustainability

Source: (Australian Institute of Criminology, 2011)

Wrap-around services

Wrap-around services are defined by Etheridge and Hubbard (2000, cited in Oser et al., 2009, p S83) as “psychosocial services that treatment programmes may provide to facilitate access, improve retention and address clients’ co-occurring problems”. Services are tailored to specific needs. For example, female offenders with mental health problems about to be released back to the community are likely to need a range of services, including support for housing, legal services, mental health care, AOD services, vocational support, as well as child care and other family care services to facilitate reconnection with their families (Oser et al., 2009). Community-based organisations that offer wrap-around services require adequate infrastructure (e.g. secure information-sharing and

communications technology), resources (appropriately skilled case managers), and well-developed relationships with different organisations across multiple sectors.

In wrap-around approaches, community health services partner with clinical health services in PHC and specialties, as well as living support services (housing, carer respite, vocational support etc.) with the intention to deliver a holistic service response (Commonwealth of Australia, 2009). To do this, innovative governance and funding models are needed to support integrated approaches and promote more flexible adaptable and person-centred responses (Commonwealth of Australia, 2009).

An Australian report on social services¹⁰ engaging with clients with mental illness reported a variety of complaints to the Ombudsman's office related to systems and protocols that do not consider the limitations of those with a mental health condition (Asher, 2010). In many cases, clients who are eligible for services (e.g. Centrelink payments) miss out due to their inability to understand the forms or compliance requirements. For example, in the 2013 National Report Card on Mental Health (Lourey et al., 2013), some evidence showed many people with a mental illness (90 per cent in a study of 372) had difficulties in their applications for public housing due to the complexity of the process. This exacerbates their distress financially, emotionally and psychologically. Although there is evidence that the staff in these agencies do their best to use any flexibility in their systems to address clients' needs, four areas were identified that need to be addressed:

- Considering clients' barriers to communication and engagement
- Training staff to identify clients with a possible mental illness
- Encouraging clients to disclose communication difficulties and mental health issues
- Transparency in recording information about a client's barriers.

Aboriginal and Torres Strait Islander populations

Following the abolition of the Aboriginal and Torres Strait Islander Commission and the Aboriginal and Torres Strait Islander Services in 2004, programmes to support Aboriginal and Torres Strait Islander populations have been administered by mainstream agencies. In addition, a single Indigenous budget stream supports Indigenous-specific initiatives, which are expected to be considered together using a whole-of-government approach (Commonwealth of Australia, 2007).

A specific mental health framework, the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2001-2013*, was designed to address the multiple disadvantages experienced in this population; and social and emotional wellbeing, including substance use and mental health, was recognised as a priority area of concern (Commonwealth of Australia, 2007). The main objectives for improving social and emotional wellbeing amongst Indigenous Australians relate to areas of social justice, population health, service access and appropriateness, workforce and quality improvement. Each of these areas has an impact on Indigenous mental health and wellbeing, particularly in terms of social disadvantage, racism/stigma, AOD use and other comorbidities; and coordinated and coherent policies and services are critical for delivering quality care and equitable opportunities. Irrespective of the way portfolios are structured, there are multiple lead agencies that need to consider the impact of their policies and actions on Indigenous health and social and emotional wellbeing.

¹⁰ Centrelink; Department of Education, Employment and Workplace Relations; Department of Families, Housing, Community Services and Indigenous Affairs

Although there are no national data to give accurate estimates, it is recognised that there is high prevalence of mental illness and social and emotional distress in Aboriginal and Torres Strait Islander communities (Jorm et al., 2012).

A key principle in integrated mental health care among Indigenous populations is engagement and partnerships with communities. Aboriginal Community Controlled Health Services empower communities to deliver appropriate, integrated health care, including mental health care (National Aboriginal Community Controlled Health Organisation, 2014).

Although Indigenous-specific mental health services and culturally-sensitive mental health professionals play a critical role in enhancing the social and emotional wellbeing of Australian Indigenous people, there remain a number of structural, social and economic inequities that are barriers to good mental health and wellbeing (Osborne et al., 2013). Thus a comprehensive approach that integrates health care across all sectors of health and social services is important.

A holistic approach is essential as complex disadvantage is common. In a review of the social and emotional wellbeing of Indigenous Australians, a holistic approach requires coordination at the level of society, community, family and the individual (Garvey, 2008). To achieve this, particularly in remote communities, capacity building in the community is required to develop “a ‘mental health literate’ community; accessible services; a trained workforce; and tools for assessment and treatment” (p 6).

Very few initiatives have been evaluated and programmes that have been designed for Aboriginal and Torres Strait Islander peoples or culturally and linguistically diverse populations are complicated by additional barriers, such as cultural differences in understanding of mental illness and the social stigma of going to see a health professional for mental health-related symptoms (Lourey et al., 2013).

Summary

Health and PHC were often mentioned in many of the macro level frameworks and policy documents related to non-health services, particularly where integration across sectors was concerned. There was evidence of many different types of collaborations and partnerships between mental health and social services. However, apart from the *PIR* initiative, there was a lack of connection with general practice or any other PHC service, despite the high prevalence of physical problems amongst people with lived experience of mental illness. Where health was included in collaborations or partnerships, it generally referred to hospital or emergency departments (e.g. with AOD use), rather than PHC.

Specialist nurses who are trained in areas such as forensic mental health or AOD have been employed in some sectors, with promising results; and there is potential for further expansion within existing collaborations to engage more PHC professionals.

Although improving access to non-health services for people with lived experience of mental illness is important, a narrow focus on access fails to recognise the interrelationships that exist between factors that impact on health and wellbeing. Without a broader perspective that brings together physical health, mental health and non-health areas, there is a danger that the traditional siloed practices will prevail.

Cost-effectiveness

Mental health care accounts for approximately 6.5 per cent of the health budget (Lourey et al., 2013). In 2010-11, the Commonwealth Government spent \$2.4 billion on mental health-related services (mainly Medicare-subsidised services and Pharmaceutical Benefits Scheme/Repatriation Pharmaceutical Benefits Scheme subsidised prescriptions (combined total \$1.7 billion)) (AIHW, 2013a). State/Territory spending was over \$4.2 billion (mainly \$1.8 billion on public hospital services (\$1.8 billion) and community mental health services (\$1.6 billion)). According to the National Mental Health Commission (2013), the appropriateness and cost-effectiveness of this expenditure was unknown.

Overall, there is limited available evidence of cost-effectiveness in the mental health field. Most of the limited research that has been conducted has focused on clinical interventions. For example, Doran (2013) recently reviewed clinical interventions in Australia, NZ, Canada, and the United Kingdom, concluding (p 7):

there is a paucity of research relating to the costs and benefits of strategies to reduce the burden of harm and cost associated with mental disorders. A total of 17 studies have been conducted in Australia. This evidence base is insufficient to guide policy decisions given that the Australian Government spends over \$10 billion each year on mental and ancillary health services. More research is required to better understand the potential costs and benefits of treatments for mental disorders to ascertain value for money).

In Australia, cost-effectiveness was not built into the evaluations of the three projects funded in the *Mental Health Integration Programme*, but retrospective analysis suggested that at worst there were no increases in Health Insurance Commission expenditure for private psychiatrists and GPs, and at best there were reductions (Eagar et al., 2005).

In the Netherlands, Stant and colleagues (2007) reviewed the cost-effectiveness of interventions for a range of mental disorders in the Dutch health care system. Stant's (2007) PhD research reviewed the cost-effectiveness of interventions for major depressive disorder and schizophrenia specifically. Stant and colleagues identified methodological problems in the assessment of cost-effectiveness. For example, some outcome measures may provide too narrow an indication of health outcomes and may mislead policy makers (Stant et al., 2007).

Reviewing economic evaluations of community mental health programmes, Roberts et al. (2005) identified three substantial methodological problems in the literature: failure to measure costs comprehensively or from a societal perspective, low-quality statistical/econometric analyses, and failure to integrate information about costs and health outcomes. They reported that there was good evidence of the superior cost-effectiveness of community care overall compared with inpatient care, but not much evidence about the relative cost-effectiveness of different types or levels of community care:

Well-conducted research shows that care in the community dominates hospital in-patient care, achieving better outcomes at lower or equal cost. It is less clear what types of community programs are most cost-effective (p 503).

In relation to deinstitutionalisation, Knapp et al. (2011) found that the economic evidence base was modest, partly because quality-adjusted life years (QALYs), which are widely used in contemporary economic analyses, had not been used in studies of hospital closure and were not well suited to

studies of severe mental illness. Knapp et al. argued that there were strong economic arguments in favour of deinstitutionalisation, but cautioned that this would not generate substantial savings.

Overall findings from the current review highlight that there has been little research into the cost-effectiveness of non-clinical interventions, let alone economic research focusing on macro level factors.

Knapp et al. (2006, p 158) identified six types of barriers to cost-effective and improved mental health care (p 158):

- Information barriers (e.g. limited evidence base)
- Insufficiency of resources (e.g. low priority)
- Resource distribution (e.g. concentration in urban areas)
- Resource inappropriateness (e.g. dominance of large institutions)
- Resource inflexibility (e.g. 'silo budgeting')
- Resource timing (e.g. training delays).

They advocated a range of pragmatic strategies to address these barriers (e.g. improving access to the evidence base, increasing data collection, and using evidence to lobby for increased resources). However, they emphasised the need for systemic change, in particular strengthening the provision of primary mental health care:

Training and mobilizing primary care services, with mental health identification and treatment woven into other tasks as standard responsibilities, may be the only realistic way to deal with the inaccessibility and inflexibility of care (p 166).

Barriers and Facilitators

The Australian Government has introduced a number of programmes in recent years to improve access to treatment and support for people with lived experience of mental illness. However, there are barriers to the effective implementation of these programmes, including organisational, financial and professional barriers. Similarly, there are barriers and facilitators in relation to integrated mental health care more generally.

Context

The Australian context is complex and involves metropolitan, regional, rural and remote communities as well as Aboriginal and Torres Strait Islander, culturally and linguistically diverse, and refugee populations. When implementing policies or enacting macro level strategies to link sectors, it is important to take into account the local needs and resources in a region. For example, integrated care will look very different in a rural area where the primary, secondary and tertiary sectors are likely to be more closely linked given the smaller, more connected workforce than is likely in the urban centres. An evaluation of the National Mental Health Integration programme suggested that no single model could fit all types of communities and populations (Eagar et al., 2005). The authors suggest that the “size, level and mix of existing resources, availability of local leaders, and existing relationships” differ between areas and will drive the way in which integration occurs.

Implementing health reform implies that there will be benefits in terms of quality, safety, effectiveness or efficiency – otherwise, why reform? However, the health reform process itself may also have some drawbacks. For example, a South Australian case study of mental health reform during the period from 2000 to 2005 examined policies related to accessing appropriate housing for people with mental illness. A key finding from this study was that ongoing reorganisation of services and portfolios during the reform period had a negative impact on intersectoral collaboration, creating instability, uncertainty, staff changes, and boundary changes that disrupt joint planning efforts (Battams and Baum, 2010). Thus, while health reform is expected to continue, the need for change in local contexts, and the potentially negative effects of prolonged periods of change need to be addressed.

Engagement and partnerships

Engagement is core in enabling integrated care at any level. However, there are various components of this. Initially, engaging key stakeholders, be they sectors, services or individuals, is required before processes for shared goals and resources can be considered. Partnerships between these stakeholders are the backbone of integrated care and can be cross-sectoral or intersectoral arrangements. The decisions as to who will be involved in partnerships will be informed by evidence of current successful practice. The outcomes for each stakeholder also need to be articulated (i.e. outlining why it is important for them to be involved). Integration relies upon mutual benefits and shared goals; however, a common challenge is trying to recruit stakeholders who see no need to change their current practices (Oliver-Baxter et al., 2013c). Lee et al. (2012) emphasised that although it was important to establish new partnerships to address specific comorbidities and social issues, historical relationships and mutual objectives enhanced collaborative efforts.

Partnerships can be confirmed with formal agreements such as memoranda of understanding which clearly articulate that which will be required from each party, as illustrated by the Government of Western Australia Mental Health Commission which provides a template for memoranda of understanding on its website (Government of Western Australia Mental Health Commission, 2010). Depending on the local context and the availability of effective communication mechanisms, it may

be sufficient to have informal agreements in place. The key issue is to ensure that the right teams are connected.

Engagement also relates to an ever-increasing focus on including people with lived experience of mental illness and their families in designing health care. The health system is centred on individuals, thus planning needs a similar approach. Involving people with lived experience of mental illness and their caregivers in developing care processes can also help to improve the nature of resources that are prepared. It has been suggested that some vulnerable populations miss out on benefits and supports they are eligible for as a result of their literacy, thus involving consumers and giving them a voice in the design of models of care and related products can help to reduce this discrimination.

It is important that all partners are involved throughout the process of designing integrated care, with particular emphasis on engaging end users from the beginning (i.e. knowledge exchange). This has the potential to facilitate the commitment and sustainability required to see real health system reform. For Canada, knowledge exchange is a priority. Throughout the Canadian policy documents, mention is made of the importance of sharing knowledge across providers to inform best practice for people with lived experience of mental illness (Mental Health Commission of Canada, 2012, p 84). The co-creation of knowledge among key stakeholders is thus an important mechanism of integration in this region.

Governance and leadership

Engagement also relates to engaging leaders or change advocates - champions for integrated care who will push the collaborative agenda. A strong voice is essential to challenge preconceptions about the capabilities of people with lived experience of mental illness to manage their lives. High level leadership and authority to implement change, forge partnerships and engage relevant service providers is critical for sustainability.

There are cross-jurisdictional challenges for leadership that are faced by countries such as Australia and Canada, stemming from the interaction between Federal Government and State/Territory/Provincial government preferences (Oliver-Baxter et al., 2013a). Consistent evidence on the development of alliances, coalitions and partnerships emphasises the value of governance. Integrated practice is only possible when there are leaders with clearly delineated roles and responsibilities. Formal agreement on processes to achieve shared organisational goals is essential to ensure that top-down directives are aligned with individual organisations' missions.

In Australia, coordinating the relationship between mental health care providers is often the responsibility of Medicare Locals. Through shared board membership with Local Health Networks, these PHC organisations attempt to address cross-sectoral integration for provision of mental health care. However, the current context of flux within the PHC sector must be acknowledged. Current governance arrangements will be altered by the expected transition to primary health networks, and these new organisations will need to be positioned to encourage the continuation of relationships with the Local Health Networks, and be informed by the practices of successful Medicare Locals.

Financing

Despite being out of the scope of this review, funding and financing arrangements did emerge in some of the materials sourced for this work. The NMHC (2013) noted that integrated care does not necessarily require integrated funding though evidence suggested that funding is important at a high level to enable the restructure of systems (Kates et al., 2011). Financial incentives may be one method for encouraging integration. This might include incentives for teamwork or continued

support for Medicare items around shared care for chronic conditions or referral for psychological services.

Funding mechanisms can also affect the availability of the workforce. In establishing GP Super Clinics in Australia, a relocation incentive was introduced. This was available for the recruitment of a range of health professionals including mental health workers. The idea was that this would encourage integration through co-location of services (Australian Government Department of Health and Ageing, 2010). Similarly, the *Mental Health Nurse Incentive Programme* provides non-Medicare funding for GPs, private psychiatrists and other health service providers to employ mental health nurses to assist with the provision of coordinated clinical care for people with severe mental disorders (Department of Health, 2014a).

The NDIS offers a different funding model and method for integrating services, with the main focus of care being on the individual with lived experience of mental illness. This approach illustrates a type of bottom-up model in which the integrated team will be determined by the individuals' needs and choices. The NDIS is currently being piloted and implementation of its various components (including the proposed coordination of the *PIR* and *PHAMs* initiatives through the NDIS) will need to be evaluated in the future.

However, it should be noted that funding and financing arrangements were not a focus of this review. Therefore, these brief comments do not reflect a considered investigation of the literature pertaining to these factors.

Infrastructure and resources

Infrastructure has been described as a key building block for the Australian Government since the introduction of the *National Primary Health Care Strategy* (Commonwealth of Australia, 2010) and the theme is strong throughout international practices (e.g. Ministry of Health, 2012). Infrastructure can be considered in terms of physical resources (e.g. co-location, sufficient space in a practice, capacity for eHealth technologies and shared IT systems), workforce resources (e.g. capacity building, training), creation of a single point of entry in the system, and social networks (e.g. encouraging shared decision making and knowledge exchange) (WHO and CGF, 2014a).

One of the overarching goals of the *Rising to the Challenge plan* in NZ pertains to developing infrastructure to support better integration across primary and specialist mental health services (Ministry of Health, 2012). As a result of working towards this goal, practical barriers have been identified for building infrastructure. These include "a lack of office space available, differences in eligible populations, separate IT systems, variable workforce capacity and a lack of monitoring of mental health and addiction responses within primary care settings" (Ministry of Health, 2012, p 18). Methods of addressing these challenges relate to use of sharing knowledge through consultation and liaison services or telephone advice, shared care arrangements, telemedicine, and delivery of specialist services via co-location at primary care sites (Ministry of Health, 2012). Adequate space and resources (rooms, computers) are required for co-located services; and sufficiently trained professionals to manage the workload in a timely manner (Lee et al., 2012).

In Australia, there have been challenges in developing the infrastructure to support the roll-out of a personally-controlled electronic health record. There are geographical limits which have presented barriers to the installation of a national broadband network which would support the technology required to enable effective telehealth and sharing of electronic health records. Electronic health records offer a potential mechanism for connecting health professionals across sectors but face

challenges relating to governance, incentives, value propositions, compatibility of systems, accuracy of data, motivation to join a network, and availability and speed of internet connection and software (Royle et al., 2013). Future implementation of shared electronic health records needs to directly target these barriers. Specifically in relation to applicability to mental health, engagement and effective consultation with relevant stakeholder groups including PHC providers, hospitals and specialists, and potentially some social service providers, will be crucial (Royle et al., 2013).

Investment in resources and ongoing evaluation is important even after good relationships and joint service partnerships have been established. In particular, fidelity to core principles is likely to be eroded if routine data collecting and monitoring of performance are not undertaken (e.g. *Housing First* models of supported employment, see page 47).

Access

Integrating services is a positive goal but there will be no patient or population benefits if individuals cannot gain access to mental health care services. Emergency departments are constantly aiming to improve waiting times for receipt of services, and mental health care services in PHC and the community could use similar targeted goals. Recently the NHS in England announced waiting time standards for mental health, aligning mental health needs and service provision with physical health care (Department of Health, 2014b).

Access also relates to issues of parity. Given the understanding presented in this document that PHC is an ideal place for mental health care to be delivered, the need for parity between physical and mental health care needs to be considered. Overall the concept of parity relates to an acknowledgement that mental health is integral to overall health and, consequently, should be adequately supported. That is, there are resources, infrastructure and funding arrangements that relate specifically to physical health access; mental health care requires the same consideration and level of investment. Further, to ensure parity it is important to explore referral pathways that allow GPs to easily obtain mental health services for individuals who need this type of assistance. It has been suggested that the focus on physical health needs over mental health discourages help-seeking and increases stigma (Shern et al., 2009). The emphasis needs to be on equivalence in timely access and high-quality care for both physical and mental health care.

Co-location

Co-location is often considered to be an important strategy for integration, with primary mental health services located in the same premises as GPs and other PHC workers (e.g. allied health practitioners). However, co-location is not a panacea. In South Australia, Lawn et al. (2014) conducted an evaluation of a GP Plus Health Care Centre, which was funded as an inter-professional education and inter-professional practice (IPP) project. The Centre was “a community health service with over 250 community health care staff from a range of resident agencies including primary health care, mental health (adult and youth), dentistry, allied health, pathology, and youth services; and visiting services including sexual health, drug and alcohol counselling, chronic disease and medical outpatient clinics” (p 1). Lawn et al. found that there were significant barriers to integration: infrastructural impediments to collaboration, territorialism, and “IPP simply not on the agenda” (p 5):

Co-located health service systems can be complex, with competing priorities and differing strategic plans and performance indicators to meet. This, coupled with the tendency for policy makers to move on to their next issue of focus, and to shift resources in the process, means that adequate time and resources for IPP are often overlooked. Shared interprofessional student placements may be one way forward.

While co-location has been described for health, considering co-location of other types of services might be an enabler for further integrated practices. For example, situating relevant services in homeless shelters and drop-in centres may be a beneficial method for improving integration between mental health and non-health parties.

Organisational culture

Differences in organisational culture can be problematic to delivery of integrated services if the differences in values, goals and priorities of the organisations are not considered, particularly where evidence-based practices appear to conflict with historical practices (Waghorn et al., 2012a). It has been said that “services will work in more collaborative ways if there is greater understanding and respect across and within sectors” (Commonwealth of Australia, 2009, p. 42). This includes respectful communication (Commonwealth of Australia, 2009), and respect for different professions’ roles and skills (Kates et al., 2011). In an evaluation of Victorian Primary Care Partnerships, Mitchell (2009, cited in Banfield et al., 2012) suggested that the lack of clarity related to roles and responsibilities between non-health and social services providers may be due to competing agendas, cultural and value differences; and these factors lead to jurisdictional conflicts between Commonwealth and State-funded services.

Respectful communication

In reviews of international literature around care coordination, Powell Davies and colleagues (2006) noted that, while systems to support coordination of care were a commonly used strategy relating to chronic disease management, communication between service providers was the most common integration strategy applied in relation to mental health. Effective communication is the cornerstone of integrated health care. This might be electronic communication with referrals and shared records or it might relate to face-to-face meetings, governance teleconferences, or corridor conversations in co-located practices.

A further aspect of respectful communication relates to confidentiality and privacy. It can be a challenge to share information across providers, particularly through electronic means, under the current confidentiality laws (Commonwealth of Australia, 2009).

Referral processes

Referral pathways are a crucial element in stepped care approaches, COC, shared information and decision making. As noted in the ATAPS projects, referral processes may take a number of forms. Referrals to different practitioners may occur through use of a voucher system, where vouchers are given to consumers by gatekeepers; a brokerage system where one health professional refers to an agency which then allocates a referral to another health professional; a register system where lists of available health providers are offered to referring practitioners; or direct referral where one health professional refers a consumer directly to another (Pirkis et al., 2006). People with lived experience of mental illness receive referrals both within health sectors and across health sectors. COC is founded on appropriate referral processes and ongoing relationships with PHC providers (Reilly et al., 2012). In developing integrated care, providing the infrastructure which enables this form of communication is vital. For example, currently, Medicare Locals, which are fund-holders for ATAPS, supply forms for electronic referrals between GPs and psychologists (Australian Government Department of Health, 2014a). As the proposed primary health networks are rolled out in 2015, the format and processes for these referrals may be affected. Further, establishing referral pathways is only one step in the process. It is essential to have appropriate and available referral options for people to be referred to. This may be particularly problematic in areas where there is poor distribution of services (e.g. rural and remote areas).

Inter-professional education

It has been suggested that it is important to consider education of students in collaborative practices and inter-professional education so that primary care physicians are competent in mental health care (Kates et al., 2011). This also involves emergency department staff and police being trained to recognise mental health issues. Further, it includes helping PHC staff to both develop their skills in dealing with mental health issues, and recognise the roles of other allied health professionals. In Australia, interdisciplinary education has been an important component of the Mental Health Professionals Network (Fletcher et al., 2014).

Stigmatisation and discrimination

Although there are many well-established initiatives promoting mental health and wellbeing, improving understanding and awareness of mental illness (e.g. *beyondblue*), people with lived experience of mental illness are often stigmatised and experience discrimination in access to employment and housing. This requires a combined effort of training frontline workers in the employment and housing sectors, as well as strengthening recruitment and retention strategies in ways that reduce stigmatisation.

Efforts to reduce stigmatisation and discrimination in the workplace towards people with lived experience of mental illness are also needed. At times of labour pressures, the availability of suitable roles may be limited; and employers may be less inclined to employ someone with a mental health condition if they perceive it as an extra stressor in a difficult labour market (Lee et al., 2012). Support is needed for employers who employ individuals with recognised mental illness (e.g. modified work, employee assistance schemes).

Data collection and quality

Decisions to integrate and who to connect with need to be based on evidence. Data needs to be collected for quality improvement, for monitoring of achievements and for records of actions. A common challenge with the collection of mental health-related data is the tendency for results from specific populations to be generalised to broader populations. For integrated care to be successful, it needs to be based on valid, high-quality evidence.

Canada, the Netherlands and Australia have made collecting data a priority to improve processes, establish accountability, share knowledge and evaluate activities (Commonwealth of Australia, 2009, Forti et al., 2014, Mental Health Commission of Canada, 2012). NZ has a similar focus with the formulation of the Programme for the Integration of Mental Health Data. This is a Ministry of Health project, established in 2008, which has created a single national mental health information collection by integrating data from the district health boards and non-government organisations. The available data illustrate the types of services being provided, by whom, and outcomes being achieved (Ministry of Health, 2013b).

The need for high-quality data and evidence is becoming increasingly important with rising prevalence of multimorbidity, which reflects a cumulative effect of health problems rather than an additive one. The very nature of multimorbidity suggests that experiences will be different for every individual, hence designing integrated models of care needs to take into account whether it is better to apply a multifaceted approach, or focus on the individual elements of the person's situation for which there is precedence (Behan et al., 2014).

Summary and discussion

Mental health is a key social and public health issue, contributing substantially to Australia's burden of disease and assuming high proportions of the total disease expenditure. Both high and low-prevalence mental conditions are complex and multifaceted; thus support for these conditions requires collaborative, multisectoral responses. International health policies consistently highlight the drive for integrated mental health care.

There are several challenges in reviewing the literature on integration and integrated care, including: inconsistent nomenclature (multiple synonyms and different meanings for the same terms); a high degree of heterogeneity in the use of models and mechanisms for integrating care; and blurred distinctions between macro, meso and micro levels of the health care system. There is also a tendency for policies, organisations and stakeholders to act across multiple levels of integration. Although health policies illustrating top-down recommendations are accessible, most evaluations of integrated care, where available, exist at the micro level.

There has been some good quality research exploring integrated mental health care. In particular, two systematic reviews highlighted system-level intersectoral linkages between mental health and non-clinical services (Whiteford and McKeon, 2012) and collaborative care models addressing comorbidity among adults with severe mental illness (Lee et al., 2012). Additional evidence illustrates some valuable examples across the four different levels of integrated mental health care examined in this review. For example, the use of financial incentives in both the *Better Access* initiative and *ATAPS* encourages integration between primary mental health and primary physical health, and primary mental health and secondary and tertiary sector mental health services. Effective referral pathways and shared medical records provide illustrative examples of valuable strategies to support integration across primary mental health and secondary and tertiary physical health services. Finally, government initiatives such as the *PIR* programme offer a wrap-around, cross-sectoral approach that addresses mental health and non-health needs.

Consistently, research highlights a number of key barriers and associated facilitators to successful integration. Such factors for consideration include local context, engagement and partnerships, governance and leadership, sustainable financing models, infrastructure and resources, organisational culture, respectful communication, inter-professional education, stigmatisation and discrimination, and data collection and quality.

Critical elements for successful programmes and partnerships that cross sectoral boundaries (Banfield et al., 2012) include:

- Effective leadership and governance
- Appropriate flexible funding models
- Sustainability beyond short-term projects.

Evidence also suggests that cross-agency or cross-sectoral collaboration is facilitated when there are mutual advantages (Fletcher et al., 2009), such as:

- Client outcomes are enhanced by working collaboratively rather than independently
- Resources, expertise or leadership is shared to achieve cross-cutting goals
- Costs are reduced by sharing resources and expertise
- Collaboration leads to opportunities to improve skills, status or professional reputation.

At the macro level, partnerships between Government departments and/or levels of Government enhance collaboration by increasing access to resources (e.g. *HASI* – jointly funded by NSW Housing and NSW Health). At the meso organisational level, collaboration is more effective when roles, responsibilities and expectations are clearly defined and communicated. Memoranda of understanding, service agreements and joint governance arrangements are enablers.

The available evidence on integrated mental health care shows some promising strategies and highlights the value in multidisciplinary teamwork for improving both patient outcomes and health system costs. However, generally there is limited up-to-date evidence available. Future research needs to consider updating data on mental health prevalence, evaluating translation of policies into practice, focusing on what increasing multimorbidity might mean for cross-sectoral care, and exploring both effectiveness and cost-effectiveness of initiatives. Moreover, evaluation to assess the elements of care coordination and COC are essential. However, progress/improvement is difficult to determine if measures are not well-designed to assess changes and appropriate data are not routinely collected.

Although the benefits of integration are widely accepted in Australia and internationally, operationalising integration raises a number of issues that need to be considered (Flatau et al., 2010):

- Integrating services may incur high establishment and ongoing costs; is resource-intensive and time-consuming
- Organisations and agencies have different cultures, processes, priorities and goals; and it can be difficult to reach a mutual understanding.
- A partnership between agencies may be difficult to establish and maintain, unless all parties are prepared to adapt and forego traditional independent ways of working
- Substantial goodwill and strong leadership is needed to maintain integrated care arrangements
- In some cases, specialisation of services that have been developed over time within an organisation may be compromised in an integrated care arrangement; and strategies are needed to avoid losing the quality and intensity that a specialised service can deliver
- Funding and governance of services, which is typically undertaken at an individual programme level, needs to be expanded to include integrated programmes.

When specific agencies and organisations providing services for people with lived experience of mental illness recognise the limits of their capacity to deal with clients' needs, it makes intuitive sense for them to reach across their organisational boundaries to work with other agencies that do have the needed resources or expertise. Well-developed policies that facilitate such inter-sectoral partnerships and collaborations are essential for delivering seamless pathways to good health and wellbeing. Policy considerations may apply across a range of themes. First, issues of engagement and infrastructure relate to the development of cross-sectoral compatible technologies; involving consumers in the design and plan of policy and practice; providing support for high-prevalence and low-prevalence conditions; and enabling co-location of services where appropriate. Second, funding and financing models, which differ across countries, may provide a potentially useful policy lever for improving quality of care and savings in national health budgets. This includes the design and support of financial incentives for multidisciplinary cross-sectoral teamwork, involving a range of different professional groups, and providing inter-professional education. Third, it is necessary to consider how the implementation of macro level strategies will influence micro level practices. For example, can policies be developed to encourage a 'no wrong door' approach to joint planning across health, hospital and community services? Finally, it is important to learn from international practices. Around the globe, different countries are implementing public health, systems level and whole-of-government approaches to tackle issues of integrating mental health care (WHO and CGF, 2014a).

There are lessons from each of these methods that could be applied in the Australian context; for example, increasing public awareness of issues; planning for a long-term future; measuring key mental health indicators; and coordinating multisectoral leadership.

Mental health is a priority for health systems internationally. Mental disorders present complex challenges for health and non-health services and people with lived experience of mental illness alike. In order to provide effective, streamlined care centred on individuals' needs, it is important to improve integration between the primary, secondary and tertiary sectors, and across mental health, physical health, and non-health services.

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Appendices

Appendix A Search terms

Search terms used were:

primary health care	mental health	integrat*	employment	Australia
primary care	psychiatric service*	intersectoral	vocational	New Zealand
	mental health service*	multiagency	education	Netherlands
	mental health system*	interagency	accommodation	Dutch
		partnership*	residential	England
		barrier	housing	Britain
		facilitat*	welfare	British
			income	United Kingdom
			disability	UK
			community	Canada

PubMed

(Psychiatric Service* OR Mental Health Service* OR Mental Health System*) AND (Employment OR Vocational OR Education OR Accommodation OR Residential OR Housing OR Welfare OR Income OR Community OR Disability) AND (Link* OR Integrat* OR Intersectoral* OR Multiagency OR Interagency OR Partnership* OR Reform*) AND (Outcome* OR Effect* OR Impact* OR Challenge* OR Barrier* OR Facilitat*)

Cochrane Library

“mental health” primary integrat* (Title, Abstract, Keywords)
 “mental health” primary collaborat* (Title, Abstract, Keywords)
 “mental health” integrat* GP (Title, Abstract, Keywords)
 “mental health” collaborat*GP (Title, Abstract, Keywords)
 “mental health” integrat* “general practi*”
 “mental health” collaborat* “general practi*”
 psych* primary integrat* (Title, Abstract, Keywords)
 psych primary collaborat* (Title, Abstract, Keywords)
 psych integrat* GP (Title, Abstract, Keywords)
 psych collaborat*GP (Title, Abstract, Keywords)
 psych integrat* “general practi*”
 psych collaborat* “general practi*”

Informit

primary

integration collaboration

“mental health”

Australia Zealand Netherlands Dutch England Britain British United Kingdom UK Canada

Google Scholar

primary

integration collaboration

“mental health”

Australia Zealand Netherlands Dutch England Britain British United Kingdom UK Canada

Appendix B Glossary

Term	General definition
comorbidity	The presence of one or more illnesses (or diseases) in a person, in addition to a primary disease or disorder; for example, chronic lung disease and diabetes.
collaboration	A mutually beneficial and well-defined relationship entered into by two or more people or organisations to achieve common goals.
high-prevalence disorders	Any disorder that is common in the population (e.g. asthma, arthritis). Specific mental health examples include anxiety disorders (e.g. phobias, post-traumatic stress disorder), affective (mood) disorders (e.g. depression), and AOD problems.
horizontal integration	Connecting systems, organisations or providers acting on the same level i.e. PHC sector acting in collaboration with the social care and community sectors.
integration	Bringing together individuals and organisations representing different sectors/fields to align practices and policies and to enhance access to quality health care.
low-prevalence disorders	Any disorder that is relatively uncommon in the population (e.g. cystic fibrosis). Specific mental health examples include schizophrenia and related disorders, bipolar disorder, depression with psychotic features, delusional disorders, and acute transient psychotic disorders.
macro level	The policy/systems level: relates to political-economic contexts, institutional arrangements, and the levels at which decision making takes place.
macro level integration	Integration across systems, which may include: coherence of policies and legislation; cross-sectoral partnerships and agreements; and joint administrative, planning and funding arrangements.
mental health services	A range of services, including counselling, pharmacological treatments, referrals and follow-up care, provided by health professionals in PHC settings (e.g. general practice) to treat or prevent mental health problems.
mental illness	Disturbances of mood or thought that can affect behaviour and distress for the person or those around them, so the person has difficulties in daily life functioning.
meso level	The organisation level: relates to structuring factors and interactions between groups.
micro level	The individual level: relates to behaviours of individuals and their interactions with others.
non-government organisation	A non-profit group, not part of a government or traditional for-profit business; task-oriented and driven by people with a common interest.
partnership	Broad term used to describe working with other organisations.

Term	General definition
person with lived experience of mental illness	A person who has a mental illness that has affected their life; sometimes referred to as a mental health 'consumer' (a term accepted by some people with lived experience but rejected by others).
prevalence	The proportion of people in a population who have a condition at a certain point in time (point prevalence) or period (e.g. 12 months) in time (period prevalence), or in their lifetime (lifetime prevalence).
primary care	Predominantly used to refer to primary medical care, family practice or general practice.
primary health care	Usually the first level of contact people have with the health system. Relates to the parts of the system that focus on protecting and promoting the health of people in communities.
primary health care mental health services	Mental health services provided in PHC settings by any PHC professional (most commonly GPs).
referral	Process in which a health worker at one level of the health system, with insufficient resources to manage a condition, seeks the assistance of someone at the same or a higher level to assist with or take over management of the case.
recovery	Personal process of changing attitudes, values, feelings, goals, skills and/or roles. Includes development of new meaning and purpose and a satisfying and contributing life.
secondary mental health care	Specialised mental health services, with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental illness or a disability arising from their illness, e.g. community mental health services, private psychiatrists.
tertiary mental health care	Hospital-based specialist mental health services (both inpatient and outpatient).
vertical integration	Connecting systems, organisations or providers acting on different levels i.e. primary and secondary/tertiary mental and physical health services.

Sources: (Lourey et al., 2012, Lourey et al., 2013, Oliver-Baxter et al., 2013a)

Appendix C History of Australian policy initiatives

Table 5 Australian policy initiatives relevant to primary mental health care

1991	<i>Principles for the protection of persons with mental illness and the improvement of mental health care</i> (Office of the High Commissioner for Human Rights, 1991)
1991	Mental Health Statement of Rights and Responsibilities (Australian Health Ministers, 1991)
1992	<i>National Mental Health Policy</i> (Australian Health Ministers, 1992b)
1992	<i>National Mental Health Plan</i> (Australian Health Ministers, 1992a)
1993	<i>Human Rights and Equal Opportunity Commission Report of the National Inquiry into the Human Rights of People with Mental Illness</i> [Burdekin report] (Human Rights and Equal Opportunity Commission, 1993)
1994	<i>First National Mental Health Report</i> (Commonwealth Department of Health and Family Services, 1994)
1996	<i>Future directions in Aboriginal and Torres Strait Islander Emotional and Social Well-Being (Mental Health) Action Plan</i> (Office for Aboriginal and Torres Strait Islander Health Services, 1996)
1997	National Survey of Mental Health and Wellbeing (NSMHW)
1997	Evaluation of First National Mental Health Plan (AHMAC, 1997a)
1997	<i>National Standards for Mental Health Services</i> (AHMAC, 1997b)
1998	<i>Mental health and wellbeing: Profile of adults, Australia, 1997</i> (McLennan, 1997) [ABS report of NSMHW]
1998	<i>Second National Mental Health Plan (1998-2003)</i> (Australian Health Ministers, 1998) launched, and <i>National Mental Health Strategy</i> reaffirmed
1998	<i>Primary care psychiatry: The last frontier</i> (Joint Consultative Committee in Psychiatry, 1997)
1999	<i>People with psychotic illnesses</i> (low-prevalence component of NSMHW) (Jablensky et al., 1999)
1999	<i>The Mental Health of Australians</i> (Andrews et al., 1999) [Commonwealth Department of Health and Aged Care report of NSMHW]
2000	<i>Application of rights analysis instrument to Australian mental health legislation</i> (Watchirs, 2000)
2000	<i>beyondblue: the national depression initiative</i>
2001	<i>Better Outcomes in Mental Health Care</i>
2003	Evaluation of <i>Second National Mental Health Plan</i> (AHMAC, 2003)
2003	<i>National Mental Health Plan 2003–2008</i> (Australian Health Ministers, 2003) launched, and <i>National Mental Health Strategy</i> reaffirmed
2004	<i>Social and emotional well being framework: A National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004-2009</i> (Social Health Reference Group and National Mental Health Working Group, 2004)

Table 5 (cont) Australian policy initiatives relevant to primary mental health care

2004	<i>GP Psych Support</i> (component of <i>Better Outcomes</i>)
2006	Senate Select Committee on Mental Health final report: <i>A national approach to mental health – from crisis to community: Final report</i> (Select Committee on Mental Health, 2006)
2006	<i>National Action Plan on Mental Health 2006-2011</i> (COAG, 2006)
2006	<i>Better Access to Psychiatrists and General Practitioners through the Medicare Benefits Schedule</i>
2007	Mental Health Nurse Incentive Programme
2008	<i>National Action Plan for Mental Health 2006–2011. Progress report 2006–07</i> (COAG, 2008)
2008	<i>National Perinatal Depression Initiative</i>
2008	Senate Standing Committee on Community Affairs (2008) report: <i>Towards recovery: Mental health services in Australia</i>
2009	<i>National Mental Health Policy 2008</i> (Commonwealth of Australia, 2009)
2009	<i>The mental health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing 2008</i> (Slade et al., 2009b)
2009	<i>Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009–2014</i> (Commonwealth of Australia, 2009)
2011	National Mental Health Commission
2012	Partners in Recovery programme
2014	National Mental Health Commission Review of Mental Health Services and Programmes

Appendix D Aspects of integration

Table 6 Matrix of integration dimensions and levels of integration

	<i>Intensity of integration continuum</i>				
	← informal			formal →	
Dimensions	Information sharing & communication	Cooperation & coordination	Collaboration	Consolidation	Integration
Partners					
Target population					
Goals					
Program policy & legislation					
Governance & authority					
Service delivery system model					
Stakeholders					
Planning & budgeting					
Financing					
Outcomes & accountability					
Licensing & contracting					
Information systems & data management					

Source: (Konrad, 1996)

Table 7 Continuum of collaborative strategies

Stage	Details
Information sharing	Relationships between agencies are not formally structured. Agency representatives may share general information about programmes, services, and clients. Communications may be less frequent or ad hoc. Activities may include sharing informational brochures, educational presentations, newsletters, or joint staff meetings.
Cooperation & coordination	Cross-agency activities are somewhat more structured. Agencies may work together to change procedures or structures to help make programmes more successful. Activities may include reciprocal client referrals and follow-up processes, verbal agreements to hold joint staff meetings, mutual agreements to provide priority responses, or joint lobbying for legislative change or funding requests.
Collaboration	Although temporary or brief collaboration can operate informally, ongoing collaborations are usually more structured. Autonomous agencies and programmes work together with a common goal, product, or outcome. Examples include partnerships with written agreements, goals, formalised operational procedures, and possibly joint funding, staff cross training, or shared information systems.
Consolidation	Consolidated systems may be those under an umbrella organisation or those with some centralised functions (e.g. programme or financial administration). Line authority for programmes or services is contained within different divisions or agencies. Cross-programme collaboration, coordination, cooperation, and information sharing are more frequent and often more structured activities. An example might be a government agency with responsibility for different human service programmes.
Integration	A fully integrated system has a single authority, with a comprehensive scope and collective operation. It addresses individual client needs; is multi-purpose and cross-cutting; has transparent categorical lines with fully blended activities and pooled funding. Clients perceive service delivery as “seamless,” with little or no organisational barriers to access. An example might be a one-stop agency with unified intake and assessment, case management and many services provided in one location. Management and operational decisions are the responsibility of a single entity.

Source: (Konrad, 1996)

Appendix E Cross-country comparisons of mental health systems

Table 8 Cross-country comparisons of mental health systems

	Australia	Canada	England	Netherlands	New Zealand
<i>Contribution of neuropsychiatric disorders to global burden of disease</i>	29.4%	33.9%	31.4%	30.8%	24.8%
<i>Suicide rate</i>	Males 16.7 per 100,000 Females 4.4 per 100,000	Males 16.8 per 100,000 Females 5.5 per 100,000	Males 10.1 per 100,000 Females 2.8 per 100,000	Males 11.6 per 100,000 Females 5.0 per 100,000	Males 18.9 per 100,000 Females 6.3 per 100,000
<i>Key policies</i>	Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009-2014 States and territories have own policies e.g., South Australia's <i>Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012</i>	Mental Health Strategy for Canada: Changing Direction, Changing Lives Provinces and territories have own legislation e.g. Alberta Mental Health Act	No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages	National Agreement on the Future of Mental Healthcare 2013-2014	Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017
<i>Governance</i>	Federal government funds and supports PHC and some national specialist services e.g. beyondblue and headspace.	National government supports mental health services for a subset of populations e.g. First Nations and Inuit population, military	Department of Health sets policy for the National Health Service (NHS). NHS provides mental health services. Local Health and Wellbeing Boards are	Ministry of Health, Welfare and Sport's role is stewardship, monitoring rather than directing. The Dutch Association of	The Ministry of Health is responsible for advising government, implementation of government policy through collaborative efforts with

	Australia	Canada	England	Netherlands	New Zealand
	State/Territory governments fund and support hospitals and community health services.	personnel, federal inmates, public servants. Provincial and territorial jurisdictions govern mental health services.	responsible for bringing together local organisations to work in partnership.	Mental Health and Addiction Care (GGZ Nederland) is the sector organisation of specialist mental health and addiction care providers.	District Health Boards and for the administration of mental health legislation. District Health Boards coordinate services at local level.
<i>Mental health expenditure (2011)</i>	7.6% of total health budget	7.2% of total health budget	10.8% of total health budget	10.7% of total health budget	10.0% of total health budget
<i>Funding</i>	Mental health-related GP and specialist consultations are reimbursed by Medicare (universal health coverage). Inpatient admissions to public hospitals are free and funded through intergovernmental hospital funding agreements.	Universal health coverage for physician-provided care in hospital or primary care (Medicare). Provinces and territories fund community services. Private health insurance covers services not funded under public programmes.	Most services are funded through the NHS (services are free), or by local authorities (some services subject to means testing). Clinical commissioning groups are responsible for planning and purchasing services. Residential care is partly funded through NHS and partly through the private sector.	Compulsory to subscribe to health insurance policy but patients choose insurers and providers. System funded through Health Insurance Act, Exceptional Medical Expenses Act, Act for Social Support, Ministry of Security and Justice, subsidies and budgetary transfers. Health insurance covers outpatient (primary and secondary) and inpatient mental health care (first 365 days, then funded through Exceptional Medical Expenses Act).	Health system funding comes through Vote Health, government agencies, private insurance and out-of-pocket payments. Three quarters of VoteHealth funds is allocated to District Health Boards who fund community and institutional care for mental health needs. Government provides free inpatient and outpatient public hospital services, and disability support for most people. In 2014 new policies provided extra funding for GPs to enable them to work

	Australia	Canada	England	Netherlands	New Zealand
					with other health care professionals in offering mental health care.
<i>Privately-funded care</i>	Private insurers subsidise admissions to private hospitals.	Private insurance covers rehabilitation services, home care, private rooms in hospitals, some non-physician consultations (e.g. psychologists - there are few publicly funded psychotherapy and counselling options).	Approximately a quarter of mental health care hospital-based services are provided by the private sector. Private insurance also covers specialist consultations.	Services are mainly provided by the private sector.	Private insurers cover cost-sharing requirements, and private outpatient specialist consultations.
<i>Primary health care</i>	<p>GPs as gatekeepers (Medicare only reimburse specialists for consultations referred by GPs).</p> <p>GPs offer non-specialised services.</p> <p>Typically patients treated in PHC have less severe conditions.</p>	<p>Primary care professionals as gatekeepers.</p> <p>Multidisciplinary care common – care coordination models often include social workers and mental health workers.</p> <p>In some areas there are registered populations.</p>	<p>GPs act as gatekeepers to specialist care.</p> <p>GPs treat patients with less serious illnesses (e.g., mild depressive and anxiety disorders).</p> <p>Clinical commissioning groups (made up of doctors, nurses, other health professionals) commission most mental health services across primary and</p>	<p>GPs as gatekeepers (hospital and specialist care only accessed by referral).</p> <p>GP and health care psychologists main providers of diagnosis and treatment.</p> <p>Primary care providers use diagnostic tools to design patient-specific intervention programmes including eHealth and specific</p>	<p>GPs gatekeepers to specialist care.</p> <p>Primary care is site for treating patients with mild to moderate mental health needs.</p> <p>Patient registration is not mandatory but GPs require registration lists for government subsidies.</p>

	Australia	Canada	England	Netherlands	New Zealand
			<p>secondary sectors. Work closely with secondary care, allied health and community partners.</p> <p>General practices have registered populations.</p>	<p>provider consultations.</p> <p>Patients registered with GP of their choice.</p> <p>If patient does not have a DSM¹¹ diagnosis, may not receive GP support.</p>	
<i>Community</i>	<p>Community services have recently taken on more responsibility for services and resources than hospitals.</p> <p>Community-based mental health services and residential care facilities provide specialised support: crisis, mobile assessment and treatment services, day programmes, outreach services and consultation services.</p>	<p>Provinces/territories provide community mental health and addiction services.</p>	<p>Some advanced treatment is provided by community-based staff.</p> <p>Accommodation services are available in community e.g. supported housing, group homes, short-term hostels, family placement schemes.</p>	<p>Outpatient care is provided in outpatient and community day treatment facilities.</p> <p>Treatment for serious problems is ideally provided in the home setting. Over 200 Flexible Assertive Community teams (holistic, customised, client-centred teams) offer long term care for people not treated in psychiatric hospitals; providing treatment, guidance, practical assistance, rehabilitation and recovery support.</p>	<p>Individuals with long-term care needs are cared for in community settings, usually by non-governmental agencies providing support on contract to District Health Boards.</p>

¹¹ Diagnostic and statistical manual of mental disorders

	Australia	Canada	England	Netherlands	New Zealand
<i>Hospitals</i>	<p>In 2011 mental hospital expenditures by Australian Department of Health reflected 8.7% of total mental health budget.</p> <p>Provide specialised services through psychiatric hospitals, psychiatric units within general acute hospitals.</p> <p>There are 17 public psychiatric hospitals which treat and care for admitted patients with psychiatric, mental or behaviour disorders.</p>	<p>There are specialty psychiatric hospitals and general hospitals with adult mental health beds.</p>	<p>In 2011 mental hospital expenditures reflected 30.9% of the total mental health budget.</p> <p>Provide inpatient care, advanced treatment.</p> <p>There are general acute hospitals, psychiatric hospitals (public or private), and purpose built units. These offer care and support, and sometimes provide accommodation for acute psychiatric illness. Psychiatric intensive care units are also available.</p>	<p>In 2011, mental hospital expenditures reflected 59.2% of the total mental health budget.</p> <p>More care occurs in specialist hospitals than general acute care hospitals. There are a high number of psychiatric beds available across the country.</p>	<p>In 2011 mental hospital expenditures were 16.0% of the total mental health budget.</p> <p>NZ has one private psychiatric hospital but there are psychiatric beds available in general hospitals.</p>

Sources: (Health Canada, 2014, Boyle, 2011, Mental Health Commission of Canada, 2012, Ministry of Health, 2012, Thomson et al., 2013, WHO, 2011, Department of Health, 2014c, Ministry of Health, 2013a)

Appendix F Four-quadrant clinical integration model

Table 9 Four-quadrant clinical integration model

Mental health status/risk/complexity	Quadrant II <ul style="list-style-type: none"> • <i>High mental health needs/risk</i> • <i>Low physical health needs/risk</i> <ul style="list-style-type: none"> ➤ horizontal integration within PHC ➤ vertical integration within the mental health system 	Quadrant IV <ul style="list-style-type: none"> • <i>High mental health needs/risk</i> • <i>High physical health needs/risk</i> <ul style="list-style-type: none"> ➤ horizontal integration within PHC ➤ vertical integration within the mental health system ➤ vertical integration within the broader health system ➤ horizontal and vertical integration with the non-health sector
	Quadrant I <ul style="list-style-type: none"> • <i>Low mental health needs/risk</i> • <i>Low physical health needs/risk</i> <ul style="list-style-type: none"> ➤ horizontal integration within PHC 	Quadrant III <ul style="list-style-type: none"> • <i>Low mental health needs/risk</i> • <i>High physical health needs/risk</i> <ul style="list-style-type: none"> ➤ horizontal integration within PHC ➤ vertical integration within the broader health system
	Physical health status/risk/complexity	

Source: (Mauer, 2003)