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 (primarily 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 (e.g. population needs and availability of services)
- 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 (e.g. understanding of other organisations’ goals and priorities)
- Encouraging respectful communication
- Providing inter-professional education
- Reducing stigmatisation and discrimination
- Collecting adequate data that assess quality of care.

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 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 representing 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 on 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 about 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 not only enable effective referrals and shared health records across the PHC sector but also 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).

For more details, see Full Report.