

Literature scan: Primary Mental Health and Addiction Models and Services and their Impact

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Prepared for: Te Hīringa Mahara –
Mental Health and Wellbeing Commission

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Te Hiringa Mahara - Mental Health and Wellbeing Commission was set up in February 2021 and works under the Mental Health and Wellbeing Commission Act 2020. Our purpose is to contribute to better and equitable mental health and wellbeing outcomes for people in Aotearoa New Zealand.

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1 Summary

In mid-2024, Te Hiringa Mahara - the Mental Health and Wellbeing Commission initiated an international literature scan about primary mental health and addiction models and services, focusing on what is delivered and their impact. The project aimed to enhance understanding of the delivery, effectiveness, and cost-effectiveness of various existing models, providing context for the ongoing monitoring of the Access and Choice programme.

The literature scan included searching for primary mental health and addiction service delivery models in the peer-reviewed academic literature and online grey literature. To be eligible to be included in this review, models were required to: have been operationalised and described; have a focus on addressing mild to moderate mental health or addiction issues; and be accessible as an initial contact point. Twenty-seven models were identified within this scope (see [Appendix 1](#) for details). These included models that were population-based, targeted towards Indigenous and ethnic communities, youth-specific models, and those already delivered in New Zealand.

The literature scan initially focused on key questions related to the relative reach, effectiveness, and value for money of the models. Comparative analysis was not possible from the available literature, so the scan's scope pivoted to include broader insights about the identified models, which are intended to be useful in putting the Access and Choice programme in context.

The key insight areas included:

- Reach - the findings about reach of the models were largely limited to a count of how many places/centres delivered the services and how many people used the services, acknowledging that the population models reach more people than the targeted models,
- Effectiveness – of those models that have been evaluated, a wide range of evaluation approaches have been used, including Randomised Controlled Trial (RCT), diagnostic before and after measures, client satisfaction data, administrative data, and adherence to processes and workforce perception measures (the scan was not able to compare the identified models to determine which were the most effective), and
- Value for Money - the availability of the literature on the models' value for money was quite limited.

Broader insights about the models included those relating to model success factors, the cohorts who most benefit from the models, holistic approaches, integration approaches, agility and localisation, workforce roles and addiction/substance abuse.

2 Introduction

Te Hiringa Mahara has responsibility for monitoring mental health and addiction services and advocating for improvement to those services. During 2024 and 2025, the Commission developed a monitoring report of Access and Choice, five years after the programme's inception. The Commission will continue to monitor what has been delivered but will also focus on how the programme has contributed to changes in the system and to changing outcomes for tāngata whaiora.

The aim of the literature scan was to understand what is currently known about existing primary mental health and addiction service delivery models, with a focus on what is delivered and their impact. Examining other models and services can provide valuable insights and potential solutions that can inform design, delivery, monitoring and evaluation of primary mental health models such as Access and Choice. International examples often showcase innovative approaches, highlight best practices, and provide evidence on what has or has not worked in various contexts. These insights can accelerate the adoption of effective practices, avoid costly mistakes, and offer alternative strategies for addressing complex mental health and addiction challenges.

The literature scan is intended to contextualise the Access and Choice programme within the broader landscape of primary mental health and addiction service delivery models. By looking at how international models have been undertaken and what they have achieved, the Commission will be able to refine its understanding of the Access and Choice programme's effectiveness and identify opportunities for improvement. This literature scan is intended to support Te Hiringa Mahara in advocating for high-quality, effective, and sustainable mental health services that are responsive to the needs of tāngata whaiora.

2.1 The Access and Choice Programme

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction found that there was an urgent need to provide better access to, and more choice of, services (Mental Health and Addiction Inquiry, 2018). As part of the response, the Access and Choice programme was developed to provide free and immediate support for people with mild to moderate mental health and addiction needs. Significantly, Access and Choice represented a change to the way services were delivered: providing services and supports to anyone who needs them, as soon as they need them, in a range of primary care and community settings.

The Access and Choice programme includes four types of services:

- Integrated primary mental health and addiction services (IPMHA) – services based in general practices that are accessible to everyone enrolled in those practices. IPMHA has established new Health Improvement Practitioner, Health Coach, and Support Worker roles,
- Kaupapa Māori services - whānau-centred services delivered by Māori for Māori, using Mātauranga Māori (Māori knowledge)

- Pacific services - Pacific-led services designed to meet the needs of Pacific aiga (families) that incorporate Pacific cultural and spiritual values, beliefs, languages, and models of care, and
- Youth primary mental health and addiction services - flexible services that are delivered in spaces that are acceptable and accessible to young people aged 12-24 years (see Appendix 1 for more details).

3 Objectives and Methodology

This literature scan sought to identify primary mental health and addiction service delivery models and to address the following objectives:

1. Identify and describe primary mental health and addiction service delivery models in New Zealand and similar international jurisdictions, including those targeted towards Indigenous populations.
2. Compare these service delivery models using measures across -
 - a. Reach (including coverage, utilisation, and drop-out)
 - b. Effectiveness (including clinical outcomes, service user experiences)
 - c. Value for money (including resources and workforce used).
3. Identify common characteristics of service delivery models that support achievement of these measures.
4. Describe the quality of information available, including gaps in information.

For the purpose of this literature scan, service delivery models were defined as those that were operational rather than theoretical. This was a broad definition allowing inclusion of a very diverse range of models (from targeted community-based models through to population based very large-scale models).

More specifically, primary mental health and addiction service delivery model eligibility criteria included services that:

- are already being delivered (i.e., excludes pilots and discussion on innovations that could be delivered in the future),
- have an operational service delivery model that can be described (i.e., implementation rather than purely conceptual model),
- have a core purpose of addressing mild to moderate mental health or addiction issues that people present with (may be both chronic or acute but is not providing specialist care), and
- are accessible as an initial contact point (i.e., does not require a referral, may be primary health care or community).

The criteria used to identify relevant programmes are outlined in Table 1.

Table 1: Search eligibility and exclusion criteria

| Model type | Inclusions | Exclusions |
|------------------------|--|---|
| Population-based | <ul style="list-style-type: none"> ▪ Large scale operational service delivery models/programmes (detailed information on delivery approach available) ▪ Primary health services focus ▪ Mild to moderate mental health or addictions symptoms or diagnosis ▪ Broad focus on mental health and/or addiction services ▪ Population-based ▪ Programme established and currently operational ▪ Relevant jurisdictions (UK, U.S., Ireland, Australia, Canada, Singapore) | <ul style="list-style-type: none"> ▪ Conceptual models ▪ Severe mental health and/or addictions symptoms or diagnosis ▪ Secondary/tertiary specific services focus ▪ Narrow focus on one problem e.g., gambling ▪ Focus on a narrow demographic (e.g., older people) ▪ Programme still in pilot mode ▪ Focus on a specific type of practice (e.g., CBT), and ▪ Screening only |
| Indigenous | <ul style="list-style-type: none"> ▪ Targets Indigenous population | |
| Ethnicity specific | <ul style="list-style-type: none"> ▪ Targets specific ethnic groups | |
| Youth | <ul style="list-style-type: none"> ▪ Focus on youth | |
| Aotearoa / New Zealand | <ul style="list-style-type: none"> ▪ New Zealand specific Community or NGO lead ▪ Focus on youth ▪ Targets Indigenous populations ▪ Targets specific ethnic groups | |

Literature searches were undertaken by the three researchers using an iterative approach. Both academic and grey literature (available online) were included. As presented in Table 2, the identified service delivery models were grouped according to areas of focus.

There is considerable value in examining other primary mental health and addiction models and services, including those from other countries. However, methodologically, there are also factors that limit the extent to which those from overseas can be compared with each other and their applicability to the New Zealand context. Firstly, health systems differ widely between countries, particularly in terms of healthcare provision and funding.

For example, Reid (2009) identifies five national health system models—the Beveridge model, the Bismarck model, National Health Insurance, Out-of-Pocket, and Hybrid models—each with distinct structures and funding mechanisms (see Appendix 2 for more details and examples).

Secondly, countries vary significantly in terms of population demographics, cultural attitudes toward mental health, policy priorities, available funding, and workforce capacity. Furthermore, even among seemingly similar provision, important variations may exist, such as service location (community hubs, GP clinics, or standalone facilities), workforce roles and training levels, and timeframes and programme structure ranging from immediate one-off consultations to structured multi-week interventions that may require waiting periods of several weeks. As such, insights from other models and services need to be applied judiciously to the New Zealand context and take full account of Te Tiriti o Waitangi, and whānau, hapū, and Iwi.

Table 2: Model overview

| Population based models | |
|--|---|
| NHS Talking Therapies | Previously Improving Access to Psychological Therapies. Based on stepped care. Delivered in the UK |
| Prompt Mental Health Care (PMHC) | Adapted from Improving Access to Psychological Therapies. Delivered in Norway |
| New Access | Adapted from Improving Access to Psychological Therapies. Delivered in Australia |
| The Health Service Executive National Counselling Service (HSE NCS) Counselling in Primary Care Service (CIPC) | Time limited counselling for adults. Delivered in Ireland |
| Primary Care Behavioural Health Model (PCBH) | Behavioural health care integrated with primary care services within the same facility. Delivered in the U.S. (Key elements of the Access and Choice programme were adapted from this model.) |
| PCBH | Adapted from Primary Care Behavioural Health Model. Delivered in Sweden |
| The Integrated Health Hub (IHH) Model. | Blended co-location services, specifically reverse shared care, with an integrated team model. Delivered in Canada |
| Mental Health Primary Care | Integrated systems approach for primary mental health. Delivered in Western Australia |
| The Collaborative Care Model (CoCM) | Treats common mental health conditions in medical settings like primary care. Delivered in the U.S. |
| Screening, Brief Intervention, and Referral to Treatment (SBIRT) | Screening (quickly assessment); brief intervention and referral to treatment (as needed). Delivered in the U.S. |
| The St. Louis Initiative for Integrated Care Excellence (SLI2CE) | Seamless integration of services based on a collaborative care model. Delivered in the U.S. |
| Doing Well | Primary care service for people with common mental health problems provided by healthcare worker. The first contact is a telephone assessment. Delivered in Scotland |
| Indigenous models | |
| Mental Wellness Teams | Community-based, multidisciplinary teams. Delivered in Canada |
| American Indian Health and Family Services | Medical clinic that provides services to all people in need. Delivered in the U.S. |
| Aboriginal and Torres Strait Islander Mental Health Programme | Funds primary health networks to engage culturally appropriate, evidence-based mental health services for Aboriginal and Torres Strait Islander people. Delivered in Australia |

Table 2: Model overview (continued)

| Ethnicity specific models | |
|---|---|
| Black Minds Matter | Talking therapy for Black people. Delivered in the UK. |
| Up My Street Project | Street therapy supporting African Caribbean men. Delivered in the UK |
| Youth specific models | |
| Integrated Child and Youth (ICY) Teams | Multidisciplinary, collaborative team-based approach. Delivered in the UK |
| headspace | Centres for delivery of enhanced primary care youth mental health services. Delivered in Australia |
| Youth Wellness Hubs | Hubs that offer walk-in access to youth-centred, community-based mental health and wellness services. Delivered in Ontario, Canada |
| Foundry | Individualised, integrated health and social services. Delivered in Canada |
| Jigsaw | Early intervention, primary care service for young people. Delivered in Ireland |
| Aotearoa / New Zealand models | |
| Gumboot Friday | Free counselling service for any young person aged 25 and under. Delivered in New Zealand |
| Mana Ake: Mana Ake – Stronger for Tomorrow | Holistic mental health and wellbeing initiative available to primary schools. Delivered in Canterbury, New Zealand |
| Youth One Stop Shop (YOSS) | Youth-focused community-based centres providing a range of primary healthcare and social/developmental services. Delivered in New Zealand. |
| Primary Mental Health Initiatives | Range of initiatives that created new roles and positions in primary care, the most common being that of a primary mental health coordinator/nurse. Delivered in New Zealand. |
| Wairua Tangata Programme | Integrated, flexible, holistic, tikanga Māori-based therapeutic service targeting underserved Māori, Pacific and Quintile 5 populations. Delivered in Hawkes Bay, New Zealand |

4 Insights

At the conception of the literature scan, insights were sought relating to the reach, effectiveness, and value for money of the identified models. The intent was to use these insights to compare existing models and identify which had the greatest impact and achievement. However, common measurement tools and meta-analysis have not been used across the models to assess reach, effectiveness or value for money, resulting in an inability to compare these aspects across models.

Having determined that the literature scan was unable to definitively determine which of the models had the greatest impact and achievement, the focus of the literature scan pivoted. While the primary goal of understanding existing models remained, broader insights that were relevant to understanding differences across primary mental health service delivery models were included. The following sections describe these insights, all of which are intended to be relevant in consideration of the delivery of primary mental health services in the context of New Zealand.

4.1 Reach

The analysis of each model's reach was largely limited to a count of how many places or centres delivered the services and how many people used the services. Predictably, the population-based models tended to reach larger numbers of people, but there were gaps in their reach (with lower take up from some groups of people). The targeted models tended to be smaller in scale and reached fewer people but drew in 'harder to reach' people via their tailored approach.

The scale of reach from some of the population-based models was very large, demonstrating that many people can be reached by population-based models rolled out by public health systems. For example, the NHS Talking Therapies service recently received over 1.7 million referrals in a single year (NHS, 2024). Similarly, headspace has achieved a high reach through 150 youth-focused services across Australia (Rickwood et al., 2023).

Notably, the population-based models sometimes struggled to reach some groups of people. For example, although the NHS Talking Therapies service reportedly reached many people, Black and minority ethnic groups were less likely to access the services (National Collaborating Centre for Mental Health, 2023). Similarly, even when intentionally targeting rural males, Australia's NewAccess service (based on the NHS Talking Therapies model) did not reach as many males as they had intended (Ernst & Young, 2015).

Service delivery models that were targeted towards specific groups tended to be community-based, holistic in their design, and delivered on a smaller scale. For example, the Wairua Tangata Programme located in the Hawkes Bay aimed to provide an integrated, flexible, holistic, tikanga Māori-based therapeutic service. It has been successful in reaching Māori, and it has achieved low non-attendance rates (Abel et al., 2012). The trade-off with targeted approaches is that they intentionally reach a smaller number of

people. Another example, Foundry (individualised health and social services to young people in Canada), is only available in 11 physical centres (soon to be 23) (Barbic et al., 2024).

Factors that have been found to limit the reach of primary and mental health care models included reliance on a scarce workforce, insecure funding, and other challenges. In Canada, Mental Wellness Teams blend traditional, cultural and population-based approaches to provide mental wellness services to First Nations communities (First Peoples Wellness Circle, 2024). The Office of Audit and Evaluation (2016) found that several factors had constrained the the Mental Wellness programmes, including resource challenges (funding amounts remaining largely unchanged over many years), short term funding cycles, high turnover of programme staff in the communities, lack of integration among Mental Wellness programmes, insufficient funding flexibility in community programming and insufficient data to assess performance. In the UK, the free culturally appropriate talking therapy for Black people delivered by Black Minds Matter is not currently available due to lack of funding (Black Minds Matter UK, 2024).

Some of the smaller models identified were noticeably insecure in their support and funding. When searching the literature, there were many times we would find mention of a relevant model (particularly in the Indigenous and ethnic specific space) only to have the search for further information 'go cold', sometimes indicating a model was only in place for a limited time (see for example, Up My Street Project). This was almost always for the targeted population models.

Significantly, a common measurement tool has not been used across the models to assess reach, resulting in the inability to compare reach across models. Similarly, no reach-related meta-analyses were identified. However, the scan did identify models with wide reach and models that sought to reach key target groups.

Overall, it does appear that the primary care service delivery models identified are reaching more individuals than would otherwise have been the case. Having committed funding and available workforce supports larger service delivery models to reach a higher number of people than otherwise would be the case. The design of smaller, targeted service delivery models enables effective reach for priority population groups.

4.2 Effectiveness

This literature scan did not identify a common measurement tool used across the models to anchor consideration of relative effectiveness, nor did the literature scan identify meta-analyses which undertook an analysis of the relative effectiveness of the models. However, the scan did identify a wide range of models that had been researched or evaluated and largely concluded that models were effective on at least one criterion. Model effectiveness was most commonly assessed through the approaches outlined in Table 3:

Table 3: Approaches to assessing model effectiveness

| Method | Models |
|--|---|
| Randomised controlled trial (RCT) | Models that used a RCT approach were population-based and large scale, reflecting the investment required to undertake this type of evaluation (AIMS Center, 2024; Robinson et al., 2020; Smith et al., 2022). See the following models for further discussion surrounding RCT as a measure of effectiveness: Primary Care Behavioural Health Model U.S., Collaborative Care Model U.S., and the Prompt Mental Health Care Norway |
| Client service satisfaction data | Models that have used client service satisfaction data include the Primary Care Behavioural Health Model U.S. and Jigsaw Ireland. |
| Administrative data (such as the number of people using a service and wait times). | Models that have used administrative data include the Prompt Mental Health Care Norway. |
| Adherence to intended processes and workforce perception data | Models that have used adherence and workforce perception data include the Collaborative Care Model U.S. |

The availability of information about model effectiveness varied. For some of the models, we were unable to identify any insights about model effectiveness. Of the 27 models identified in the scan, approximately half documented having attempted to measure the model’s effectiveness (see Table 4).

Table 4: Model effectiveness

| Model effectiveness |
|---|
| <p>NHS Talking Therapies, UK. NHS Talking Therapies effectiveness is measured through continuous monitoring of treatment outcomes. Drawing upon this and other data, Wakefield et al. (2021) concluded in their systematic review and meta-analysis of 10 years of practice-based evidence, which included 47 peer-reviewed studies, that the programme is generally effective and “associated with large pre-post treatment effect sizes in depression and anxiety measures” (p. 2). According to the latest published NHS England (2024) administrative data, the programme helps approximately 49.9% of those who complete treatment (two or more sessions) to achieve significant symptom relief or recovery; the ‘target recovery rate’ is 50% (Nuffield Trust). However, it should be noted that the majority of those referred do not ‘complete treatment’; either they do not start treatment in the first place, or they attend a single session with no further sessions planned or they subsequently drop out. There is also a significant difference in recovery rate amongst those who complete treatment, depending on address deprivation decile ranging from</p> |

42% for those from the most deprived 10% of the population to 55% for those from the least deprived 10% of the population; generally the lower the deprivation decile the higher the dropout rate (Nuffield Trust).

Prompt Mental Health Care (PMHC), Norway. Results from a randomised controlled trial of PMHC versus treatment as usual (TAU) indicated substantial treatment effects on symptoms of depression and anxiety, (reliable) recovery rate, functional status, health related quality of life, and positive mental well-being at six-month follow-up. These treatment effects were maintained at 12-month follow-up (Smith et al., 2022). Improvements were also maintained at 24- and 36-month follow-up for symptoms of depression and anxiety, (reliable) recovery rate, and health-related quality of life. Small linear improvements since six-month follow-up were observed for work participation, functional status, and positive mental well-being (Smith et al., 2022).

NewAccess, Australia. The (Ernst & Young, 2015) evaluation of the demonstration sites concluded that NewAccess was effective in achieving a recovery rate of 67.5% and achieved a higher recovery rate than Improving Access to Psychological Therapies (IAPT) in the UK. The evaluation also indicated that the programme was culturally appropriate for the Australian context.

The HSE NCS Counselling in Primary Care Service (CIPC), Ireland. A National Evaluation of the CIPC was carried out by the Health Service Executive (HSE) National Counselling Service. This national study found that CIPC counselling is highly effective and makes a real difference to people's lives (Ward et al., 2022). The CIPC national evaluation study was a combination of evaluative enquiry and practice-based evidence gathering; practice-based studies focus on routine data collection from clients attending services (Ward et al., 2022).

Primary Care Behavioural Health Model (PCBH), U.S. Numerous studies have variously identified a wide range of benefits associated with PCBH. These benefits include: patient preference for PCBH services (Ogbeide et al., 2018), improved access to mental health care (Hodgkinson et al., 2017; Pomerantz et al., 2010); increased engagement and linkage to specialty mental health treatment when needed (Bohnert et al., 2016; Brawer et al., 2010; Wray et al., 2012; Zanjani et al., 2008), reduced wait time for mental health services (Pomerantz et al., 2008; Pomerantz et al., 2010), significant reductions in no-show rates (Pomerantz et al., 2010), improved relationship between patient and provider (Corso et al., 2012), and improved patient outcomes (Reiter & Bauman, 2016). Further, results from a randomised controlled trial demonstrated that, compared to a control group (usual care), patients receiving PCBH services reported greater use of coping strategies, greater adherence to relapse prevention plans, and greater use, and adherence, of antidepressant medication, and satisfaction highest among patients who received PCBH services (Robinson et al., 2020),

While there have been many research studies on PCBH, Hunter et al. (2017) found overall that: “the quality of the outcome research needs to be strengthened to fully understand, not only the impact of the PCBH model on patient and implementation outcomes, but to understand important implementation and contextual variables that account for variability in effectiveness” (p. 15). Hunter et al. (2017) caution that, while the PCBH model may be a promising approach, there is limited rigorous evidence of the model's effectiveness. Given that the Access and Choice Model was based on the PCBH model this caution is relevant.

The Collaborative Care Model (CoCM), U.S. The AIMS Center (2024) stated that CoCM has now been tested in more than 90 randomised controlled trials in the U.S. and offshore and is widely agreed upon as the integrated care approach with the most robust evidence base. The AIMS Center (2024) also stated that CoCM leads to significantly better clinical outcomes, greater

patient and provider satisfaction, improved functioning, and reduced health care costs. While Collaborative Care does necessitate practice change on multiple levels, the AIMS Center concludes that it does work. This is because providers have the resources they need to most effectively treat patients, and the patients are twice as likely to get better in significantly less time (86 days vs. 614 days in usual care) (The AIMS Center, 2024). Studies of CoCM have also shown increased provider satisfaction and increased provider confidence in managing behavioural health problems (Reist et al., 2022).

Mental Wellness Teams, Canada. In July 2016, the “*Evaluation of the First Nations & Inuit Mental Wellness Programs 2010-2011 to 2014-2015*” was published by the Office of Audit and Evaluation (2016). It concluded that there was a continued need for mental wellness programming in First Nation and Inuit communities. While they found that it was difficult to accurately measure programme performance due to limited performance measurement data, they concluded that the available performance data, combined with the field work findings, indicated that the Mental Wellness Teams had made progress towards their intended outcomes (Office of Audit and Evaluation, 2016).

headspace, Australia. A preliminary external evaluation in 2009 of the first 30 centres showed that young people found the approach to be acceptable (Rickwood et al., 2023). A comparative study, using routinely collected data from 2009–2012, concluded that headspace both delivered free or low-cost psychological services to 12–25 year-olds with different characteristics and had promising effects on mental health, filling a service gap for young people in a complementary way (Bassilios et al., 2017; Rickwood et al., 2023). A 2015 evaluation reported that centres: were highly accessible and utilised by a diverse range of young people with high psychological distress; facilitated access for young people living outside major cities; demonstrated a statistically significant small programme effect; and that young people whose mental health improved also had positive economic and social outcomes and reduced suicidal ideation. A further government-commissioned external evaluation showed continuing strong youth and community support and evidence of cost effectiveness (Rickwood et al., 2023). Measures (combined clinician assessment and self-report) show change improvement after interaction with headspace. While the results show positive outcomes for most headspace clients, a limitation was reported to be the lack of a control group and that comparative data is difficult to find. headspace clients present for a wide range of reasons, treatments are varied, and centres are uniquely adapted to their varied communities and circumstances; consequently, few other services are comparable (Rickwood et al., 2023)

Jigsaw, Ireland. Young people seeking help from Jigsaw are often experiencing high levels of psychological distress. After engaging with Jigsaw, most young people report clinically significant reductions in psychological distress. Young people also report making reliable progress towards their goals after coming to Jigsaw (Jigsaw, 2024). Surveys of young people who have used the service show over 99% felt that they were listened to by Jigsaw staff and that their worries were taken seriously. A very high 95% agree that the support they received helped them deal with their problems and 97% would recommend Jigsaw to a friend if they needed help (Jigsaw, 2024).

Parents and caregivers surveyed also show high levels of satisfaction with the service. 97% report that the young person in their care improved as a result of coming to Jigsaw (Jigsaw, 2024).

Mana Ake: Mana Ake – Stronger for Tomorrow, New Zealand. Malatest (2021) reported that the outcome tools used by Mana Ake (Tū Taurira and the Child Outcomes Rating scale) both showed significant improvements across all the domains they measure after tamariki participation in Mana Ake.

The challenges associated with determining model effectiveness were repeatedly acknowledged in the literature. Hunter et al. (2017) reviewed published studies about PCBH models and was only able to conclude that the PCBH may be a promising approach. The authors noted that there are multiple scientific limitations present in the evaluations of these models, including: lack of comparative data; lack of measures of adherence (fidelity); lack of focus on patient outcomes; the challenges of understanding the relative impact of comorbidities; the lack of standardised measures; lack of assessment of potentially confounding variables, and lack of assessment of how the model works for different groups of people. Likewise, Hetrick (2017) set out to identify the best available evidence on the effectiveness of integrated youth health care models and was unable to identify best practice.

Similar to the challenges associated with determining model effectiveness there is a lack of research dedicated to establishing the long-term outcomes associated with the various models. Specifically, we were unable to locate research that has demonstrated:

- a positive correlation between specific models and mental health outcomes, and
- the relative impact of the models compared to other mental health initiatives.

Given the significant investment required to establish and maintain these models, and therefore the lost opportunity to invest in other mental health services (e.g., secondary services), the lack of outcome data is a significant gap, as addressed by Moise et al. (2021):

Despite increases in collaborative care implementation and reimbursement, prevalence rates of major depression in the United States remain unchanged while anxiety and suicide rates continue to climb ... why we are not making headway in treating common mental health conditions in primary care (p. 271).

4.3 Value for money

Cost-related information, while rarely discussed in identified literature, largely relied on workforce salaries and the costs associated with the model's operation. Of the 27 models identified in the scan, the minority documented an attempt to measure the model's value for money (see Table 5).

Table 5: Value for money

| Model value for money |
|---|
| <p>PCBH, U.S. Although Hunter et al. (2017) identified that cost analysis for model delivery is not widely undertaken across the sites where PCBH is delivered, Landoll et al. (2019) assessed cost related to shifting the access to mental health services from speciality clinics to primary care via a pilot study across the U.S. Airforce (using the PCBH model). The study identified that the participating sites (compared with the non-participating sites) had a decrease in costs incurred with outside community providers. The study concluded that the findings provided initial evidence for cost-saving models but noted that further systematic research was required to be certain of any potential benefit.</p> <p>Integrated Health Hub Model, Canada. Malachowski (2019) determined that shifting integrated mental health into the community via the Integrated Health Hub model is a sensible economic decision because community mental health services are five times less expensive than hospital-based care.</p> <p>Collaborative Care Model, U.S. The Aims Center (University of Washington) asserted that the costs of delivering Collaborative Care are generally offset by longer-term health care savings (AIMS Center, 2024).</p> <p>Improving Access to Psychological Therapy, UK. Mukuria et al. (2013) reported on the cost-effectiveness of an Improving Access to Psychological Therapies (IAPT) service. The study used an economic evaluation, comparing costs and health outcomes at the demonstration site with a control site. The study found that the IAPT site had higher service costs and was associated with small additional gains in quality-adjusted life-years (QALYs) compared with its comparator sites, resulting in a cost per QALY gained of £29 500 using the Short Form (SF-6D). However, the study findings were inconclusive, suggesting that the service was probably effective but noting there was considerable uncertainty in the measures achieved.</p> <p>NewAccess, Australia. Ernst & Young (2015) found via economic analysis that the NewAccess model was economically viable and had the potential to deliver an economic benefit. The study determined that <i>for every dollar invested in NewAccess, \$1.50 in benefits are estimated to arise</i> (p. 14).</p> |

The literature scan did not identify insights about value for money for the majority of the models, nor did the scan identify meta-analyses which undertook an analysis of the relative value for money of the models and was therefore unable to determine which models were better value for money. However, the literature scan did identify a small number of studies that did consider model value for money and largely concluded that the models did have a positive economic benefit.

4.4 Model-specific success factors

For some of the models, researchers have identified critical success factors for delivery of their services. We have compiled insights on two of the most relevant models: Primary Care Behavioural Health and NHS Talking Therapies. The insights on ‘what matters most’ for these programmes may inform the monitoring and assessment of Access and Choice delivery.

Primary Care Behavioural Health (PCBH)

The American PCBH model integrates behavioural health care with primary care services within the same facility. This model is designed to improve access to mental health care, reduce the stigma associated with seeking mental health services, and address the comprehensive health needs of patients. In the PCBH model, Behavioural Health Consultants (BHCs) work alongside primary care providers within primary care settings. BHCs provide consultation-based services, brief interventions, and collaborate on the management of patients with chronic conditions.

There is no single PCBH model. As such, applications may vary in their use of terminology and training (and scope of adaptations). However, Reiter and colleagues (2018) have developed what they claim to be the first concise operationalised PCBH definition, developed from multiple published resources and consultation with nationally recognised PCBH model experts. This definition largely reflects the essential components identified by Robinson and Reiter (2015) (see Table 6).

Table 6: Essential components of PCBH

| Component | Definition |
|---|--|
| Generalist Approach (no conditions for programme entry) | Accepting every referral request from a primary care provider (regardless of age and condition (not screened out prior to contact). |
| Accessible | The Behavioural Health Consultants (BHC) aim to see all patients on the same day that the primary care provider requests help. A warm hand off is made between the primary care provider and the BHC (in person introduction), the visits are intended to be focused (brief) and use a ‘consultant’ rather than a ‘therapist’ approach. |
| Team-based integration | BHCs are part of a primary care team. Rather than working independently, the BHC works in concert with primary care providers, nurses, medical assistants and any other team members involved in service delivery. There are several PCBH service delivery strategies that can promote the team-based approach: sharing of clinic resources, being easily accessible for consultation, a flexible approach to contributing to the team, mutually developed and reinforced care plans, the use of biopsychological clinical pathways and having the BHC |

| | |
|-------------------|---|
| | engage in clinical behaviours that are consistent with the primary care provider. |
| High productivity | BHCs are intentionally targeted with seeing a high volume of patients, with some aiming to see 10-14 patients per day. Strategies for achieving high productivity tend to be interrelated to those for accessibility (focused visits, same day visits and BHC inclusion in specific primary care provider clinical visits). One-to-one sessions can be delivered either in person, over the phone or as a video consultation. |
| Educator | As well as seeing patients, BHCs have an educational role within their team. The BHCs seek to upskill other members of their team to make them more confident, skilled, and efficient in their work with biophysical issues of patients. |
| Routine | BHCs are intentionally positioned as a routine member of health care teams to patients and staff. They are intentionally integrated into the team to maximise their impact on the patient population. |

NHS Talking Therapies

The United Kingdom NHS Talking Therapies programme for anxiety and depression (formerly known as Improving Access to Psychological Therapies, IAPT) was established in 2008 to provide psychological interventions for adults and older adults with anxiety disorders and/or depression. This can be standalone or in the context of a long-term physical health condition.

Referral pathways have been specifically developed to promote access and equality. They include self-referrals, community or voluntary service referral, primary care referral, and secondary care referral (including both mental health and physical health care services). Patients are typically seen by a trained therapist within six weeks, and treatments of potentially up to 20 sessions may be one-to-one, in a group, online, over the phone, with family, or with a partner. All talking therapies involve the patient and therapist/practitioner working as a team to understand problems, overcome current difficulties and achieve identified goals. As well as talking, therapy typically includes practical exercises and tasks both in and outside of sessions. It is an active process, and the therapist or practitioner will regularly check in with the patient to ensure progress. There are three key principles of the NHS Talking Therapies principles (NHS, 2024), see Table 7.

Table 7: Key principles of NHS Talking Therapies

| Component | Definition |
|--|--|
| All psychological therapies offered are evidence-based and delivered at the appropriate dose | National Institute for Health and Clinical Excellence (NICE) recommended therapies are matched to the mental health problem, and the intensity and duration of delivery is designed to optimise clinical outcomes. The number of sessions is usually between 5 and 20 and each session typically lasts for 30-60 minutes. |
| The clinical workforce is appropriately trained and supervised | <p>All clinicians are appropriately trained and supervised to ensure high-quality care is provided by clinicians who are trained to an agreed level of competence and accredited in the specific therapies they deliver. The clinicians receive weekly outcomes focused supervision from senior clinical practitioners with the relevant competences to support continual improvement.</p> <p>The workforce profile is intentionally evolving to best meet patient needs. Studies of the NHS workforce are being used to inform workforce planning and identifying staff groups who could benefit from further learning. 35% of the programme’s clinical workforce are Psychological Wellbeing Practitioners (PWP) and more highly qualified and trained High Intensity Therapists (HITs); PWP must complete a British Psychological Society accredited PWP programme and register with either the British Psychological Society or the British Association for Behavioural and Cognitive Psychotherapies, while HITs must hold a postgraduate qualification in CBT or similar and be trained in each individual high intensity intervention. The NHS Talking Therapies workforce also includes employment advisers, support staff, data specialists and clinical leads.</p> |
| Routine outcome monitoring | Routine monitoring at both an individual level (session by session basis for both clinician and patient) and meta level (published outcomes of all NHS talking therapies for public transparency). |

4.5 Other considerations

Looking beyond individual model success factors, here we draw more broadly on possible lessons and monitoring considerations for primary mental health delivery in NZ. However, given the significant differences between models and their contexts, such learning was not necessarily universal, and some were contradictory factors.

Population-based versus targeted models

In terms of the people who are intended to use specific models of primary mental health services, models identified in the literature scan tended to be population-based (i.e. designed for the general population) or targeted (i.e. specifically designed for a subgroup of the general population that is generally at higher risk of mental health issues and/or harder to reach with mainstream service delivery). While population-based models are intended to reach a wide range of people, inevitably some groups of people will not access the services.

To understand who may be missed by population-based services, two models have assessed demographic differences between those who accessed their services and those who did not (see Table 9).

Table 9: Groups not accessing population-based models

| Cohorts |
|--|
| <p>IAPT/NHS Talking Therapies, UK. Sharland et al. (2023) determined that access to IAPT in the UK differed markedly by a range of socio-economic factors. Specifically, those with lower access tended to be older, male, born outside the UK, identified as disabled, and without academic/professional qualifications. Furthermore, an assessment of 10 years of NHS Talking Therapies patient data was undertaken and it was identified that people from Black and minority ethnic groups were less likely to access the service (National Collaborating Centre for Mental Health, 2023).</p> <p>Prompt Mental Health Care Norway. Hanevik et al. (2023) assessed demographic differences between those who disengage from the services and those who did not and found that younger people who are unemployed with lower levels of education and poor social support were more likely to disengage from the intervention.</p> |

In contrast to population-based models, targeted models aim to serve a particular group of people. As a result, their reach may be smaller than population-based models but effective in meeting service gaps for certain groups. These targeted models may have different designs to suit a particular group’s needs. Examples of groups targeted by the identified models in the scan include indigenous peoples, young people, older people, and men living in rural areas.

Holistic approaches

A focus on a holistic approach was evident across the youth models, i.e., they consider the person as a whole, rather than a singular focus on the individual’s mental health. For instance, headspace in Australia aims to holistically address the main mental health and wellbeing needs of youth (mental health, sexual health, alcohol and other drugs and work/study issues) (Rickwood et al., 2023). A holistic approach is also central to the philosophy of the Youth Wellness Hubs in Ontario (Varatharasan et al., 2024). Likewise, Jigsaw in Ireland promotes a holistic view of client, which is inextricable from the contexts of their lives (Jigsaw, 2024).

The New Zealand Youth one stop shops (YOSSs) are also described as being distinguished by their wraparound holistic models of care (Garrett et al., 2020).

A focus on a holistic approach was more common among the other targeted models too. This was particularly common across community-based one-stop-shop models and Indigenous primary mental health care models (Malachowski et al., 2019, Rickwod et al., 2023, Varatharasan et al., 2024, Jigsaw, 2024, Garrett et al., 2020, Department of Health and Aged Care, 2024, Abel et al., 2012). For example, the Aboriginal and Torres Strait Islander Mental Health Programme links to broader social and emotional wellbeing services (Department of Health and Aged Care, 2024). Within New Zealand, Mana Ake also views tamariki in the wider context of their family, whānau and community (Malatest, 2021) and the Wairua Tangata Programme aimed to provide an integrated, flexible, holistic, tikanga Māori-based therapeutic service (Abel et al., 2012).

A holistic approach was less evident in the population-based models. Only the Integrated Health Hub (IHH) Model, a small and locally driven programme in Canada, identified itself as being founded upon a wrap-around service focusing on the client as a whole (Malachowski et al., 2019). Instead, population-based models tend to focus on mental health more specifically.

Co-design

Involvement of the intended target group for the model in the ongoing evolution of the programme was also evident in the engagement with youth as stakeholders in the youth programmes. An example of youth co-design is the headspace model. Youth participation is considered a key driver of the headspace model (Rickwood et al., 2023). Another example is the Wairua Tangata Programme, where the programme design was developed by a predominantly Māori team (Abel et al., 2012).

Localisation, agility, and fidelity

Some of the individual models were developed from an international model, having evolved to fit their local environment. For example, the Improving Access to Psychological Therapy model (initiated in the UK) has evolved for the Norwegian context via Prompt Mental Health Care (PMHC), known locally as "Rask Psykisk Helsehjelp" (Knapstad et al., 2018). Improving Access to Psychological Therapies has also evolved in Australia as NewAccess (Cromarty et al., 2016). The PCBH model (developed in the U.S.) has been adapted for the Swedish context and is commonly known as PCBH Sweden (Farnsworth von Cederwald et al., 2023).

Many of the identified models have been described as agile and have adapted according to their own internal evaluations and changing contexts (see for example, headspace and Wairua Tangata). The headspace model in Australia was enhanced in 2011 with the launch of online services (ehespace), followed by online work and study support starting in 2016. Recently, new centre service innovations like satellite services and remote outreach have also been implemented. These developments have broadened the capacity for youth mental healthcare, extending its reach and catering to the diverse needs of young people in various communities throughout Australia (Rickwood et al., 2023).

The Canadian ICY Teams are also adapted to local environments. Core resourcing and services are the same for many of the teams, but the teams are also augmented with other key roles to meet local needs (Ministry of Mental Health and Addictions, 2024).

While localisation is considered a strength, as it enables the models to be tailored to local contexts, it has also been noted as a barrier to understanding, measuring, and replicating the various models (Hetrick et al., 2017). The Integrated Health Hub (IHH) Model was developed organically and locally in Canada. While the local adaptation could be considered a strength, it has also been described as a limitation, as it would be exceptionally difficult to replicate elsewhere (Malachowski et al., 2019). Similarly, Hetrick et al. (2017) set out to identify the best available evidence on the effectiveness of integrated youth health care models (including Jigsaw in Ireland, YOSS in New Zealand and headspace in Australia).

Having assessed the programmes and data available, Hetrick et al. (2017) concluded that while one of the key strengths of the models was that they were locally tailored and continued to adapt to meet local needs, this made systematic identification of best practice unachievable (Hetrick et al., 2017).

Nature of the interventions

Across the models, the individual patient interventions took many different forms, and these generally aligned with the therapist's or practitioner's qualifications and training. Interventions ranged from 'brief interventions', which could be as short as a single session (e.g., Primary Care Behavioural Health, US), to multi-session goal setting and coaching (e.g., NewAccess, Australia which offers a highly structured 6 session format which they refer to as Low Intensity Cognitive Behavioural Therapy) or high intensity Cognitive Behavioural Therapy (e.g., NHS Talking Therapies, England). While all of NHS Talking Therapies' interventions are prescribed Manualised Evidence-based Treatments (MESTs) and can only be delivered by those with the necessary training in that specific intervention, the evidence base to support the individual patient interventions used by other models is much more variable. Indeed, in some instances the use of Manualised Evidence-based Treatments (MESTs) is either not a requirement or the focus of the service is about connecting to support and services, including peer support, rather than clinical interventions per se (e.g., Integrated Child and Youth Teams, Canada, and Youth Wellness Hubs, Ontario, Canada).

Integration Spectrum

The various models differed according to levels of integration with other health services. On one level, integration differs in terms of which professionals are included in the integration. For some models, integration parties include the general practitioner, the in-house 'wellbeing' person, a team working within a community hub, or professionals and members of the individual's support system, such as whānau. On the other hand, many models operate more as a stand-alone service, e.g., NHS Talking Therapies.

On a second level, integration also varied according to the degree to which the model was integrated into primary care. As most identified models primarily sit within either a formal setting (for instance a primary medical care clinic) or a community setting (e.g., a community hub), integration ranged from co-ordinated (driven by communication), to co-located (benefits from proximity), and integrated (fully transformed care) (Horstman et al.,

Sept. 15, 2022). As high quality integration underpins most of the models we reviewed, it was surprising to see an absence of critical assessment about the quality of integration from a patient care perspective. Another research gap was identified by Hunter et al. (2017), who suggest a need for an improved understanding of patient perceptions about their data being shared to allow integration in PCBH models.

Workforce roles and qualifications

There is diversity across the models in how the service delivery roles are specified and resourced. Some of the services are primarily delivered by highly qualified clinical specialists; for instance the NHS Talking Therapies high intensity interventions are delivered by highly qualified and trained High Intensity Therapists (HIT), while the mental health services provided by SLI2CE are delivered by a team of seven psychologists (Brawer et al., 2010). The PCBH model also includes a licensed behavioural health professional, such as a psychologist (American Psychological Association, 2022). Some of the models primarily deliver services via the GP, for instance: Mental Health Primary Care, Western Australia; The Integrated Health Hub (IHH) Model, Canada; and Screening, Brief Intervention, and Referral to Treatment, U.S. For some models, delivery is via new roles created specifically for the service with professionals having a range of backgrounds and possibly no prior education or training in mental health, for instance, the Primary Mental Health Initiatives in New Zealand (Dowell et al., 2009) and PCBH Behavioral Health Consultants in the U.S.

There are strengths and weaknesses of designing models with different kinds of roles. For example, a workforce with specialist non-clinical skills (e.g., cultural or language skills) may enhance service delivery and be more appropriate for holistic service delivery. Non-clinical roles may be easier to recruit and require fewer intensive qualifications, enhancing their availability. However, non-clinical roles involve less formal training on management of mental health issues.

Addiction and Substance Abuse

This literature scan sought to include models that incorporated addiction and substance abuse services alongside mild to moderate mental health services. There was a noticeable paucity of analysis particular to the delivery of the addiction and substance abuse services within the models included in this scan. Several models did not appear to address addiction issues at all, and for those that did, addiction and substance abuse seemed somewhat peripheral in terms of programme design and/or uptake. This is an area that warrants further attention and investigation.

5 Conclusion

The aim of the literature scan was to understand what is currently known about existing primary mental health and addiction service delivery models in terms of the range of delivery models and the comparative impact and achievements of these.

A wide range of models were identified (27 in total). There was considerable variation in the way the models were operationalised, including how the services are accessed, who delivers the services, how the services are delivered, the degree to which services are integrated, and how integration is defined and operationalised. The variation in reach between models is also notable. Population-based approaches reach more people, but risk priority group populations either not engaging or disengaging from the services. Significantly, within the context of population-based approaches, specific cohorts of people are more likely to have poorer outcomes. In contrast, targeted models may result in fewer people accessing the services but are more likely to reach those cohorts identified as needing a targeted approach.

Primary Care Behavioural Health and Improving Access to Psychological Therapies are the two key models that have been replicated internationally. They have not been rolled out in an identical form to the parent model, but rather have been tailored to fit the local context.

The literature scan did not identify common measurement tools or meta-analysis that gave insight about the relative effectiveness of the models. Robust assessment of the effectiveness of the models is important. Investment made in the delivery of service models should be monitored to ensure that the intended purpose of the investment is being achieved.

It is important for mental health systems to be clear about the purpose of a proposed model and who is intended to benefit from it in order to identify which model might be most appropriate and how it should be contextually adapted. Commissioners of services should implement robust monitoring and evaluation frameworks to examine the impacts and effectiveness of the models and associated services that are being delivered. Beyond volume outputs, our insights from the literature scan on key monitoring and evaluation questions that are central to primary mental health care initiatives include:

1. Was the programme implemented as intended?
2. Are the key indicators of success (immediate, intermediate and longer-term outcomes) for the programme well established, measured and transparently reported?
3. To what extent is the programme meeting the needs of intended groups, including those with higher needs? Are patients experiencing better access, choice, and quality in relation to both primary mental health and addiction service?
4. Is the programme valued by patients?
5. Is the programme patient centric? Is the patient being considered holistically (including co-morbidities)? Is the programme providing an integrated service experience for the patient?
6. Is the mix of population-based, targeted, holistic, specialist, evidence-based and low intensity support components optimal?

7. Is the workforce design appropriate? Does the workforce have sufficient qualifications, knowledge, skills, values, and experience to deliver on the intended outcomes, and is it being appropriately developed and retained?
8. Is the programme the best use of resources for improving mental health outcomes for the population?
9. Are there any unintended consequences?
10. How can the programme be improved or strengthened?

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Appendix 1: Literature scan models

| Model | Evidence |
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| Population based | |
| <p>NHS [National Health Service] Talking Therapies, England. The NHS Talking Therapies programme for anxiety and depression (formerly known as Improving Access to Psychological Therapies, IAPT) was established in 2008. It was developed to improve the delivery of, and access to, evidence-based, National Institute for Health and Clinical Excellence (NICE) recommended, psychological therapies for depression and anxiety disorders i.e. Manualised Evidence-based Treatments (MESTs). Their range of low and high intensity interventions are available for a range of specific conditions and circumstances including Cognitive Behavioural Therapy (CBT), Behavioural Activation (BA), and Couple Therapy for Depression (CTfD). Referral pathways have been developed to promote access and equality. They include:</p> <ol style="list-style-type: none"> 1. Self-referral into every service, 2. Community or voluntary service referral, 3. Primary care referral, and 4. Secondary care referral (including both mental health and physical health care services). | <p>Reach: Designed to be inclusive, it offers services to all adults aged 18 and over who are registered with a GP. This is a large-scale programme, with a current annual target of providing timely access to treatment for approximately 32% of the prevalence of depression and anxiety disorders (Nuffield Trust). The latest annual report states that there were 1.76m referrals during 2022/23 (NHS, 2024). Sharland et al. (2023) determined that access to IAPT in the UK differed markedly by a range of socio-economic factors. Specifically, those with lower access tended to be older, male, born outside the UK, identified as disabled, and without academic/professional qualifications. Furthermore, an assessment of 10 years of NHS Talking Therapies patient data found that people from Black and minority ethnic groups had less access to the service (National Collaborating Centre for Mental Health, 2023).</p> <p>Effectiveness: NHS Talking Therapies effectiveness is measured through continuous monitoring of treatment outcomes. Drawing upon this and other data, Wakefield et al. (2021) concluded in their systematic review and meta-analysis of 10 years of practice-based evidence, which included 47 peer-reviewed studies, that the programme is generally effective and “associated with large pre-post treatment effect sizes in depression and anxiety measures” (p. 2). According to the latest published NHS England (2024) administrative data, the programme helps approximately 49.9% of those who complete treatment (two or more sessions) to achieve significant symptom relief or recovery; the ‘target recovery rate’ is 50% (Nuffield Trust). However, it should be noted that the majority of those referred do not ‘complete treatment’; either they do not start treatment in the first place, or they attend a single session with no further sessions planned or they subsequently dropout. There is also a significant difference in recovery rate amongst those who complete treatment, depending on address deprivation decile ranging from 42% for those from the most deprived 10% of the population, to 55% for those from the least deprived 10% of the population; generally the lower the deprivation decile the higher the dropout rate (Nuffield Trust).</p> |

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| <p>Patients are typically seen within six weeks, with treatment being delivered by either a Psychological Wellbeing Practitioner PWP) or a more highly qualified and trained High Intensity Therapist (HIT). Treatments of potentially up to 20 sessions may be one-to-one, in a group, online, over the phone, with family, or with a partner. All talking therapies involve the patient and therapist, or practitioner, working as a team to understand problems, overcome current difficulties and achieve identified goals. As well as talking, therapy typically includes practical exercises and tasks both in and outside of sessions. It is an active process, and the therapist or practitioner will regularly check in with the patient to ensure progress (NHS, 2024).</p> | <p>Resource: A study by Mukuria et al. (2013), comparing one of the original IAPT demonstration sites with comparator sites, concluded that the programme “was probably cost-effective” (p. 1); this was in line with other early IAPT cost-effectiveness research. However, these researchers went on to caution that there was considerable uncertainty surrounding the costs and outcome differences” (p. 1). Despite continued expansion, no subsequent IAPT cost-effectiveness research has been identified.</p> |
| <p>Prompt Mental Health Care (PMHC), Norway. Prompt Mental Health Care (PMHC, known locally as "Rask Psykisk Helsehjelp," RPH) is a Norwegian initiative, based on the English ‘Improving Access to Psychological Therapy’ (IAPT) model. The initiative aims to provide low-threshold access to primary care treatment for persons with symptoms of anxiety and depression. The key characteristics of this approach are that (a) clients can directly contact PMHC, while contact with standard mental health services requires a referral from a GP, (b) PMHC aims to provide access to mental health treatment within 48 hours, while standard waiting lists are often up to 12 weeks, and (c) by including less therapist contact per client through</p> | <p>Reach: Prompt Mental Health Care was commissioned by the Norwegian Ministry of Health and Care in 2012 and as of 2022 was in use in around 70 Norwegian municipalities.</p> <p>Effectiveness: Results from a randomised controlled trial of PMHC versus treatment as usual (TAU) indicated substantial treatment effects on symptoms of depression and anxiety, (reliable) recovery rate, functional status, health related quality of life, and positive mental well-being at six-month follow-up. These treatment effects were maintained at 12-month follow-up (Smith et al., 2022). Improvements were also maintained at 24- and 36-month follow-up for symptoms of depression and anxiety, (reliable) recovery rate, and health-related quality of life. Small linear improvements since six-month follow-up were observed for work participation, functional status, and positive mental well-being (Smith et al., 2022).</p> <p>Resource: All therapists receive training in delivering CBT. Both low intensity care (i.e., guided self-help and psycho-educative courses) and high intensity care (individual face-to-face therapy) are offered, in stepped care variants (Smith et al., 2022).</p> |

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| <p>focused and brief treatment and “low-intensity treatments” (such as guided self-help and group courses), more clients can receive treatment. Collaboration with the GP, the Social Insurance Agency, and other relevant professionals at the local and secondary care level is emphasised in order to achieve an integrated treatment and rehabilitation process (Knapstad et al., 2020).</p> | |
| <p>NewAccess, Australia. NewAccess is also based on the Improving Access to Psychological Therapies (IAPT) approach, although there are many important differences. While New Access uses similar key performance indicators to IAPT, it specifically focuses on Low Intensity Cognitive Behavioural Therapy (LICBT) using a highly structured six session programme format. The practitioners who are recruited and trained to deliver the programme, are referred to as coaches. NewAccess is aimed at people not currently accessing mental health services, including ‘hard to reach groups’, for example men and rural communities where access to traditional mental health services is lower (Cromarty et al., 2016). A GP referral is not required. NewAccess was developed by Beyond Blue and is available to both individuals and small business owners.</p> | <p>Reach: NewAccess is currently available in parts of New South Wales and Queensland (Beyond Blue, 2024). The service is small scale, currently provided as part of the service offer from eight local providers ((Beyond Blue, 2024). The implementation of NewAccess was trailed in three demonstration sites. The evaluation of the demonstration sites found that NewAccess appeared to improve access to mental health care for males and in rural communities on the North Coast of NSW. Across the three sites the proportion of male clients ranged from 35% to 47%, with the highest proportion in North Coast NSW. The overall proportion of male participants, although encouraging, did not reach the original target level for the programme (40%). There was a decrease in the overall proportion of males over the life of the demonstration. The evaluation also determined that the programme appeared to be reaching older people in residential aged care facilities in at least one site. The programme was not tested in a remote rural environment or specifically with Aboriginal and Torres Strait Islander communities (Ernst & Young, 2015).</p> <p>Effectiveness: The (Ernst & Young, 2015) evaluation of the demonstration sites concluded that NewAccess was effective in achieving a recovery rate of 67.5%, demonstrating appropriateness to the Australian context, and achieved a higher recovery rate than IAPT in the UK.</p> <p>Resource: The evaluation of the demonstration sites also concluded the programme was economically viable and had the potential to deliver an economic benefit. The key benefit of NewAccess was the improvement in the quality of life for individuals who have recovered. There are also benefits in terms of reduced usage of (and expenditure on) existing mental health services and improved productivity. Over the period examined (October 2013 to December 2014) NewAccess was assessed as having achieved a benefit-cost ratio of 1:5 (Ernst & Young, 2015).</p> |

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| <p>The Health Service Executive (HSE) National Counselling Service (NCS) Counselling in Primary Care Service (CIPC), Ireland. The CIPC provides time-limited counselling to adults across Ireland. This service is available to adults over 18 years who are medical card holders and experiencing mild to moderate psychological and emotional difficulties such as depression, anxiety, panic reactions, relationship problems, loss issues, and stress. Counselling is delivered from a variety of different sites including primary care centres, dedicated NCS counselling locations as well as local community/voluntary sector centres. NCS Directors of Counselling hold clinical and operational responsibility for the service, which is coordinated by local CIPC Clinical Coordinators (Ward et al., 2022).</p> | <p>Reach: Counselling in Primary Care (CIPC) operates from over 240 locations situated throughout Ireland, typically local primary care centres (Ward et al., 2022). CIPC was launched in 2013, and 5,153 clients were referred that year. By the end of 2021 almost 150,000 people were referred to CIPC (Ward et al., 2022). Eligibility criteria currently limits referrals to patients holding a valid General Medical Services (GMS) card or referral from their GP or Primary Care Practitioner. CIPC has been described as a ‘welcome development’ by GPs and other mental health stakeholders however it has been criticised as inequitable given that access remains limited to GMS card holders (Ward et al., 2022).</p> <p>Effectiveness: A National Evaluation of the CIPC was carried out by the Health Service Executive (HSE) National Counselling Service. This national study found that CIPC counselling is highly effective and makes a real difference to people’s lives (Ward et al., 2022). The CIPC national evaluation study was a combination of evaluative enquiry and practice-based evidence gathering; practice-based studies focus on routine data collection from clients attending real services (Ward et al., 2022).</p> <p>Resource: CIPC counselling is delivered by a mix of employed counsellors/therapists and counsellors/therapists contracted through an agency (CIPC National Research Group, 2018). All counsellors/therapists meet minimum qualification criteria including a recognised qualification at Level 7 or higher in a relevant human science as well as an accredited qualification in counselling or psychotherapy. This qualification must be recognised by the Irish Association for Counselling and Psychotherapy or the Irish Council for Psychotherapy together with a minimum of two years’ clinical experience. A postgraduate qualification in counselling or clinical psychology recognised by the Psychological Society of Ireland is also recognised (Ward et al., 2022).</p> |
| <p>Primary Care Behavioural Health Model (PCBH), U.S. The PCBH model integrates behavioural health care with primary care services within the same facility. This model is designed to improve access to mental health care, reduce the stigma associated with seeking mental health services, and address the comprehensive health needs of patients. In the PCBH model, Behavioral Health Consultants (BHCs) work alongside primary</p> | <p>Reach: The PCBH model has been disseminated, implemented, and sustained is widely implemented across the United States, particularly in Federally Qualified Health Centers (FQHCs) and Veteran Affairs Health Systems, to address the broad needs of diverse populations, including underserved rural and urban communities.</p> <p>Effectiveness: While there have been many research studies on PCBH, Hunter et al. (2017) found overall that: “the quality of the outcome research needs to be strengthened to fully understand, not only the impact of the PCBH model on patient and implementation outcomes, but to understand important implementation and contextual variables that account for variability in effectiveness” (p. 15).</p> |

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| <p>care providers within primary care settings. BHCs provide consultation-based services, brief interventions, and collaborate on the management of patients with chronic conditions.</p> <p>There is no single PCBH model. As such applications may vary in their use of terminology and training (and scope of adaptations). However, Reiter and colleagues (2018) have developed what they claim to be the first concise operationalised PCBH definition, developed from multiple published resources and consultation with nationally recognised PCBH model experts. This definition largely reflects the following six key components from the work of Robinson et al. (2016):</p> <ul style="list-style-type: none"> • generalist approach, • accessible, • team-based, • high volume (productivity), • educator, and • routine. <p>From her widely cited version of the model, Robinson (n.d.) particularly highlights that the consultancy role is markedly different to that of a conventional therapist role, across multiple dimensions including primary consumer, care context, accessibility, ownership of care, referral generation, productivity, care intensity, problem scope, and termination care.</p> | <p>However, numerous individual research have variously identified a wide range of PCBH benefits including:</p> <ul style="list-style-type: none"> • PCBH improves the patient/family experience of care (satisfaction with care); • Patient preference for PCBH services (Ogbeide et al., 2018), • Improves access to mental health care (Hodgkinson et al., 2017; Pomerantz et al., 2010); • Increases engagement and linkage to specialty mental health treatment when needed (Bohnert et al., 2016; Brawer et al., 2010; Wray et al., 2012; Zanjani et al., 2008), • Increases antidepressant adherence (Szymanski et al., 2013), • Reduces wait time for mental health services (Pomerantz et al., 2008; Pomerantz et al., 2010) and no-show rates (Pomerantz et al., 2010), • Improves relationship between patient and provider (Corso et al., 2012), • Improves patient outcomes (improves population health; Reiter & Bauman, 2016). • Increases provider adherence to treatment guidelines and appropriate antidepressant prescribing (Brawer et al., 2010; Serrano & Monden, 2011), • Decreases in level of patient distress found two years post integrated primary care intervention (Cigrang et al., 2006), • Randomised controlled trial demonstrated that as compared to a control group (usual care), patients receiving PCBH services reported greater use of coping strategies, greater adherence to relapse prevention plans, and greater use of antidepressant medication with retention and satisfaction highest among patients who received PCBH services (Robinson et al., 2020), • Medical providers consider BHCs to be valuable members of integrated health care, noting that BHCs contribute to improvement in providers' abilities to provide care (Torrence et al., 2014), • Integrated behavioural health services in adult primary care have been shown to result in clinically significant decreases in depressive and anxiety symptoms among patients with depressive and anxiety disorders (Bogucki, Craner, Berg, Miller, et al., 2021; Bogucki, Craner, Berg, Wolsey, et al., 2021; Reppeto et al., 2021; Sawchuk et al., 2018), and • Integrated behavioural health programmes were able to quickly adapt to the challenges posed by the COVID-19 pandemic, ensuring continued access to evidence-based mental health services for the primary care population (Bogucki, Mattson, et al., 2021). <p>Resource:</p> |
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| | <p>PCBH as being cost-effective care (reduces cost of care; Reiter & Bauman, 2016), as supported by the following studies:</p> <ul style="list-style-type: none"> • Cost effective, namely reducing the cost of care compared to Treatment as Usual (Reiter et al., 2018), • Large reductions in specialty mental health referral rate (Cummings et al., 2009; Landoll et al., 2019; Monson et al., 2012; Serrano & Monden, 2011), • Primary care providers see more patients, spend less time in visits, and collect more revenue on days when a behavioural health provider is present (Cummings et al., 2009; Gouge et al., 2016; Monson et al., 2012), and • Reduces mental health care costs (Landoll et al., 2019; Yu et al., 2017); |
| <p>Primary Care Behavioural Health (PCBH), Sweden. PCBH Sweden is based on the U.S. Primary Care Behavioural Health Model. In Sweden the services are delivered via Primary Care Centres (PCC). The interventions are short (approximately 30 minutes) and are one visit at a time (rather than a planned series of visits) (Farnsworth von Cederwald et al., 2023).</p> | <p>Reach: Information not identified.</p> <p>Effectiveness: A randomised comparison of PCBH and traditional primary care is underway in Sweden. It is interesting to note that Farnsworth von Cederwald et al., 2023) concluded that a randomised comparison of PCBH and traditional primary care has not been made before. The authors acknowledged that the naturalistic setting and the intricacies of implementation of such programmes pose challenges for evaluation and that they have designed way they have designed their study will allow an effort to ne made evaluate the causal effects of PCBH despite these complex aspects. The authors conclude that the results of this project will be helpful in guiding decisions on how to organise the delivery of behavioural interventions and psychological treatment within the context of primary care in Sweden and elsewhere (Farnsworth von Cederwald et al., 2023).</p> <p>Resource: Information not identified.</p> |
| <p>The Integrated Health Hub (IHH) Model, Canada. The Canadian Mental Health Association-Durham Branch (CMHA-D) developed an Integrated Health Hub Model (IHHM) approach for programmes and services to serve their clients. The IHHM has blended co-location services, specifically reverse shared care, with an integrated team model (Malachowski et al., 2019). In this approach, the</p> | <p>Reach: Information not identified.</p> <p>Effectiveness: Malachowski et al. (2019) found that by including several key determinants of health within their model, The Canadian Mental Health Association-Durham Branch (CMHA-D) organically developed their model of service delivery, as opposed to selecting and implementing a particular model. The study concluded that the organic approach to developing this model was not designed to be a best-practice and may not be appropriate in other communities. However, the five key strategies used by the model to evolve their programmes</p> |

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| <p>mental health clinician is the primary service provider, and primary care services are provided within the mental health care setting. The model also incorporates an integrated team model, which provides an all-inclusive ‘wraparound’ service for the individual. The integrated team model approach seeks to ensure that all determinants of health are provided for, either directly through the organisation, or through community partnerships with other organisations. Furthermore, the services are delivered in a way that is intended to be congruent with the “Hub Model” concept (Malachowski et al., 2019).</p> | <p>and services could be replicated by other organisations to enhance services and programmes within their own unique community settings (Malachowski et al., 2019).</p> <p>Resource: The onsite primary care clinic is a Nurse Practitioner Lead Clinic (NPLC) comprised of three nurse practitioners, two registered nurses, three registered practical nurses and 2.4 administration staff. Psychiatric consults occur as needed, usually via one-time using sessional funds, or via telemedicine where ongoing specialist care is needed. Malachowski et al. (2019) concluded that shifting integrated mental health care to the community is unequivocally the most sensible economic decision, as community mental health services are up to five times less expensive than hospital-based care.</p> |
| <p>Mental Health Primary Care, Western Australia. The Western Australian Public Health Organisation (WAPHA, 2016) describes this model as an integrated systems approach for primary mental health care, underpinned by the following:</p> <ul style="list-style-type: none"> • a focus on person-centred care involving GPs and support services in partnership with the people they care for, • local by design and by default - developing place based and virtual pathways for comprehensive care; enabling flexibility in design and delivery to meet local community needs and resources, • providing GP led care as the norm – supporting primary care to respond to the whole person, | <p>Reach: Information not identified.</p> <p>Effectiveness: Information not identified.</p> <p>Resource: Information not identified.</p> |

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| <p>creating more accessible and timely services through simplifying access and entry.</p> <ul style="list-style-type: none"> • improving the continuum of care for people as they enter and navigate between systems, and • targeting low intensity psychological interventions to support people with, or at risk of, mild to moderate mental illness (including problematic alcohol and drug use) (WAPHA, 2016). | |
| <p>The Collaborative Care Model (CoCM), U.S. CoCM is a specific type of integrated care developed at the University of Washington to treat common mental health conditions in medical settings like primary care. Behavioural health conditions such as depression, anxiety, PTSD, alcohol, or substance use disorders are among the most common and disabling health conditions worldwide. Based on principles of effective chronic illness care, CoCM focuses on defined patient populations who are tracked in a registry to monitor treatment progression. The treatment plan focuses on measurement-based treatment to try to ensure the patients goal's and outcomes are met (AIMS Center, 2024).</p> | <p>Reach: Reist et al. (2022), stated that the unique strength of CoCM is its ability to adapt to the unique concerns of specific populations, such as students, geriatric patients, women's health, and substance abuse treatment.</p> <p>Effectiveness: The AIMS Center (2024) stated that CoCM has now been tested in more than 90 randomised controlled trials in the U.S. and offshore and is widely agreed upon as the integrated care approach with the most robust evidence base. The AIMS Center (2024), also stated that CoCM leads to significantly better clinical outcomes, greater patient and provider satisfaction, improved functioning, and reduces health care costs. While Collaborative Care does necessitate practice change on multiple levels the AIMS Center concludes that it does work. This is because providers have the resources they need to most effectively treat patients and the patients are twice as likely to get better in significantly less time (86 days vs. 614 days in usual care) (The AIMS Center, 2024). Studies of CoCM have also shown increased provider satisfaction and increased provider confidence in managing behavioural health problems (Reist et al., 2022). Key findings of studies assessing the effectiveness of CoCM:</p> <ul style="list-style-type: none"> • Kroenke et al. (2017) found that CoCM can play a crucial role in increasing access to mental health care within the primary care setting, where only 50% of patients with a mental health disorder are recognised, and only 12.5% of those are properly treated, • Guo et al. (2015) found that patients treated with collaborative interventions reach a diagnosis and initiate treatment within 6 months 75% of the time; this is in contrast to treatment as usual, where less than 25% of patients receive appropriate care within the same time frame, |

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| | <ul style="list-style-type: none"> • Bickman et al. (2011) reviewed randomised controlled trials examining remote CoCM teams and found 9 published studies that collectively supported the effectiveness of the model in treating a range of behavioural health conditions, including many mood and anxiety disorders, and • Huffman et al. (2014) concluded that CoCM has been shown to improve access to behavioural health services, deliver patient-centred behavioural and physical health care in the same setting, and improve overall clinical outcomes. <p>Resource: CoCM requires a team of providers. Trained Primary Care Providers (PCP) work with embedded Behavioural Health Care Managers (BHCM) to provide evidence-based medication or psychosocial treatments. The PCP and BHCM are supported by a psychiatric consultant who meets regularly with the BHCM for Systematic Caseload Review, where they consult on patients and adjust treatment for those who are not improving as expected (AIMS Center, 2024). BHCMs hired, and consulting psychiatrists identified, suggest a considerable investment of time and money. However, these upfront costs are reported to be generally offset by longer-term health care savings vis-a-vis lower overall healthcare utilisation, better medical treatment adherence and so on (AIMS Center, 2024).</p> |
| <p>Screening, Brief Intervention, and Referral to Treatment (SBIRT), U.S. The SBIRT approach delivers a less resource intense service at the primary care level than the other models. The primary care providers are only required to undertake the following: screening quickly assesses the severity of substance use and identifies the appropriate level of treatment; brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioural change, and; referral to treatment provides those identified as needing more extensive treatment with access to specialty care (Hargraves et al., 2017).</p> | <p>Reach: Information not identified</p> <p>Effectiveness: Hargraves et al. (2017) assessed the effectiveness of SBIRT via the role of out of the programme in ten primary care practices. Each practice chose the conditions for which they would screen, the screening tools, and how they would provide brief intervention and referral to treatment within their setting. An evaluation team communicated with each practice throughout the process, collecting quantitative and qualitative data regarding facilitators and barriers to SBIRT success. Using the editing method, the qualitative data were analysed and key strategies for success are detailed for implementing SBIRT in primary care. The study found that SBIRT is an effective tool that can empower primary care providers to identify and treat patients with substance use and mental health problems before costly symptoms emerge.</p> <p>Resource: Light resource required from primary care (screen, brief intervention and referral only) (Hargraves et al., 2017).</p> |

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| <p>The St. Louis Initiative for Integrated Care Excellence’s (SLI2CE), U.S. The initiative’s goal was to provide a seamless integration of services based on a collaborative care model between mental health and primary care providers (PCPs). In order for the Primary Care-Mental Health Integration Team to truly be considered “integrated,” each psychologist was provided with their own office space embedded within their respective primary care clinic (Brawer et al., 2010).</p> | <p>Reach: Information not identified.</p> <p>Effectiveness: Brawer et al. (2010) concluded that there is clear evidence that the SLI2CE initiative rather dramatically increased access to health care and modified primary care practitioners’ willingness to address mental health issues within the primary care setting.</p> <p>Resource: Initially, a total of seven psychologists were embedded within the system, with an additional nurse in a support/ nonclinical role. Since its inception, another full-time psychologist, full-time psychiatrist, and postdoctoral fellow have been added (Brawer et al., 2010).</p> |
| <p>Doing Well, Scotland. The Doing Well, Renfrewshire Primary Care Mental Health Team (PCMHT) offers a primary care service for people with common mental health problems. The service is provided by healthcare workers offering treatment, information, advice and support. The first contact is a telephone assessment or one-to-one appointment. Clients complete about six to eight 45-minute sessions. The team usually receives referrals to the service from a GP or other health or social care professional, or by self-referral (NHS Inform, 2024)</p> | <p>Reach: Information not identified.</p> <p>Effectiveness: Information not identified.</p> <p>Resource: The team is made up of a range of professionals including psychiatrists, a psychologist, primary care liaison workers and administrative staff (NHS Inform, 2024).</p> |
| <p>Indigenous services</p> | |
| <p>Mental Wellness Teams, Canada. Mental Wellness Teams (MWT) are community-based, multidisciplinary teams which provide culturally appropriate services that can include but are not limited to capacity-building, trauma-informed care, land-based care, early</p> | <p>Reach: As of January 2022, 58 teams provide this service (First Peoples Wellness Circle, 2024).</p> <p>Effectiveness: In July 2016, the “<i>Evaluation of the First Nations & Inuit Mental Wellness Programs 2010-2011 to 2014-2015</i>” was published by the Office of Audit and Evaluation (2016).</p> |

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| <p>intervention and screening, crisis response, aftercare, and care coordination. They support an enhanced continuum of care by building partnerships across federal, provincial, and territorial jurisdictions. The Mental Health Wellness Teams blend traditional, cultural and population-based approaches to provide mental wellness services to First Nations communities (First Peoples Wellness Circle, 2024).</p> | <p>It concluded that there was a continued need for mental wellness programming in First Nation and Inuit communities. While they found that it was difficult to accurately measure programme performance due to limited performance measurement data, they concluded that the available performance data, combined with the field work findings, indicated that the Mental Wellness Teams had made progress towards their intended outcomes (Office of Audit and Evaluation, 2016).</p> <p>Resource: The Office of Audit and Evaluation (2016) found that the Mental Wellness Teams had undertaken a number of resource maximisation measures to enhance their economy and efficiency. However, there remained several factors that had constrained the efficiency and economy of the Mental Wellness programmes, including resource challenges as funding amounts remaining largely unchanged over many years, short term funding cycles, high turnover of programme staff in the communities, lack of integration among Mental Wellness programmes, insufficient funding flexibility in community programming and insufficient data to assess the performance of MW Programmes and allocate resources to the most effective Mental Wellness programming.</p> |
| <p>American Indian Health and Family Services, U.S. The American Indian Health and Family Services (AIHFS) has a medical clinic that is open to persons with or without insurance. AIHFS provides services to all people in need, regardless of their ethnicity, nationality, gender, race, religion, age, or sexual orientation. Alaskan Natives, American Indians enrolled in a federally recognised tribe, or first or second-degree descendants of enrolled tribal members are eligible for services at no cost. The service is a Federally Qualified Health Center. This means the service is a healthcare delivery approach that focuses on the whole person and integrates and coordinates primary care, behavioral health, other healthcare, and community and social</p> | <p>Reach: Information not identified.</p> <p>Effectiveness: Information not identified.</p> <p>Resource: Information not identified.</p> |

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| support services. (American Indian Health and Family Services, 2024). | |
| <p>Aboriginal and Torres Strait Islander Mental Health Programme, Australia. This programme funds primary health networks to engage culturally appropriate, evidence-based mental health services for Aboriginal and Torres Strait Islander people. In many areas, local Aboriginal Community Controlled Health Services deliver these services, which are tailored to meet the individual needs of the local population. Services include, but are not limited to: psychological therapies, complex mental health support, case management, and clinical care coordination. They also complement and link to other activities, like drug and alcohol services, suicide prevention and broader social and emotional wellbeing services (Department of Health and Aged Care, 2024).</p> | <p>Reach: Information not identified.</p> <p>Effectiveness: Information not identified.</p> <p>Resource: Information not identified.</p> |
| Ethnicity specific services | |
| <p>Black Minds Matter, UK. This programme offered free, one to one, culturally appropriate talking therapy for Black people in the UK, Black Minds Matter UK is a registered charity connecting Black individuals and families with free 1-2-1 talking therapy delivered by qualified and accredited Black therapists (Black Minds Matter UK, 2024).</p> | <p>Reach: Used by 4,000 people to date. However, the service is currently not available because of lack of funding (Black Minds Matter UK, 2024).</p> <p>Effectiveness: Information not identified.</p> <p>Resource: Information not identified.</p> |
| <p>Up My Street Project, UK. In 2016 an ‘Up My Street Project’, which supported young African Caribbean men aged 15 to 25 was run. The programme was intended to help them build</p> | <p>Reach: Information not identified.</p> <p>Effectiveness: Information not identified.</p> |

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| <p>their mental health resilience and talk to each other and their families. The programme used a street therapy approach, going out to talk with young people on the street, or in a youth centre. The providers concluded that the programme helped young people to get the support they needed in a flexible and informal way (Mind, 2024).</p> | <p>Resource: Information not identified.</p> |
| <p>Youth specific services</p> | |
| <p>Integrated Child and Youth (ICY) Teams, Canada. ICY Teams are intended to address service delivery gaps in the provision of child and youth mental health and substance use services through a multidisciplinary, collaborative team-based approach with meaningful child, youth, family/caregiver, and community engagement (Ministry of Mental Health and Addictions, 2024).</p> <p>ICY Teams are designed to bring together new and existing service provider roles to work collaboratively in a formal, multidisciplinary team setting with a focus on delivering wraparound services to children, youth, and their families/caregivers. ICY Teams use a collaborative care planning process to create an integrated care plan for each child and youth receiving services from more than one team member.</p> | <p>Reach: Integrated Child and Youth (ICY) Teams are intended to provide services to children and youth from birth to age 19 who have identified mental health and/or substance use needs as defined by impairment or disruption in key areas of human development (Ministry of Mental Health and Addictions, 2024).</p> <p>Effectiveness: Information not identified</p> <p>Resource: Each ICY Team is designed to include core and supplemental team members as well as functional linkages with key services and supports to provide wraparound care. Core team members are mostly the same for each team, with some additional core positions based on locally identified needs and community context. Supplemental members are person-specific—they vary based on the unique strengths, needs and preferences of a specific child, youth, family/caregiver, and the participating schools and communities (Ministry of Mental Health and Addictions, 2024).</p> |

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| <p>The intent is to create a seamless, coordinated, and accessible set of services, and to shift the responsibility of system and service navigation from the family/caregiver to the team. Children, youth, and families/caregivers can access an ICY Team through many sources—there is no wrong door. Consultation, treatment, and support services are delivered collaboratively between partners including through an integrated care plan developed with the child or youth and their family/caregiver. The involvement of families/caregivers in care planning is a given, not an exception; where circumstances make it difficult for youth and families/caregivers to work together on an integrated care plan, peer support workers can help engage both parties in the process (Ministry of Mental Health and Addictions, 2024).</p> | |
| <p>Headspace, Australia. Headspace centres have been co-designed with young people to break down the barriers that they typically experience to accessing in-person mental healthcare. Such barriers include lack of mental health literacy and uncertainty regarding need, stigma, fears about confidentiality, cost, and poor experiences of care. Centres provide easy-access, youth-friendly, integrated primary care services, with four core streams of service delivery to</p> | <p>Reach: Headspace is reported to now comprise the largest national network of enhanced primary care, youth mental health services, world-wide, with over 150 headspace centres across Australia (Rickwood et al., 2023). The headspace centre network has been augmented by the introduction of other services over time, this has included eheadspace (online services), early psychosis, online work and study support and, more recently, centre service innovations such as satellites and remote outreach. All of these have been introduced to expand capacity in youth mental healthcare to increase reach and address the varied needs of young people in diverse communities across the wide expanse of Australia (Rickwood et al., 2023).</p> |

holistically address the main health and wellbeing needs for young people aged 12–25 years: mental health, physical and sexual health, alcohol and other drugs, and work and study issues.

The centre model was designed primarily for young people with mild to moderate common mental health problems, and to encourage them to seek help early in the development of problems. Notwithstanding the design focus, centres have a ‘no wrong door’ approach so that young people are supported to access support as early and easily as possible whatever their mental health status. Importantly, young people can self-refer, be referred by other services, or by family and friends (Rickwood et al., 2023).

The needs of young people and their families are the main drivers of the headspace model, which has 10 service components (youth participation, family and friends participation, community awareness, enhanced access, early intervention, appropriate care, evidence informed practice, four core streams, service integration, supported transitions) and six enabling components (national network, Lead Agency governance, Consortia, multidisciplinary workforce, blended funding,

Effectiveness: A preliminary external evaluation in 2009, of the first 30 centres showed that young people found the approach to be acceptable (Rickwood et al., 2023). A comparative study, using routinely collected data from 2009–2012, concluded that headspace both delivered free or low-cost psychological services to 12–25 year-olds with different characteristics, and had promising effects on mental health, filling a service gap for young people in a complementary way (Bassilios et al., 2017; Rickwood et al., 2023).

A 2015 evaluation reported that centres: were highly accessible and utilised by a diverse range of young people with high psychological distress; facilitated access for young people living outside major cities; demonstrated a statistically significant small programme effect; and that young people whose mental health improved also had positive economic and social outcomes and reduced suicidal ideation. A further government-commissioned external evaluation showed continuing strong youth and community support, and evidence of cost effectiveness (Rickwood et al., 2023). Measures (combined clinician assessment and self-report) show change improvement after interaction with headspace. While the results shows positive outcomes for most headspace clients, a limitation was reported to be the lack of a control group, and that comparative data is difficult to find. headspace clients present for a wide range of reasons, treatments are varied, and centres are uniquely adapted to their varied communities and circumstances; consequently, few other services are comparable (Rickwood et al., 2023).

Resource: Services are delivered by allied health professionals (e.g., psychologists, social workers), youth workers, nurses, general practitioners, alcohol and other drug workers, and vocational workers. Core staff are directly employed through the headspace centre grant, while others are employed through contracted private practitioner arrangements or via in-kind contributions (Rickwood et al., 2023; Rickwood et al., 2019).

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| <p>monitoring and evaluation) (Rickwood et al., 2023).</p> | |
| <p>Youth Wellness Hubs, Ontario. These Hubs offer walk-in access to youth-centred, community-based mental health and wellness services. The Youth Wellness Hubs have core features as well as being locally adapted to offer and connect to a range of evidence-based, and developmentally appropriate services such as mental health care, substance use, primary health care, education, employment, housing, peer support, family support and care navigation in youth-friendly spaces. Services are expected to be integrated and co-located with a common consent form and shared processes and communication tools so that youth experience a seamless and less fragmented service experience. The values and commitments that underpin the YWHO model include 1) meaningful engagement; 2) access, equity and inclusion for diverse youth; 3) high visibility and stigma-free; 4) integration across sectors; 5) continuous learning and quality improvement; and 6) service approaches that are youth-centred, developmentally appropriate and holistic (Varatharasan et al., 2024).</p> | <p>Reach: Across Ontario, there are 27 Youth Wellness Hubs (with five more coming soon) that are intended to provide high-quality integrated youth services to support the well-being of young people aged 12 to 25, including mental health and substance use supports, primary health care, community and social supports, and more (YWHO, 2024).</p> <p>Effectiveness: The literature scan identified an evaluation on barriers and facilitators to implementation (Varatharasan et al., 2024), but did not identify an effectiveness evaluation.</p> <p>Resource: The Youth Wellness Hub services are designed to be delivered by appropriately qualified and experienced allied health professionals (e.g., psychologists, social workers), youth workers, nurses, general practitioners, alcohol and other drug workers, and vocational workers).</p> |
| <p>Foundry, Canada. Foundry is intended to improve care pathways for young people through individualised, integrated health and social services (Barbic et al., 2024)</p> | <p>Reach: After a pilot phase involving six centres, Foundry expanded to 11 physical centres (soon to be 23) and launched a virtual service (Barbic et al., 2024).</p> <p>Effectiveness: Salmon et al., 2018 undertook a Developmental Evaluation of Foundry’s Proof of Concept and concluded that Foundry is best understood to be achieving system</p> |

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| | <p>transformation by “not just [having] everything under one roof” but by facilitating “everyone working together” and “understanding the community” where Foundry operates.</p> <p>Resource: Information not identified.</p> |
| <p>Jigsaw, Ireland. Jigsaw is an early intervention, primary care service that offers supports to young experiencing mild to moderate mental health difficulties (Jigsaw, 2024). Jigsaw advocates for a holistic and integrated view of the individual, which is inextricable from the contexts of their lives. Both online and in-person services around the country, advice and support is made available to young people aged 12–25 years-old (Jigsaw, 2024). The Jigsaw model of therapeutic support is brief and evidence-informed. Following initial intake and assessment young people may attend for a therapeutic intervention of up to eight sessions (referred to in Jigsaw as a brief intervention); the average is five (O'Reilly et al., 2022).</p> | <p>Reach: Grown from five pilot sites in 2010 to 14 services in 2020 (O'Reilly et al., 2022). Demand at each centre was high in 2022, with Cork recording 2,746 sessions attended, 2,044 in Tralee, 1,864 in Limerick and 1,617 in Thurles (Griffin, 2023).</p> <p>Effectiveness: Young people seeking help from Jigsaw are often experiencing high levels of psychological distress. After engaging with Jigsaw, most young people report clinically significant reductions in psychological distress. Young people also report making reliable progress towards their goals after coming to Jigsaw (Jigsaw, 2024).</p> <p>Surveys of young people who have used the service show over 99% felt that they were listened to by Jigsaw staff, and that their worries were taken seriously.</p> <p>95% agree that the support they received helped them deal with their problems. 97% would recommend Jigsaw to a friend if they needed help (Jigsaw, 2024).</p> <p>Parents and caregivers surveyed also show high levels of satisfaction with the service. 97% report that the young person in their care improved as a result of coming to Jigsaw (Jigsaw, 2024).</p> <p>Resource: Information not identified.</p> |
| <p>New Zealand services</p> | |
| <p>Gumboot Friday, New Zealand. Gumboot Friday was founded by mental health advocate Mike King and is a free counselling service for any young person in New Zealand aged 25 and under (ImpactLab, 2023).</p> | <p>Reach: Young people either access Gumboot Friday Counselling themselves (or through a trusted support person – e.g., parent, teacher, etc.), are referred from public services (e.g., the DHB, ACC, GPs), or signed up through an existing practitioner (ImpactLab, 2023).</p> <p>Effectiveness: Independent evaluation of effectiveness not identified.</p> <p>Resource: Information not identified.</p> |
| <p>Mana Ake – Stronger for Tomorrow, New Zealand. Mana Ake is a holistic mental health and wellbeing initiative. Mana Ake aims to</p> | <p>Reach: Mana Ake is available to primary and intermediate schools in the Canterbury region (Malatest, 2021).</p> |

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| <p>support tamariki to be resilient, and experience positive mental health and continued engagement in learning. The initiative views tamariki in the wider context of their family, whānau and community. The approach provides immediate assistance, as well a larger scale tailored and holistic response (Malatest, 2021).</p> | <p>Effectiveness: Malatest (2021) reported that the outcome tools used by Mana Ake (Tū Taurira and the Child Outcomes Rating scale) both showed significant improvements after tamariki participation in Mana Ake across all the domains they measure.</p> <p>Resource: Mana Ake kaimahi (workers) are employed by one of 12 NGO providers and support schools, families and whānau when children are experiencing issues that impact their wellbeing such as managing emotions, friendships and bullying, parental separation and grief and loss. Kaimahi have a diverse range of skills and include psychologists, social workers, counsellors, teachers and youth workers (Manake Ake, 2024).</p> |
| <p>Youth One Stop Shop (YOSS), New Zealand. Youth One Stop Shop is a youth-focused community-based centre providing a range of primary healthcare and social/developmental services at little or no direct cost for 10 to 25 year olds (Garrett et al., 2020). The working philosophy of Youth One Stop Shop is reflected in the expectation that staff ‘lift themselves above the boundaries of their professional training to view young people from a broad holistic perspective’ and focus on the positive healthy development of the young person. (Hanna & Bagshaw, 2005) The distinguishing feature of the programme is reported to be the use of wraparound or holistic models of care. Wraparound care is explained as being an individualised, family-driven and youth-guided team planning process that is underpinned by a strong value base that dictates the manner in which services for youth with complex needs should be delivered.</p> | <p>Reach: There are 10 YOSSs that belong to the national YOSS network – five are located in the central region of the North Island, one in Whangārei, two in the Te Manawa Taki region and two in the South Island (Garrett et al., 2020)</p> <p>Effectiveness: A self-report assessment of the programme, demonstrated that the majority of young people aged 10–25 years who attend a YOSS report a very positive experience.</p> <p>Resource: Each individual YOSS operates independently, however most are primarily involved in providing general health/primary care, sexual and reproductive health, mental health services and alcohol and drug services (Garrett et al., 2020). While this type of adaptive, community-orientated approach is very flexible, it has led to a degree of variation between each YOSS (Platform Charitable Trust, 2023).</p> |
| <p>Primary Mental Health Initiatives, New Zealand. Seven models of operational service delivery were initiated from the Primary Mental</p> | <p>Reach: Information not identified</p> <p>Effectiveness: Information not identified</p> |

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| <p>Health Initiatives (PMHIs). The models included use of a primary mental health clinician serving one or a smaller number of practices and multidisciplinary mental health teams (Dowell et al., 2009).</p> | <p>Resource: All of the PMHIs created new roles and positions in primary care, the most common being that of a primary mental health coordinator/nurse. Despite being resource-intensive, Dowell et al. (2009) reported that models where the coordinator is able to visit regularly with each practice and take a more active mentoring role appear to be more effective in building staff capacity, efficacy, and teamwork.</p> |
| <p>Wairua Tangata Programme, New Zealand. The Wairua Tangata Programme (WTP) is a Hawkes Bay PMHI, aimed to provide an integrated, flexible, holistic, tikanga Māori-based therapeutic service targeting underserved Māori, Pacific and Quintile 5 populations (Abel et al., 2012)</p> | <p>Reach: Abel et al., (2012) reported that programme data showed that the Wairua Tangata Programme successfully reached and maintained engagement with many of the historically underserved Māori target population (and particularly women).</p> <p>Other findings were low non-attendance rates, good improvements in mental health assessment exit scores, strong stakeholder support and service user gratitude.</p> <p>Effectiveness: Information not identified</p> <p>Resource: The programme was led by a Māori service development manager. The team included a Māori therapist and lead practitioner. The team was supported by a programme advisory team and the PHO management and board. The therapeutic team comprised the full-time lead practitioner, a part-time Pacific social worker and a number of therapists or counsellors who were contracted part-time to the programme (Abel et al., 2012).</p> |
| <p>Access and Choice, New Zealand. The Access and Choice programme funds four types of services:</p> <ul style="list-style-type: none"> • Integrated primary mental health and addiction services (IPMHA) • Kaupapa Māori services • Pacific services • Youth primary mental health and addiction services <p>The services are also being expanded in initiatives for takatāpui rangatahi, gender</p> | <p>Integrated primary mental health and addiction services (IPMHA) Reach: As of 1 July 2024, the Integrated primary mental health and addiction services (IPMHA) were offered via 583 sites. 70% of enrolled (with a primary care practice) New Zealanders are enrolled with a practice that offers IPMHA services. For the month ending 1 July 2024, use of IPMHA was higher for the female population (63% of those seen are female and 35% male (Te Whatu Ora, 2024c).</p> <p>Effectiveness: Information not identified.</p> <p>Resource: IPMHA has established new Health Improvement Practitioner, Health Coach, and Community Support Worker roles</p> <p>Kaupapa Māori services Reach: As of 1 July 2024, the Kaupapa Māori services offered approximately 10,000 sessions per month. Across 2024, between 1,400 and 3,100 new users accessed the service each month (Te Whatu Ora, 2024b).</p> |

diverse, and same sex attracted young people over four years (Te Whatu Ora, 2024a).

Resource: Whānau-centred services delivered by Māori for Māori, using mātauranga Māori (Māori knowledge).

Pacific services

Reach: As of 1 July 2024, the Kaupapa Māori services offered approximately 2,400 sessions per month. Across 2024, between 1,100 and 2,400 new users accessed the service each month (Te Whatu Ora, 2024b).

Effectiveness: Information not identified.

Resource: Pacific-led services designed to meet the needs of Pacific aiga (families) that incorporate Pacific cultural and spiritual values, beliefs, languages, and models of care.

Youth primary mental health and addiction services

Reach: As of 1 July 2024, the youth services offered approximately 5,400 sessions per month. Across 2024, between 700 and 900 new users accessed the service each month (Te Whatu Ora, 2024b).

Effectiveness: Information not identified.

Resource: flexible services that are delivered in spaces that are acceptable and accessible to young people aged 12-24 years.

Appendix 2: Reid’s (2009) five health care systems

| Health System Model | Overview |
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| Beveridge Model (e.g., UK, Finland, Italy, Norway, Spain, and Sweden) | In Beveridge models, primary mental health and addiction services are largely publicly funded and provided by the government. Mental health care is typically integrated into the general healthcare system, meaning services are universally accessible through primary care providers, community health services, or specialised government-run clinics. For example, the UK’s NHS Talking Therapies (Improving Access to Psychological Therapies) programme is accessible at no cost to the patient, funded by tax revenue |
| Bismarck Model (e.g., Germany, Japan, Belgium and Switzerland) | In Bismarck models, health insurance schemes (funded by employers and employees) cover mental health and addiction services. Access to primary mental health care, such as therapy or addiction counselling, is included in the insurance coverage, and services are often delivered by both public and private providers. While coverage is comprehensive, patients may have to navigate co-payments or select from within networks of approved therapists or counsellors. Germany’s health insurance system, for example, provides access to a range of psychological and addiction treatments within the primary care setting |
| National Health Insurance Model (e.g., Australia, Canada, Taiwan and South Korea) | In National Health Insurance models, mental health and addiction services are typically funded by a government-run insurance programmes that covers the entire population. Mental health care, including primary services such as therapy and addiction counselling, is generally accessible through a single-payer system, though access to specialised services may depend on provider availability. In Canada, for example, mental health services are integrated within the broader healthcare system, but there can be variability in access depending on provincial or territorial policies |
| Out-of-Pocket Model (e.g., Most low-income countries and the United States pre-Affordable Care Act) | In systems that rely heavily on private insurance, access to mental health and addiction services are regularly tied to the individual’s insurance coverage. Those without insurance or adequate coverage face significant barriers to care. Mental health and addiction services are often considered supplemental, meaning patients may need to purchase separate or higher-tier plans to access comprehensive care. In the U.S., prior to reforms under the Affordable Care Act, |

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| | many individuals were underinsured or uninsured, making access to primary mental health and addiction services limited and costly |
| Hybrid Model | In reality, countries may have more than one model. Reid (2009) goes on to suggest that the U.S. actually has elements of all four: the Bismarck Model for working people under 65; the Beveridge Model for Native Americans, military personnel, and veterans; the National Health Insurance Model for those over 65; and the Out of Pocket Model for the 45 million uninsured Americans |

