

# A Canadian Call for Addressing Physical Health in Specialized Mental Health Settings

## Appel pour la santé physique dans les milieux spécialisés en santé mentale au Canada



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### Abstract

People with serious mental illness experience poorer physical health and higher mortality rates than the general population. One option for responding to this disparity is *reverse integration*, which promotes physical health monitoring in secondary and tertiary mental health

settings. Health leaders in Canada can learn from reverse integration approaches that have been adopted or proposed in other jurisdictions. We conducted a jurisdictional scan and applied the 3I framework for policy analysis to suggest that Canadian adaptations of existing approaches should foreground equity, build on existing infrastructure and human resources and prioritize leadership of people with lived experience.

## Résumé

Les personnes atteintes de maladies mentales graves ont une moins bonne santé physique et présentent des taux de mortalité plus élevés que la population générale. Une des réponses à cette disparité est « l'intégration inverse », qui favorise la surveillance de la santé physique dans les établissements de santé mentale secondaires et tertiaires. Les dirigeants de la santé au Canada peuvent tirer des leçons des initiatives d'intégration inverse qui ont été adoptées ou proposées dans d'autres administrations. L'analyse que nous avons effectuée auprès des administrations et le cadre des « 3I » que nous avons employé pour l'analyse des politiques nous portent à proposer que l'adaptation de ces initiatives au Canada devrait privilégier l'équité, s'appuyer sur les infrastructures et les ressources humaines en place et donner la priorité au leadership de personnes ayant une expérience vécue.



## Introduction

People with serious mental illness (SMI) experience poorer physical health and higher mortality rates and die on average 10–20 years earlier than the general population (de Mooij et al. 2019; Olfson et al. 2015). Health inequities for people with SMI have many contributing factors, including poverty and unstable housing (Topor et al. 2016), poor access to primary care, pervasive stigma and other systematic barriers to engagement, leading to poor quality and experiences of care (Ronaldson et al. 2020). While a full review of literature is beyond the scope of this commentary, these inequities are long-standing and well-documented.

Current population and policy trends in Canada may contribute to a policy window to address this health inequity. As health policy makers are acutely aware, increasing numbers of people are living with multiple chronic illnesses, posing a challenge to siloed, biomedical models of care that focus on a single disease (Nicholson et al. 2019). Concurrently, health inequities are an area of increasing (and overdue) policy focus. The poor health and early deaths of people with SMI are deeply interwoven with other injustices, including anti-Black and anti-Indigenous racism (Asonye et al. 2020; Bingham et al. 2019). This inequity also manifests in the disproportionate involuntary hospitalization of racialized people with SMI, in particular Black people with SMI (Walker et al. 2019). The COVID-19 pandemic further sharpened the policy focus on these health inequities: both racialized people and people with SMI experienced higher mortality rates due to COVID-19 (Blair et al. 2022; Pardamean et al. 2022).

This equity-focused policy window is influenced by attention to possible solutions. Healthcare integration, including integration across physical health, mental health and social services, is a policy priority in many Canadian provinces (MHCC 2021). Policy makers' attunement to the challenges of multi-morbidity and social inequity, along with the potential of health and social care integration as a response, creates possibilities for tackling health inequities among people with SMI.

### *Integration and reverse integration*

Broadly, healthcare integration refers to linking health services across sectors and/or across the continuum of healthcare (Valentijn et al. 2013). In mental health, integration research and practice has focused on co-locating mental health specialists in primary care settings or offering consultative specialist support to promote timely access and treatment of common mental disorders (Reilly et al. 2013). However, people with SMI may be in more regular contact with specialized mental health services than with primary care or any other element of the healthcare system. In this commentary, we focus on individuals with SMI who are receiving longitudinal care through community-based mental health services, such as intensive case management or assertive community treatment teams. These individuals typically have complex, ongoing needs that cannot be successfully addressed in primary care (Ontario Association for ACT and FACT n.d.). For these individuals, mental health services represent their *health home*, where their holistic needs may be best understood and addressed.

*Reverse integration* leverages this health home by promoting physical health monitoring in secondary and tertiary mental health settings, advancing a no-wrong-door approach to comprehensive healthcare (Ward and Druss 2017). The emerging evidence for reverse integration approaches is promising. Integrating physical healthcare into community-based secondary mental health settings has been found to improve rates of access to primary care (Johnson et al. 2022) and uptake of screening (Tse et al. 2021) and has been positively received by consumers (Talley et al. 2019). However, it is important to note that reverse integration does not refer to a single model of care. Rather, the academic literature describes an array of approaches, involving different providers and interventions embedded within mental health services at different scales. For instance, examples include outreach-based nurse practitioner care provided through an assertive community treatment (ACT) team (Henwood et al. 2018) and care planning and care coordination provided through a statewide adoption of a health home model in outpatient mental health clinics (McGinty et al. 2020).

Reverse integration is, therefore, a promising concept, and although the evidence base is still preliminary, there is growing momentum internationally. Canada can learn from and build on this momentum as part of a multi-faceted response to health inequities faced by SMI. The 3I policy analysis framework is one tool for analyzing approaches to policy development and implementation. It draws on a wide range of political science theories to suggest three categories of factors that influence these policy processes: *ideas*, including evidence and values; *institutions*, including the administrative capacities and prior policies that create

resources for future policy making; and *interests*, such as interest groups and policy entrepreneurs (i.e., individuals who push forward particular policy solutions) (Lavis et al. 2002). We use this framework to explore international approaches to reverse integration and assess their feasibility in the Canadian context. We considered approaches at the level of a health system (e.g., an integrated delivery system) or a national or subnational scale. We excluded initiatives based within a single organization or small number of organizations. We did not limit our scope to governmental policy and, instead, also included large-scale initiatives or broad frameworks developed by any health system stakeholders. Finally, as noted earlier, reverse integration is not a single model of care but rather a conceptual approach to service design in which physical healthcare is addressed in mental health settings. The breadth of this definition is reflected in the range of approaches we identified.

### *Ideas, interests and institutions: Considering international approaches and the Canadian context*

Our team conducted a jurisdictional scan of international approaches to reverse integration. These approaches – summarized in Table 1 – include collaborative efforts led by networks of health service organizations, governmental policies and frameworks intended to inform system design. In the following sections, we briefly explore how ideas, institutions and interests shaped international approaches to reverse integration, and what this means for policy learning here in Canada.

#### IDEATIONAL FACTORS

International approaches to reverse integration respond to the well-documented evidence of health inequities and premature mortality for people with SMI. For instance, in the US, grants were established to integrate primary care into community-based mental health services (Primary and Behavioral Health Care Integration [PBHCI]). An evaluation of the grant program notes that people with SMI are twice as likely to die prematurely from chronic disease when compared with the general population (Scharf et al. 2013). Meanwhile an Australian roadmap document, produced by a collective of governmental and non-governmental stakeholders called Equally Well Australia, cites evidence that people with SMI are six times as likely to die from cardiovascular illness and four times as likely to die from respiratory illness (Morgan et al. 2021).

The problem reflected in these statistics has been framed in varying ways. A group of health service organizations in New Zealand formed the first of several international Equally Well collectives. Their consensus position paper endorses “the rights of all New Zealanders to reach their full health potential” and the right of people with SMI to access appropriate healthcare (Te Pou 2014). Organizations in the UK were inspired by their New Zealand counterparts to form a similar collective. The charter of Equally Well UK similarly states that “we all, regardless of where we live, have an equal right to good health

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**TABLE 1.** International approaches to reverse integration

| Approach   | Type   | Jurisdiction     | Description   |
|--|--|------------------|---|
| Equally Well New Zealand                               | Inter-organizational network                             | New Zealand      | Equally Well New Zealand adopts a collective impact approach in which a “backbone team” facilitates the voluntary engagement of relevant partner organizations. The backbone team supports “partner-driven actions” to promote physical health among people with SMI, i.e., initiatives developed by signatory organizations that contribute to Equally Well’s objectives such as adapting screening tools or creating indicators at a district level. It has over 100 signatory organizations (Equally Well n.d.). |
| Equally Well Australia                                 | Inter-organizational network (with governmental support) | Australia        | Equally Well Australia was inspired by Equally Well New Zealand and adopts a collective impact approach, supported by endorsement from regional health authorities and the Mental Health Commission of Australia. Initiatives organized under Equally Well Australia primarily have a clinical focus, such as the development of guidelines or integrated care programs. It has over 90 signatory organizations (Morgan et al. 2021).   |
| Equally Well UK  | Inter-organizational network                             | The UK           | Equally Well UK adopts a collective impact approach and encourages organizations to develop their own initiatives as well as promote shared learning. It has over 60 signatory organizations (Equally Well UK n.d.).  |
| Comprehensive Healthcare Integration (CHI) Framework   | System design framework                                  | The US           | The CHI Framework describes key elements of bidirectional integration across a number of domains related to care and coordination, quality improvement and sustainability at three different levels of integration. It can be taken up on a voluntary basis by provider organizations and can be supported by funding agreements with payers (National Council for Mental Wellbeing 2022).  |
| Primary and Behavioral Health Care Integration (PBHCI) | Governmental policy                                      | The US           | Through PBHCI grants, funding was made available to embed primary care services in community mental health organizations (Scharf et al. 2013).  |
| Commissioning for Quality and Innovation (CQUIN)       | Governmental policy                                      | The UK (England) | CQUIN is a financial incentive program incentivizing performance for specific indicators, including those relating to physical health of people with SMI. These indicators have been primarily related to process measures, such as assessment or creation of a care plan (NHS England 2018).   |

SMI = serious mental illness.

and effective health care” (Equally Well UK n.d.: 1). Meanwhile, both the Comprehensive Healthcare Integration (CHI) Framework, produced in the US by the National Council for Mental Wellbeing, and NHS England’s policy framework, Commissioning for Quality and Innovation (CQUIN), frame the problem in terms of quality. The CHI Framework document argues that integration enables higher-quality and higher-value care (National Council for Mental Wellbeing 2022). CQUIN similarly “aim[s] to improve quality and outcomes for patients including reducing health inequalities [and] encourag[es] collaboration across different providers” (NHS England 2018: 3).

Problem framing shapes the choice of solution; however, there is limited evidence related to the various *solutions* adopted. Some initiatives are yet to be implemented at scale, such as the CHI Framework. In other cases, preliminary evaluation has been conducted. A process evaluation of Equally Well New Zealand noted strengths of its governance structure and found facilitators of collaboration but noted that – seven years into the collaborative’s existence – it is too early to measure health equity outcomes (Te Pou 2021). Health indicators such as blood pressure and cholesterol were measured in an evaluation of PBHCI, with varying results (Scharf et al. 2013). None of the initiatives included in the jurisdictional scan have been evaluated for their impact on outcomes such as mortality or quality of life. Meanwhile, a further factor that could underpin the lack of a cumulative evidence base across initiatives is heterogeneity. The wide range of approaches to reverse integration may pose a challenge for comparison and learning.

Given the above-mentioned considerations, a Canadian reverse integration approach will require framing the problem in terms that resonate with stakeholders. It will also require drawing on evidence about *what works* – to the extent that such evidence is available. Given the current emergent nature of the evidence base for reverse integration, Canadian efforts will require a robust evaluation plan and may benefit from adopting learning health system principles to enable rigorous and ongoing monitoring and improvement. Healthcare providers will also need to be equipped with the new knowledge needed to implement the selected approach.

#### INSTITUTIONAL FACTORS

The inter-jurisdictional approaches described above are each embedded in a unique institutional context. For instance, Equally Well Australia is an inter-organizational network inspired by its New Zealand counterpart but differs from the other Equally Well initiatives in the extent of government involvement – a differentiation made possible by Australia’s unique mental health policymaking infrastructure. The collective is spearheaded by the National Mental Health Commission, a governmental agency that provides independent advice and reporting (Morgan et al. 2021). Meanwhile, CQUIN and the CHI Framework build on the unique value-based payment infrastructures of the UK and the US respectively, where the former includes commissioners under the National Health Service and the latter encompasses a complex array of payors and delivery systems.

The Canadian policy context will similarly influence the design of reverse integration initiatives. Canada does not have a single health system, but rather a patchwork of provincial, territorial and federal systems. This poses a challenge to the collaboration that underpins the various Equally Well initiatives, as most relevant health and social service organizations are local or provincial in scope and are not embedded in national networks or collaborations. Some efforts at national collaboration in the mental health sector in Canada have focused on the creation of non-binding standards and frameworks, as seen in the National Mental Health and Substance Use Standardization Collaborative; however, widespread implementation of standards will still require a coordinated effort and dedicated funding. Nonetheless, coordination is possible, as demonstrated by the success of integrated youth services (IYSs). IYSs were first championed in Canada through a governmental and philanthropic funding initiative that resulted in a national research and evaluation platform, Access Open Minds (Halsall et al. 2019). While Access Open Minds supported several early IYSs in Canada, other IYSs developed separately. Today, a knowledge translation platform called Frayme supports the generation and dissemination of knowledge about key principles and elements of IYSs, provides implementation support and fosters advocacy (Halsall et al. 2019). Efforts to promote reverse integration across Canada can learn from the IYS experience, including the mobilization of core principles, international evidence, intermediary supports and diverse funding sources.

#### INTEREST FACTORS

Different interest groups – inside and outside of government – also played a role in the development of the approaches mentioned above. Equally Well New Zealand was driven by an organization representing the mental health and disability workforce and was initially launched by eight organizations, including organizations that represent mental health consumers. This origin informed its bottom-up, collective impact approach, which focuses on how organizations can achieve change through collaboration. The leadership of Māori community members is reflected in Ngā Waka o Matariki, the Equally Well Māori Health Strategy 2020–2025 (Equally Well n.d.). The CHI Framework was developed by an expert panel of individuals holding leadership positions in mental health services, policy and payor organizations across the US (National Council for Mental Wellbeing 2022). The emphasis on quality and scalable and flexible approaches reflects the breadth of the council's members.

A number of interest groups in Canada will be essential to the development of reverse integration approaches and initiatives. The knowledge of people with lived experience of SMI, family members and medical and non-medical healthcare providers can be brought forward by national interest groups such as the Canadian Alliance on Mental Illness and Mental Health, the Canadian Mental Health Association, the Mental Health Commission of Canada, the National Network on Mental Health and the Schizophrenia Society of Canada. Groups such as the Black Health Alliance, the Hong Fook Mental Health Association, the South Asian Health Network and the Thunderbird Partnership

Foundation can deepen the conversation with knowledge of specific communities. Moreover, while a pan-Canadian approach may be appropriate, Canada does not have a single health system, and local champions and experts will be needed to translate approaches into action on the ground in each region.

### *A Canadian call to action*

There are preliminary actions underway in Canada that align with the aims of reverse integration. For instance, the Mental Health Commission of Canada is collaborating with Ontario Shores Centre for Mental Health Sciences to implement Ontario Health's Schizophrenia Quality Standards at demonstration sites in four different provinces. The standards address physical health assessment, physical health promotion and smoking cessation. This is an exciting development that can be understood within ideas, institutions and interests in the Canadian context. Framed around quality, the initiative leverages existing intermediaries and evidence supports and relies on voluntary demonstration sites that are rather aspiring for broad collaboration across a decentralized context. However, while standards offer one lever for prompting action, there continues to be scope for broader policies and multi-sectoral and multi-faceted interventions that can leverage and build on the momentum for reverse integration. Although more specific recommendations will need to leverage input from patients, families, health providers and organizational and policy leaders, we suggest the following considerations for a made-in-Canada reverse integration approach.

First, taking the role of ideas seriously means foregrounding both values and evidence. A Canadian approach should prioritize health equity: Indigenous, racialized, immigrant and other communities have distinct values, needs and worldviews that should be front and centre. Meanwhile, a learning health system approach can ensure that evidence is generated and fed into practice in real time.

Second, institutional capacities will need to be leveraged and expanded. Reverse integration can build on existing infrastructure and human resources, but it will need to contend with the current health human resource crisis. Moreover, reverse integration will also require new knowledge, practices and attitudes, making training and new dedicated roles essential. A Canadian approach will further need to balance an overarching framework with local solutions. Communities have unique needs and unique knowledge, which should be reflected at a local level.

Third, reverse integration is relevant to a range of interest groups. People with lived experience of SMI and family carers must hold positions of leadership in the design, implementation and evaluation of reverse integration approaches. It will also be critical to engage broadly with health and social care workers, including nurse practitioners, allied healthcare providers and peer workers. Pan-Canadian organizations also have an important role in mobilizing knowledge to build momentum and support policy development and implementation.

Finally, a key recommendation is a call to action. Health and mortality inequities for people with SMI are well-documented; concerted policy action will be needed to move toward healthier and longer lives for people with SMI in Canada.

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