TE POU

Integrated competencies for co-existing issues: Holistic support for people accessing mental health and addiction services

Literature review

April 2022

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Contents

Executive summary

Background

Key documents such as *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* (2018) and *Kia Manawanui Aotearoa: Long Term Pathway to Mental Wellbeing* (2021) emphasise the importance of people-centred and integrated, interconnected systems to support wellbeing and recovery for people experiencing multiple health issues. Co-existing issues refers to more than one health issue and can include mental health challenges and substance use issues simultaneously, and/or gambling harm and physical health problems. Co-existing issues can compound challenges for people in their life, making it more difficult for people to reach their wellbeing or recovery goals.

Co-existing issues are common among people accessing the mental health and addiction system. There are significant gaps in identifying and supporting people experiencing co-existing issues across services. *Te Whare o Tiki* (Matua Raki & Te Pou, 2013) is a framework focusing on the competencies required for working with people experiencing co-existing mental health challenges, substance use issues and gambling harm. Given the increasing emphasis on holistic wellbeing and integrated care or support[1] and the different processes used across different services, there is a need to understand:

- current concepts of integration
- effective approaches for managing co-existing issues in an integrated way
- the competencies required by the workforce for integrated support across a range of settings.

Aims and objectives

This review aims to provide direction on how to support people with co-existing issues in an integrated way by summarising common enablers and competencies required across different settings.

The objectives are to identify:

- what holistic integrated support is and what it looks like for people accessing services
- practical steps for organisations to work in an integrated way
- the competencies (including values, attitudes, knowledge and skills) required to work in an integrated way.

The information in this review will be used alongside sector consultation to create a practical tool for integrated competencies.

[1] Integrated care is the term often used in the literature. However, we use integrated support for this report as it is preferred by people with lived experience.

Method

A literature review was undertaken in November 2021 using EBSCO, Google Scholar and Google (grey literature). This covered national and international studies, and guidelines or frameworks from January 2011 until November 2021.

Key findings

What is integrated support

The integrated model of support is considered best practice for people with co-existing issues (SAMHSA, 2020). Integrated support ensures a single point of contact with a team of providers who work closely together, provides consistency and coordinated support driven by common objectives, and supports a range of people's needs including medical, social and psychological together (Naylor et al., 2016; SAMHSA, 2020). Common elements include continuity of support, coordination, and the adoption of a people-centred approach with whānau involvement (Savic et al., 2017).

Enablers for integrated support

Enablers for achieving integrated support are at system, organisation and workforce levels. Enablers are varied and include collaboration and linkages between and within organisations, a shared vision of integration, taking a holistic and people-centred approach to support, infrastructure (such as IT systems that support sharing information), the right organisational culture, and a workforce trained with the right values, attitudes, knowledge and skills.

Values, attitudes, knowledge and skills for integrated support

A range of guidelines, frameworks and journal articles are available outlining the values, attitudes, knowledge and skills required for integrated co-existing issues in a range of settings.

Values are important as they inform and direct everything people do (Te Pou, 2019). The fundamental values and attitudes in *Let's get real*[2] are also required for integrated support. The values and attitudes identified as important to integrated support include challenging stigma or prejudice, being non-judgemental, optimism and willingness to support people, having a strong professional identity, people and human rights focused, openness, self-awareness and having hope. A values informed approach supports engagement, outcomes and wellbeing for people accessing services.

Having a strong values base is important to underpin the knowledge and skills needed for effective support. A range of skills and knowledge are required for effective integrated support for co-existing issues including:

[2] *Let's get real* is a framework that describes the values, attitudes, knowledge, and skills required for working effectively with people and whānau experiencing mental health and addiction needs.

- ability to build rapport and communicate effectively with people, whānau, colleagues and other services
- ability to collaborate effectively as part of a team, including multi organisation teams
- ability to use a range of approaches while prioritising placing people at the centre, such as working in partnership with people and whānau, motivational interviewing, and adapting support to meet the needs of a diverse range of people
- knowledge of common mental health, substance use, physical and social issues, and modes of gambling, including the complexities and interactions between these
- ability to identify and assess a range of biopsychosocial measures
- awareness of people's rights and ability to advocate for people's involvement in health decisions
- involvement of identified whānau[3] in assessment and treatment
- ability to effectively coordinate a support and wellbeing plan
- knowledge of appropriate referral processes and available services, including community supports
- ability to use technology that supports integration
- commitment to ongoing professional development specific to working in an integrated way
- flexibility and an ability to adapt to a range of situations.

The knowledge and skills required for integrated support have been mapped to those in *Let's get real* and *Te Whare o* Tiki. Many of the knowledge and skills needed for integrated support align with those required in both frameworks. However, a wider range of knowledge and skills appear to be needed for effective integration than those included in both frameworks. Conversely, there is less of a focus on cultural competencies in the integrated literature compared to *Let's get real* and *Te Whare o Tiki.*

Barriers to integration

Barriers mainly relate to not having the most useful workforce attitudes and capability, lack of clarity, lack of time or resources, insufficient infrastructure, and lack of organisational support or conducive environments. These can be addressed through proper implementation and training at system, organisation and workforce levels.

Steps for implementation of integrated support

A few international resources are available to guide implementation of integrated support into organisations, such as the *Integrating Behavioral Health and Primary Care Playbook* (Agency for Healthcare Research and Quality, n.d.). Generally, the steps involve:

- baseline assessment and planning

[3] Family and whānau are not limited to blood ties, but may include partners, friends and others in a person's wider support network. It is up to each whānau and each individual to define for themselves who their whānau is (Government Inquiry into Mental Health and Addiction, 2018).

- setting goals, engaging organisations, and creating a shared vision
- designing the transition including necessary infrastructure and processes
- piloting the integrated approach
- ensuring ongoing improvement through monitoring and evaluation with people accessing the services.

Conclusion

Integrated support is seen as beneficial for people experiencing co-existing issues. Integrated support is intended to provide more effective treatment to people experiencing co-existing issues, so they can enter any service and receive the support they need. Holistic integrated support also considers other factors in a person's life alongside mental health challenges, substance use issues and gambling harm, such as physical health, employment, housing, relationships, and their personal history and experiences.

Many enabling factors need to be in place for effective holistic integrated support at system, organisation and workforce levels. Lack of these enabling factors, or the presence of a range of barriers can impede effective integration that supports recovery and wellbeing.

A wide range of competencies are required by the workforce to work in an integrated way with a diverse range of people experiencing co-existing issues. These competencies will support people to achieve their recovery and wellbeing goals and give people hope. Values form an important foundation for the knowledge and skills required by the workforce. Many of the knowledge and skills needed for effective integrated support align with those required in *Let's get real* and *Te Whare o Tiki.* However, a wider range of knowledge and skills are needed for integration than those included in both frameworks. Conversely, *Let's get real* and *Te Whare o Tiki* take a stronger focus on cultural competencies specific to working with Māori and *Te Whare o Tiki* has a stronger focus on gambling harm than the integrated literature.

Let's get real and *Te Whare o Tiki* can be used as the foundation for a new tool or framework for the workforce with the addition of extra required competencies and a focus on working with Māori and diverse cultures. This should include competencies related to understanding the impact of colonisation and acknowledging institutional racism.

When designing a new tool, involving Māori and people with lived experience of mental health challenges, substance use issues and gambling harm will be crucial. It is also important to ensure a tool is relevant to diverse cultures and identities, including Pasifika, Asian, disabled people, and the Rainbow community. The ultimate goal of effective integrated support should be to empower people and whānau, provide people with options, and support people accessing services with the tools they need to achieve the life they want to live, no matter which service they access.

Background

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (2018) highlights the need to build people-centred and integrated services to support increased access and choice for people experiencing mental health challenges, substance use issues and gambling harm. This includes better connection between mental health and addiction services. The subsequent publication of *Kia Kaha, Kia Māia, Kia Ora Aotearoa: COVID 19 Psychosocial and Mental Wellbeing Plan* (2020a) promotes a holistic approach to mental wellbeing. The long-term pathway to mental wellbeing, *Kia Manawanui* (2021), envisages a future wellbeing system where people experience interconnected, integrated, and more people-centred services resulting from a joined-up cross government approach to wellbeing.

Integrated Solutions (Ministry of Health) was published in 2010 as a guide for services in implementing approaches for co-existing mental health challenges, substance use issues and gambling harm. It recognises that co-existing issues are common among people accessing both mental health and addiction services and significant gaps exist in services identifying and responding to them. The guide supports the expectation that all mental health and addiction services will become capable of supporting people with co-existing issues so that 'any door is the right door'. It further recognises that integrated support aims to enhance people's overall wellbeing rather than any specific problem and requires partnership between health professionals and coordination across services.

Te Ariari o te Oranga: The Assessment and Management of People with Co-existing Mental Health and Substance Use Problems (Todd, 2010) is the companion document to *Integrated Solutions* which provides detailed clinical guidance to services and health professionals. This was also published over 10 years ago. One of the key principles in *Te Ariari o te Oranga* is integrated support. The guide highlights the need to consider issues outside of mental health and addiction to enhance people's overall wellbeing. This includes physical health, social relationships, cultural, educational and occupational needs, and interactions with the justice system.

Te Whare o Tiki (Matua Raki & Te Pou, 2013), the co-existing issues knowledge and skills framework, was subsequently published in 2013. This describes the knowledge and skills required by the mental health and addiction workforce to be able to respond effectively to the needs of people with co-existing issues and their whānau. *Te Whare o Tiki* complements and adds to existing frameworks including *Let's get real* and *Real Skills Plus CAMHS*. While the framework includes knowledge and skills for integrated support, it mainly focuses on assessment and management of people with co-existing issues.

Given *Te Ariari o te Oranga* and *Te Whare o Tiki* were published around 10 years ago and the increasing emphasis on integrated support, there is a need to understand current conceptualisations of integrated support, and the competencies required by the workforce to

work in an integrated way. There is a particular gap for holistic or generic integrated support, with most current resources or tools aimed at a specific component.

Aims & objectives

This review aims to provide direction on how to work in an integrated way by summarising common enablers and competencies required across different settings.
The objectives are to identify:

- what holistic integrated support is and what it looks like for people accessing services
- practical steps for organisations to work in an integrated way
- competencies (including values, attitudes, knowledge and skills) required to work in an integrated way.

The information in this review will be used alongside sector consultation to create a practical tool for integrated competencies.

Method

A literature review was undertaken in November 2021 using EBSCO, Google Scholar and Google (grey literature). This covered national and international studies, and guidelines or frameworks from January 2011 until November 2021.

Key words included:

- complex care, integrated care, integrated models of health, integrated framework, multidisciplinary
- workforce, skills, knowledge, competency, capability
- high and complex needs, moderate to severe
- co-existing, co-occurring, comorbid, co-morbidity, concurrent, dual diagnosis
- holistic, physical health, medical conditions, mental health, psychiatric, addiction, substance use, social, homelessness, employment, behavioural health.

Results

Results in this section are set out as follows.

- What is integrated support?
- How to work in an integrated way
    - Enablers at different levels - system, organisation, workforce.
    - Values, attitudes, knowledge and skills needed by the workforce.
    - Barriers to integrated support.
    - Basic steps for implementing integrated support into an organisation.

What is integrated support?

Supporting people with co-existing issues requires a holistic approach to wellbeing that puts people at the centre (Marel et al., 2016). Integrated support for co-existing mental health challenges, substance use issues and gambling harm means both the person's mental

health needs as well as problematic substance use and gambling can be supported simultaneously by the same provider (NSW Ministry of Health, 2015). A holistic approach goes beyond this, considering a range of other needs including physical health and social factors. The integrated model of support is considered best practice for people with co-existing issues (SAMHSA, 2020).

There are many varied definitions of integrated support. In general, integrated support includes:

- a single point of contact with a team of providers who work closely together
- consistency and coordination of care with common objectives
- a person-centred approach
- the ability to support a range of people's needs including medical, social and psychological together (Naylor et al., 2016; SAMHSA, 2020; Savic et al., 2017).

Integration happens at three different levels - system, service and workforce/person levels. At a system level, integrated support includes coordination, collaboration, or linkages between independent service providers to facilitate coordinated support (Merkes et al., 2010). At a service level, an addiction, mental health or primary care service may serve as the primary provider of integrated support. At a workforce level, integrated support reflects coordinated treatment of both mental health and addiction by a single service or clinician, with clinicians working in multidisciplinary teams (Merkes et al., 2010).

Integrated support for Māori

It is important to consider how the needs of Māori fit within an integrated support approach. While limited literature is available specifically on Māori and integrated support, two key documents outline the importance of integrated and holistic support for Māori and whānau. We support the recommendations outlined below and included in *Whakamaua: The Māori Health Action Plan 2020-2025* (2020b) and *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Enquiry (Wai2575 Waitangi Tribunal Report 2019).*

Hauora (Waitangi Tribunal, 2019) states that the current system and alienation of Māori from decision making has resulted in an inability to deliver effective and integrated healthcare. Māori are often blamed for disengaging from support, without recognising and understanding the cultural and holistic views of Māori which will support better engagement, recovery and wellbeing.

Whakatātaka Tuarua: Māori Health Action Plan 2006–2011 identified and promoted successful integrated service delivery models that showed real improvement for Māori and whānau. Integrated service delivery continues to be a key area of the 2020-2025 plan.

One of the key recommendations under priority area four of *Whakamaua: The Māori Health Action Plan* is to "invest in growing the capacity of iwi and the Māori health sector as a

connected network of providers to deliver whānau centred and kaupapa Māori services to provide holistic, locally led, integrated health and disability support" (Ministry of Health, 2020b, p. 42). Similarly, a key part of priority area five is that cross sector action is locally driven to support integrated, timely, holistic, whānau centred approaches.

Integrated holistic approaches place the needs of Māori and their whānau at the centre of quality health and disability services (Ministry of Health, 2020b). Integrated services ensure that whānau are supported in ways that address the broader determinants and whole of life health and wellbeing challenges that Māori face (Ministry of Health, 2020b). In order to honour Crown obligations under Te Tiriti, Māori providers need to be fairly treated and adequately resourced to provide timely outreach and culturally safe, holistic and integrated services. Investing early and in the right things is necessary to deliver the changes set out in the plan.

How to achieve integration

This section summarises the enablers (including workforce competencies), barriers and implementation steps required to achieve integration.

Enablers for achieving integration

Enablers for effective integrated support are needed at system, organisation and workforce levels. Enablers are varied and include collaboration[4] and linkages between and within organisations, a shared vision of integration, taking a holistic and people-centred approach to support, infrastructure that supports shared information, a conducive organisational culture, and a workforce trained with the right values, attitudes, knowledge and skills.

System level enablers

Theme	Enablers
Shared vision	• A shared vision for integrated care across services (Addiction and Mental Health Collaborative Project Steering Committee, 2014; González-Ortiz et al., 2018; Savic et al., 2017; World Health Organization, 2016).
Linkages	• Development and maintenance of linkages and partnerships with a diverse range of services and organisations (Merkes et al., 2010).
Recognition in different settings	• Incorporation of mental health and addiction into public health programmes (Naylor et al., 2016). • Strengthening mental health and addiction support and recognition in a range of settings including primary care, acute hospitals and in perinatal care (Naylor et al., 2016). • Recognition of physical health and social determinants in mental health and addiction settings (Addiction and Mental Health Collaborative Project Steering Committee, 2014; Naylor et al., 2016).

[4] More information about collaboration in the mental health and addiction sector can be found here https://www.tepou.co.nz/resources/collaborative-capability-in-the-mental-health-and-addiction-sector-literature-review-full-report

	• Recognition of the cultural and holistic views of Māori in all settings (Waitangi Tribunal, 2019).
Funding	• Flexible funding across systems, including joint funding (rather than separate funding streams) (Addiction and Mental Health Collaborative Project Steering Committee, 2014; Rodgers et al., 2018; Sterling et al., 2011). • Invest in more specialist services (Savic et al., 2017), particularly more addiction services (Lee & Allsop, 2020). • Invest in growing working relationships with iwi and the Māori health sector as a connected network of providers to deliver whānau centred and kaupapa Māori services (Ministry of Health, 2020b).
Policy, procedures or contracts	• Contracts or service specifications requiring integrated working (Rodgers et al., 2018; Savic et al., 2017) with a focus on shared outcomes and deliverables (World Health Organization, 2016). • Develop an intentional implementation plan (Savic et al., 2017).
Monitoring	• Development and adoption of standardised key performance indicators (KPIs) for integrated support (NSW Ministry of Health, 2015; Sterling et al., 2011).
Infrastructure	• IT infrastructure like shared information systems to support collaborative care, being able to access information from electronic medical records across providers (Addiction and Mental Health Collaborative Project Steering Committee, 2014; Langins & Borgermans, 2016; Rodgers et al., 2018; Sterling et al., 2011). • Co-location of services (Langins & Borgermans, 2016; Lee & Allsop, 2020; Savic et al., 2017; Sterling et al., 2011) – this is only helpful when staff understand their roles and responsibilities, and willingly collaborate together (Rodgers et al., 2018).

Organisation level enablers

Theme	Enablers
Leadership	• Support for collaboration at all levels of the organisation, including top-down management support (Addiction and Mental Health Collaborative Project Steering Committee, 2014). • Leadership and clear governance that supports integration (Te Pou, 2020b; The Meadows Mental Health Policy Institute, 2016; World Health Organization, 2016). • Clearly identified and empowered champions for integration (The Meadows Mental Health Policy Institute, 2016).
Vision and culture	• An organisational vision for integration (The Meadows Mental Health Policy Institute, 2016; World Health Organization, 2016). • Adopting a ‘no wrong door’ policy (Sterling et al., 2011). • A culture and philosophy of harm reduction (Sterling et al., 2011). • A culture of stigma or prejudice reduction for people experiencing complex mental health needs or addiction (Rodgers et al., 2018).
People-centred support	• Effective relapse prevention and/or follow up support (NSW Ministry of Health, 2015). • Service delivery with people’s needs at the centre (González-Ortiz et al., 2018). • Services that provide whānau centred support for Māori (Ministry of Health, 2020b).

Policies and procedures	• Explicit documented policies and evidence-based procedures relating to intake, comprehensive screening and assessment processes, treatment guidelines, referral pathways, care coordination procedures, and discharge planning (Ee et al., 2020; Interior Health, 2021; Langins & Borgermans, 2016; Merkes et al., 2010; NSW Ministry of Health, 2015; Sterling et al., 2011; The Meadows Mental Health Policy Institute, 2016; Wamsley et al., n.d.). • Screening that occurs at all entry points using brief, easy to administer, psychometrically valid tools (NSW Ministry of Health, 2015). • Identify and address problems leading to treatment dropout, particularly transfers between providers and between services/sectors (NSW Ministry of Health, 2015). • Clear roles and responsibilities for the workforce when addressing issues beyond a person's expertise (Savic et al., 2017; Skills Care, 2014). • A policy and procedure for managing mental distress in physical health settings, including assessment and management of suicide risk (Ee et al., 2020).
Collaboration and communication	• Openness to sharing information between organisations and services (Savic et al., 2017; Sterling et al., 2011). • Multidisciplinary teams within the organisation (NSW Ministry of Health, 2015; Rodgers et al., 2018). • Consistent and regular communication between team members and people accessing services (Wamsley et al., n.d.). • Establish relationships with other sectors including healthcare, housing, education and employment (Interior Health, 2021; NSW Ministry of Health, 2015) – provide opportunities to allow the development of networks (Addiction and Mental Health Collaborative Project Steering Committee, 2014; Savic et al., 2017). This increases likelihood to receive referrals, share information and engage in joint consultation (Savic et al., 2017).
Monitoring and evaluation	• Adequate evaluation and quality improvement of treatment programmes (NSW Ministry of Health, 2015; World Health Organization, 2016). • Mechanisms where people and whānau provide feedback for ongoing development of services (NSW Ministry of Health, 2015) and are engaged to design collaborative care processes that address their needs (Addiction and Mental Health Collaborative Project Steering Committee, 2014). • Commitment and active involvement in a continuous learning cycle (Stein, 2016).

Workforce level enablers

General enablers are listed below. The required competencies, including values, attitudes, knowledge and skills are covered in more detail in the next section.

Theme	Enablers
Training and development	• Well qualified staff with generous provision of supervision and professional training in identifying and addressing co-existing issues (González-Ortiz et al., 2018; Lee & Allsop, 2020; Merkes et al., 2010; NSW Ministry of Health, 2015; Rodgers et al., 2018; Savic et al., 2017; Stein, 2016).

	• Lived experience input from people and whānau into staff training (NSW Ministry of Health, 2015). • Interdisciplinary training of staff (Sterling et al., 2011).
Knowledge, skills, values and attitudes	• The right attitudes, behaviours, skills and knowledge, with pathways in place to achieve these (Naylor et al., 2016). • Good communication and engagement skills (Naylor et al., 2016).
Holistic care	• Taking a whole of person perspective that considers a person's values, lifestyle and social context (Naylor et al., 2016; The Meadows Mental Health Policy Institute, 2016). • Openness to explore a person's needs beyond individual specialties (Naylor et al., 2016). • Use of a harm reduction model which honours the autonomy of people and the complexity of interactions between co-existing issues (Wamsley et al., n.d.).[5]
Time or resources	• Time to dedicate to collaboration with other staff (Rodgers et al., 2018).
Care planning	• Support of all health issues as 'primary' (Sterling et al., 2011) • Incorporate consent before treatment starts, as this allows for case management and information sharing with other agencies (Savic et al., 2017). • Use of a range of treatment/support modalities offering people choice (Wamsley et al., n.d.).
Culture	• Able to provide culturally relevant information and support to people to best provide for their needs (Wamsley et al., n.d.).

New roles	• New support coordination roles:
	  ○ coordinator roles to ensure continuity of care from screening to discharge/referral and to manage communication between services (NSW Ministry of Health, 2015)
	  ○ case managers are particularly useful for people with multiple or complex needs (Savic et al., 2017) and for providing holistic care (Lee & Allsop, 2020)
	  ○ liaison roles between services (Rodgers et al., 2018)
	  ○ navigator roles that help people navigate through complex health and social care systems (Rodgers et al., 2018).
	• New roles supporting holistic care such as support workers, health improvement practitioners, and health coaches as part of the integrated primary mental health and addiction model. These roles improve access to a range of personalised interventions, as well as cultural and social supports in the local community (Te Pou, 2020a).

[5] The goal of a harm reduction approach is for the person and health worker to work together to achieve a reduction in harmful or risky substance use. Harm reduction is a tool for possible engagement in the change process. It honours the ambiguity that many people experience in relation to changes in substance use and allows people to work together to explore possible goals like safer use rather than abstinence (Wamsley et al., n.d.).

Values and attitudes for integration and alignment with *Let's get real*

Important values and attitudes for integrated support are compiled below. Key values and attitudes from the literature are aligned with *Let's get real*. A solid values base is important as values inform and direct everything we do. Personal and organisational values impact how health services are provided (Te Pou, 2019).

Values and attitudes for integration	Inclusion in *Let's get real*
Challenges expectations, assumptions and stigma (Naylor et al., 2016; Wakida et al., 2018)	Real Skill 5: Challenging discrimination. Attitude: Open-minded
Non-judgemental (Marel et al., 2016)	Attitude: Open-minded
Non-confrontational (Marel et al., 2016)	Value: Partnership
Desire and willingness to work with people who experience co-existing issues (SAMHSA, 2020)	Values: Respect, manaaki, hope. Attitudes: Compassionate, open-minded, optimistic
Recognition of own limitations (SAMHSA, 2020) and strong professional identity (Skills Care, 2014)	Attitudes: Genuine, honest. Value: Partnership
Patience and optimism (Delaney et al., 2013; SAMHSA, 2020)	Attitudes: Compassionate, optimistic
Strong human rights focus (SAMHSA, 2020)	Real Skill 6: Applying law, policy and standards
Strengths focused (SAMHSA, 2020)	Attitudes: Compassionate, optimistic. Values: Hope, wellbeing
Openness (to new information and feedback) (SAMHSA, 2020) and sharing of own knowledge and experiences with others (Skills Care, 2014)	Values: Partnership, whanaungatanga. Attitude: Open-minded
Self-awareness of personal reactions and feelings (SAMHSA, 2020)	Attitude: Honest
Person-centred (SAMHSA, 2020)	Values: Respect, manaaki, hope, partnership, wellbeing, whanaungatanga
Recovery oriented/seeing people capable of wellness, or having hope (Delaney et al., 2013)	Values: Hope, wellbeing. Attitude: Optimistic

Knowledge and skills for integrated support

The following competencies are compiled from a range of guidelines, frameworks and journal articles focusing on integrated co-existing issues in a range of settings. More information about the type of document and integration setting for each document contributing to the competencies below is included in the Appendix – Documents informing the integrated competencies: type and setting. A small number of Māori related competencies are also included from government documents due to the lack of presence in competency frameworks.

Most documents did not separate or specify basic or advanced competencies. Only three competency frameworks looked at different levels required similarly to *Let's get real,* with basic, intermediate and/or advanced competencies.[6] The table below includes competencies either at a basic level or general/unspecified level.

Knowledge or skills needed	Components	Inclusion in *Let's get real*	Inclusion in Te Whare o Tiki
Communication	• Build rapport to actively engage people (Hoge et al., 2014; NSW Ministry of Health, 2015; SAMHSA, 2020; The Meadows Mental Health Policy Institute, 2016). • Communicate and collaborate effectively with colleagues (Hoge et al., 2014; The Meadows Mental Health Policy Institute, 2016). • Empathise with people on an emotional level (Delaney et al., 2013). • Actively listen (Delaney et al., 2013; Langins & Borgermans, 2016). • Communicate in a non-judgemental manner (Langins & Borgermans, 2016). • Communicate free of clinical jargon (Langins & Borgermans, 2016). • Adapt communication style to a diverse range of people (Langins & Borgermans, 2016). • Mobilise resources to suit language, cultural norms and individual preferences (eg interpreters) (Langins & Borgermans, 2016).	Real Skill 1: Building rapport and providing targeted information for people and whānau Real Skill 5: Challenging discrimination	2.1 Person-focused care 1.1 Minority ethnicities and cultures 3.1 Active engagement strategies 7.1 Person centred and wellbeing

[6] The three frameworks that break down competencies into different levels are: *Skills for integration* from Te Pou, *Substance Use Disorder Treatment for People with Co-Occurring Disorders* from SAMHSA and *Integrated Care Framework—Integrated Care Competencies* from NSW Health Education England.

			focused care as basis for integration
Engagement techniques	• Use motivational interviewing to support behaviour change (Langins & Borgermans, 2016; Naylor et al., 2016; Sterling et al., 2011; The Meadows Mental Health Policy Institute, 2016), that is responsive to different needs, settings and formats (Te Pou, 2020b). • Explore psychosocial issues during a physical health consultation (Naylor et al., 2016) and include biopsychosocial approaches in the support plan (Langins & Borgermans, 2016). • Set holistic goals with people (Naylor et al., 2016). • Use mindfulness techniques (Naylor et al., 2016). • Use psychotherapeutic techniques like cognitive behavioural therapy at a basic level (Naylor et al., 2016). • Integrate treatment/support approaches, including (where appropriate) psychosocial and pharmacological strategies (NSW Ministry of Health, 2015). • Identify appropriate support including discussion of risks and benefits in the process of obtaining informed consent. Informed decision making is enhanced by knowledge of available guidelines, clinical pathways and evidence (Ee et al., 2020). • Take a holistic and people-centred approach (Marel et al., 2016; NHS Health Education England, n.d.). • Recognise and understand the cultural and holistic views of Māori (Waitangi Tribunal, 2019). • Work collaboratively with people to meet their support needs (Marel et al., 2016). • Focus on what the person is seeking assistance for (Te Pou, 2020b). • Ensure support plans take into account people's concerns, are based on a discussion with the person and take their preferences into account (National Institute for Health and Care Excellence, 2016). • Facilitate shared decision-making; provide information and advice as needed in appropriate language and form that is relevant to the person and their context (Te Pou, 2020b).	Real Skill 1: Engagement and assessment and planning processes	2.1 Person-focused care 2.2 Wellbeing oriented care 3.1 Active engagement strategies 4 Motivation 5.2 Brief interventions 6.8 Psychological treatments including talking therapies

	• Work effectively with all age groups (Te Pou, 2020b). • Explore barriers to self-care for a person's physical health (National Institute for Health and Care Excellence, 2016). • Use basic de-escalation techniques (SAMHSA, 2020). • Match and adjust the type and intensity of services to the needs of the person, ensuring the timely and unduplicated provision of support (Langins & Borgermans, 2016). • Assess treatment use in a non-judgemental manner (Langins & Borgermans, 2016). • Promote individual responsibility (NHS Health Education England, n.d.).		
Awareness of common issues	Knowledge of: • common mental health challenges, substance use issues and gambling harm among people with long term physical health conditions, or during the perinatal period (Naylor et al., 2016) • the physical health side effects of psychotropic medications (Naylor et al., 2016) • common physical health conditions affecting people experiencing mental health challenges, substance use issues and gambling harm (National Institute for Health and Care Excellence, 2016) • the range of social needs people might have, including social isolation, homelessness or lack of stable housing, financial issues or employment (National Institute for Health and Care Excellence, 2016) • the complexities and interactions between mental health and physical health issues (Delaney et al., 2013), as well as substance use and gambling. • the basic body of knowledge relevant to integrative medicine (The Consortium of Academic Health Centers for Integrative Medicine, 2012).	Real Skill 1: relating to concepts of wellbeing, and understanding of the range of mental health and addiction-related issues and concerns people can experience	5.7 Assessment of relationships between substance use, problem gambling and mental health issues 6.7 Pharmacological treatments for mental health and substance use 6.13 Co-existing physical health conditions Service and organisational skills

			2: public health, mental health, substance use and gambling
Identification of common issues	• Screen for the presence of co-existing issues (Hoge et al., 2014; SAMHSA, 2020), including physical health issues (Naylor et al., 2016), and use various assessment tools (Ee et al., 2020; Hoge et al., 2014; National Institute for Health and Care Excellence, 2016; Naylor et al., 2016). • Collect relevant information from people about mental health, care providers, presenting issues, family situation, substance use history, gambling, current situation, personal/medical/family/trauma history, risk assessments (including for suicide), criminal history, strengths and weaknesses, and readiness for change (Langins & Borgermans, 2016; Marel et al., 2016; SAMHSA, 2020). • Undertake collaborative assessment processes appropriate to the needs of the person and appropriate to the practice/service setting (Te Pou, 2020b). • As relevant to the needs of the person (eg, where needs are complex and/or ongoing), develop and update integrated, culturally responsive, holistic wellbeing plans in partnership with people accessing services and their whānau, other team members and other providers (Te Pou, 2020b).	Real Skill 1: Information gathering and assessment processes appropriate to role	1.1 Minority ethnicities and cultures 2.2 Wellbeing oriented care 5.1 Screening for substance use, mental health and problem gambling 5.3 Mental health, substance use and gambling assessment 5.5 Mental state examination 5.6 Risk management 6.1 Pregnancy 7.2 Assessment strategies

Collaboration and teamwork	• Demonstrate a broad understanding of the concept of 'team' as applied in an integrated approach (Te Pou, 2020b). • Demonstrate commitment to team work as a central component of an integrated approach aimed at providing seamless support (Te Pou, 2020b). • Include people and whānau as core team members, advocating for this as needed (Te Pou, 2020b). • Consider and contribute to culturally safe processes for all team members (Te Pou, 2020b). • Respect and acknowledge the range of disciplines, cultures, values, approaches, models and styles of working that support wellbeing (Te Pou, 2020b). • Describe own role and skills and share relevant information to support others to understand the role (Te Pou, 2020b). • Proactively develop an understanding of roles and scopes of team members (eg, within own service, across primary, secondary and tertiary health and across other relevant organisations and sectors) (Langins & Borgermans, 2016; Te Pou, 2020b). • Contribute to the development of a shared understanding of the respective roles and responsibilities of team members and how these are interconnected (Te Pou, 2020b). • Work collaboratively to utilise the expertise of all team members and roles (Te Pou, 2020b). • Share expertise with other team members (Te Pou, 2020b). • Demonstrate understanding of and contribute to the development of team values and goals (Te Pou, 2020b). • Contribute as an effective member of inter-professional and inter-agency teams, as needed to support the wellbeing of people and their whānau (Hoge et al., 2014; Te Pou, 2020b). • Develop strong working relationships with other team members (Te Pou, 2020b). • Use terms and language readily understandable by all team members (Te Pou, 2020b). • Use communication tools that are conducive to integration (Te Pou, 2020b).	Real Skill 7: Teamwork	1.1 Minority ethnicities and cultures 7.3 MDT functioning 7.4 Collaboration and referral

	• Assertively represent professional opinions, encourage other team members to express opinions, and contribute to resolving differences of opinion or conflicts quickly (Langins & Borgermans, 2016; Te Pou, 2020b). • Work respectfully and collaboratively to resolve differing perspectives, priorities and conflicting schedules (Te Pou, 2020b). • Understand and account for the impact of own experience, expertise, culture, power and place in team hierarchy, working to contribute to effective, inter-professional relationships (Te Pou, 2020b). • Respect and respond to the leadership of others in the team context (Te Pou, 2020b). • Support connections (including warm handovers) between people and whānau and other team members (Te Pou, 2020b). • Share relevant information to support collaboration, ensuring permission is obtained from the person (as required) (Te Pou, 2020b). • Utilise own specialised knowledge and expertise in a way that is efficient, adaptive, collaborative, holistic and ethical (Te Pou, 2020b). • Participate in and use varying systems and resources to communicate within the team to maximise collaboration. For example, huddles, daily/weekly meetings, warm handovers, debriefs, multidisciplinary team meetings, team supervision and training, shared records, digital technologies, and mobile service options (Te Pou, 2020b). • Collaborate with team members (and others as needed) to match the type and intensity of planned services to the person's needs, ensuring timely and unduplicated responses (Te Pou, 2020b). • Participate in multidisciplinary case review meetings (National Institute for Health and Care Excellence, 2016). • Demonstrate practicality, flexibility and adaptability in working with others (Langins & Borgermans, 2016).		

	• Support people to consider and access complementary and alternative services to support health and wellness (Langins & Borgermans, 2016). • Promote diversity in the multidisciplinary team (Langins & Borgermans, 2016).		
Advocacy	• Advocate for the person and whānau in healthcare decisions (Langins & Borgermans, 2016). • Awareness of health and social rights and able to educate others about people's rights (Langins & Borgermans, 2016). • Understand the effect of disparities on health care access and quality (Langins & Borgermans, 2016). • Advocate for the incorporation of people's outcomes into organisation strategies (Langins & Borgermans, 2016).	Real Skill 5: Challenging discrimination Real Skill 6: Rights	
Whānau involvement	• Involve whānau and others of a person's choice when supporting people (Langins & Borgermans, 2016; Marel et al., 2016). • Ensure whānau are offered an assessment and support for their own needs (National Institute for Health and Care Excellence, 2016).	Real Skill 3: Working with whānau	5.4 Assessment of impact of substance use, gambling and mental health on children, family and whānau
Referrals and coordination	• Understand the appropriate person/service to refer to (Naylor et al., 2016; SAMHSA, 2020). • Understand referral criteria for different services (Naylor et al., 2016). • Coordinate support with external speciality providers (The Meadows Mental Health Policy Institute, 2016), including kaupapa Māori providers (Ministry of Health, 2020b). • Ongoing consultation and collaboration with other health providers (Marel et al., 2016). • As per the person's wellbeing plan, and with regard for informed consent and confidentiality requirements, link multiple services, health providers, and community resources to meet the person's health and wellbeing needs (Te Pou, 2020b). • Ensure the flow and exchange of information among the person, whānau members, team members and other providers (Te Pou, 2020b).	Real Skill 7: Teamwork	2.1 Person focused care 2.2 Wellbeing oriented care 7.4 Collaboration and referral

	• Work collaboratively to ensure people and whānau experience seamless interface between primary and secondary health services (Te Pou, 2020b). • Identify and work with others to overcome other barriers to coordination (Te Pou, 2020b). • Regularly seek feedback from the person, whānau and others involved to ensure the integrated wellbeing plan is led by and is meeting the needs of the person, negotiating adjustments as needed (Te Pou, 2020b). • Liaise and coordinate with team members (applying a broad concept of team) to ensure continuity (Te Pou, 2020b). • Ensure appropriate follow up and continuity of care to support people at different transition points in their life (National Institute for Health and Care Excellence, 2016). • Use consistent referral processes (National Institute for Health and Care Excellence, 2016). • Able to plan for potential crises after discharge from a service (National Institute for Health and Care Excellence, 2016). • Referral to those who can carry out specific diagnostic assessments as required (SAMHSA, 2020). • Ability to create and implement integrated support plans ensuring access to a variety of linked services (Hoge et al., 2014).		
Community support	• Knowledge of resources available for support (Naylor et al., 2016). • Knowledge of peer support groups in the community (Naylor et al., 2016). • Give advice and information about a range of services (NHS Health Education England, n.d.). • Demonstrate understanding of the importance of participating in local networks to ensure people and their whānau have access to the range of services they need (Te Pou, 2020b).	Real Skill 4: Working within communities	6.10 Self-help approaches
Technology and infrastructure	• Use of e-therapies or other relevant technology relevant to people's wellbeing plans to support treatment, including for early intervention (Ee et al., 2020; Hoge et al., 2014; Langins & Borgermans, 2016; NSW Ministry of Health, 2015; Te Pou, 2020b).	Real Skill 7: Quality	6.10 Self-help approaches

	• Use information technology to support improved accessibility to integrated support, while safeguarding privacy and confidentiality (Hoge et al., 2014; Te Pou, 2020b). • Demonstrate understanding of administrative systems, reporting systems and outcome measures relevant to an integrated approach (Te Pou, 2020b). • Contribute to quality systems as needed to support an integrated approach, consistently considering equity for Māori and other priority groups (Te Pou, 2020b). • Recognise the importance of monitoring outcomes in the aggregate and demonstrate ability to interpret outcomes monitoring reports to inform provision of an integrated approach (Te Pou, 2020b). • Record keeping using appropriate technology (NHS Health Education England, n.d.).	Real Skill 6: Record-keeping	
Professional development	• Engage in ongoing professional development (Langins & Borgermans, 2016; Marel et al., 2016). • Participate in practice-based learning and improvement activities that involve investigation and evaluation of people's experiences, evidence and resources (Langins & Borgermans, 2016). • Identify evidence to inform practice and integrated support (Langins & Borgermans, 2016). • Participate in audits as needed (Langins & Borgermans, 2016). • Assess and continually improve the services delivered (Hoge et al., 2014; The Consortium of Academic Health Centers for Integrative Medicine, 2012).	Real Skill 7: Maintaining professional and personal development	
Effective ways of working	• Respond immediately, if possible, to requests from people accessing services, other team members and networks (Te Pou, 2020b). • Prioritise requests where an immediate response is not possible (Te Pou, 2020b). • Demonstrate flexibility, for example, respond effectively to interruptions and needs for re-scheduling and use a range of contact strategies (email, telephone, in person, virtual meeting technologies, portals) (Te Pou, 2020b). • Utilise shared information to support efficiency (Te Pou, 2020b). • Demonstrate ability to engage with people and whānau quickly, assessing and responding to needs and priorities (including physical, social and housing needs), including cultural and age-	Real Skill 1: Working with people	2.1 Person focused care

	related needs and preferences (National Institute for Health and Care Excellence, 2016; Te Pou, 2020b). • Use the physical workspace to maximise accessible support for people and whānau. For example, ensure visibility of the service being offered and be comfortable working in any workspace available (Te Pou, 2020b). • Demonstrate a 'can do' approach, stepping in to do whatever is needed to support integration (as possible within their scope of practice), rather than strictly adhering to position descriptions (Te Pou, 2020b). • Apply relevant practice guidelines to support integration (Te Pou, 2020b). • Adapt as needed to the workflow and pace typical in the primary health setting - depending on role this can include managing a high volume of contacts (Te Pou, 2020b). • Work to maintain the overall daily schedule (Te Pou, 2020b). • Demonstrate awareness of and responsiveness to the schedules of others in the primary health environment (Te Pou, 2020b). • Respond to feedback and adapt support accordingly (Langins & Borgermans, 2016). • Adapt services that are relevant to the culture of people and whānau (Hoge et al., 2014). • Ability to function effectively within the organisational and financial structures of the local system of healthcare (Hoge et al., 2014). • Demonstrate compassionate, appropriate, and effective support based on existing evidence in integrative medicine (The Consortium of Academic Health Centers for Integrative Medicine, 2012). • Demonstrate professionalism, through a commitment to professional responsibilities, adherence to ethical principles, sensitivity to a diverse population, and appropriate self-reflection (The Consortium of Academic Health Centers for Integrative Medicine, 2012). • Demonstrate an awareness of and responsiveness to the larger context and system of health care (The Consortium of Academic Health Centers for Integrative Medicine, 2012).		

Comparison to existing frameworks

Mapping each group of competencies to similar concepts in ***Let's get real*** and *Te Whare o Tiki* revealed strong alignment in some areas and minimal alignment in others.

Let's get real alignment

- The integrated competencies listed above align:
    - strongly with Real Skill 1: Working with people experiencing mental health and addiction needs, Real Skill 5: Challenging discrimination, and Real Skill 7: Maintaining professional and personal development
    - moderately with Real Skill 6: Applying law, policy, and standards, Real Skill 4: Working within communities, and Real Skill 3 Working with whānau
    - minimally with Real Skill 2: Working with Māori - while there is mention of the importance of being able to adapt to cultural needs when working with people, whānau and teams, specific details of how to work with Māori and use of tikanga is missing.

While *Let's get real* would form a strong foundation for a new integrated support tool, a wider range of competencies are required for integrated support. In particular, a new tool must place importance on Te Tiriti o Waitangi, and competencies for working with Māori and a range of diverse cultures.

Te Whare o Tiki alignment

Components missing from *Te Whare o Tiki* that have a greater emphasis in the recent literature	Components included in *Te Whare o Tiki* that are minimal or missing from the recent literature
• An emphasis on holistic screening – screening beyond mental health, substance use and gambling harm, including physical and social issues as well. • Greater detail on how to work in an integrated, collaboration and teamwork competencies needed for integrated support, and support planning and coordination. • Advocacy for people specifically related to involvement in everyday healthcare decisions. • Competencies related to using technology to support integrated support and information sharing. • The need for ongoing commitment to and involvement in professional development activities.	• Cultural considerations – more detail is needed in terms of specific competencies for working with Māori and people from a diverse range of cultures – a few competencies for Māori have been included based on actions from *Whakamaua* rather than existing competency frameworks. • A focus specifically on recovery, relapse prevention and harm reduction. • Knowledge and management of a range of issues at different life stages (eg adolescence, pregnancy, mid-life, older adults). • Specific impacts and screening for tobacco and gambling harm related issues. • Knowledge of the different legislation that applies in the mental health and addiction space.

Barriers to effective integration

Barriers mainly relate to workforce attitudes and capability, clarity, resources, infrastructure and a lack of organisational support or the right environment.

- Lack of skills or willingness to address co-existing issues (Lee & Allsop, 2020), and lack of training (Addiction and Mental Health Collaborative Project Steering Committee, 2014; Wakida et al., 2018).
- Inability to recognise or treat mental health challenges, lack of knowledge about medications used, psychosocial interventions, processes for managing mental health, and screening tools (Wakida et al., 2018).
- Differences in culture, philosophy, workforce, and treatment approaches between addiction and mental health services (Lee & Allsop, 2020).

- Stigmatising attitudes or beliefs around mental health or addiction such as being more difficult to diagnose or being difficult to work with (Addiction and Mental Health Collaborative Project Steering Committee, 2014; Wakida et al., 2018).
- Integration increasing workload but having limited time and resources for effective service delivery (Akehurst et al., 2021; Wakida et al., 2018).
- Inadequate support from supervisors and managers (Wakida et al., 2018), including lack of cultural leadership (Te Pou, 2020b).
- Low prioritisation of mental health support in other settings (Wakida et al., 2018).
- Lack of clarity of roles and responsibilities (Marel et al., 2016; Te Pou, 2020b).
- Competition between services which creates tension between agencies (Marel et al., 2016) and siloed funding (Te Pou, 2020b).
- Lack of incentives to change, fear of change, or lack of belief in the value of collaboration and integration (Addiction and Mental Health Collaborative Project Steering Committee, 2014).
- Inadequate technology supporting integration (Te Pou, 2020b).

Steps for implementing integrated care

The *Integrating Behavioral Health and Primary Care Playbook* appears particularly useful to guide organisations through implementing integrated support. The playbook includes a self-assessment checklist so organisations can customise their implementation approach.[7]

Stage	Steps
Determining the "why" and baseline assessments	• Determine why a workforce plan is necessary and how it will support achievement of objectives (Skills for Health, n.d.). • Services should conduct a baseline assessment by mapping existing inter-service relationships to identify needs and priorities (Savic et al., 2017). • Assess organisational readiness and desire to change (Agency for Healthcare Research and Quality, n.d.).
Set goals for integration and start planning	• Set integrated working goals based on the baseline assessment and agree how to implement these goals (Savic et al., 2017; Skills for Health, n.d.). • Assemble a planning and implementation team (Agency for Healthcare Research and Quality, n.d.).

[7] https://integrationacademy.ahrq.gov/sites/default/files/2020-09/self_assessment_checklist_1.6.16.pdf

Engage the organisation and set a vision	• Engage leadership, providers and staff, including an orientation to integrated support (Agency for Healthcare Research and Quality, n.d.). • Map additional workforce requirements needed to meet future service needs (Skills for Health, n.d.), and identify options to manage future supply of the needed workforce (Skills for Health, n.d.). • Create a formal vision statement for integrated support and consider different integration approaches (Agency for Healthcare Research and Quality, n.d.).
Design the transition and necessary infrastructure and processes	• Design transition processes for how implementation will unfold (Agency for Healthcare Research and Quality, n.d.). • Establish infrastructure – operational systems, financial support, use of data, build a culture of integration, and bring in multidisciplinary expertise (Agency for Healthcare Research and Quality, n.d.). • Establish protocols for integrated support with people (Agency for Healthcare Research and Quality, n.d.). • Adopt a balance between formal structures and procedures and flexibility to respond to diverse people (Looman et al., 2021). • Take the time to build a multidisciplinary team culture with mutual recognition of others' roles (Looman et al., 2021). • Develop new roles and competencies for integrated support (such as care coordinators) (Looman et al., 2021). • Establish IT systems that support collaboration and communication, rather than separate systems (Looman et al., 2021).
Pilot an integrated approach	• Rollout and pilot of implementation approaches (Savic et al., 2017). • Develop an incremental approach to adopting integrated support, building on what is already there (eg existing collaborative networks) (Looman et al., 2021). • Collaborative governance with shared vision at all levels and supportive leadership is necessary for effective implementation (Looman et al., 2021).
Monitoring, evaluation and ongoing improvement	• Monitoring, evaluation and dissemination in order to determine whether integrated strategies have been successful (Savic et al., 2017; Skills for Health, n.d.). Including feedback from people using the service (Looman et al., 2021) – develop processes for tracking people, monitoring outcomes, and maintaining engagement (Agency for Healthcare Research and Quality, n.d.).

Conclusion

Integrated support is seen as beneficial for people experiencing co-existing issues. Integrated support is intended to provide more effective and seamless support to people experiencing co-existing issues, so they can enter any service and receive the support they need. Holistic integrated support is an extension of integrated support and considers other factors in a person's life. In addition to mental health challenges, substance use issues and gambling harm, holistic support also considers a person's physical health, employment, housing, personal history and experiences.

Many enabling factors need to be in place for effective holistic integrated support at system, organisation, and workforce levels. Lack of these enabling factors, or the presence of a range of barriers can hinder effective integrated support.

Particular competencies are required by the workforce to work with a diverse range of people experiencing co-existing issues. These include knowledge of biopsychosocial issues, engagement techniques, effective communication and collaboration, consultation techniques, advocating for people, whānau involvement, effective referrals and coordination, knowledge of community support, use of technology and infrastructure, commitment to professional development, and adopting a range of effective ways of working in an integrated approach.

Many of the knowledge and skills needed align with those required in *Let's get real* and *Te Whare o Tiki.* However, a wider range of knowledge and skills are needed for integration than that included in both documents. Conversely, *Let's get real* and *Te Whare o Tiki* have a stronger focus on cultural competencies specific to working with Māori than the integrated literature. *Let's get real* and *Te Whare o Tiki* can be used as the foundation for a new tool or framework with the addition of extra required competencies including a focus on cultural competencies.

When designing a new tool, involving Māori, people of diverse cultures and identities, and people with lived experience of mental health challenges, substance use issues, and gambling harm will be crucial. The ultimate goal of effective integrated support should be to empower people and whānau, provide people with options, and support people accessing services with the tools they need to achieve the life they want to live.

Appendix – Documents informing the integrated competencies: type and setting

Document name and author	Type of document	Type of integration
Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment setting (Marel et al., 2016)	Guideline	Mental health and addiction
Skills for integration (Te Pou, 2020b)	Online tool	Primary care, mental health and addiction
Coexisting severe mental illness and substance misuse: community health and social care services (National Institute for Health and Care Excellence, 2016)	Guideline	Mental health and addiction integrated with wider health and social needs (including employment and housing)
Integrating behavioral health and primary care playbook (Agency for Healthcare Research and Quality, n.d.)	Online tool	Mental health and primary care or other ambulatory settings
Substance use disorder treatment for people with co-occurring disorders (SAMHSA, 2020)	Protocol	Addiction and mental health
Strengthening a competent health workforce for the provision of coordinated/ integrated health services (Langins & Borgermans, 2016)	Competencies framework	General health
Core competencies for integrated behavioral health and primary care (Hoge et al., 2014)	Competencies framework	Behavioural health and primary care
Integrative medicine clinical fellowship core competencies (The Consortium of Academic Health Centers for Integrative Medicine, 2012)	Competencies framework	General health

Bringing together physical and mental health: A new frontier for integrated care (Naylor et al., 2016)	Guideline	Mental health and addiction with physical health
Development of integrated mental health care: Critical workforce competencies (Delaney et al., 2013)	Journal article	Mental health and physical health
An integrative collaborative care model for people with mental illness and physical comorbidities (Ee et al., 2020)	Journal article	Mental health and addiction with physical health
Effective models of care for comorbid mental illness and illicit substance use (NSW Ministry of Health, 2015)	Evidence review	Mental health and substance use
Best practices in integrated behavioral health (The Meadows Mental Health Policy Institute, 2016)	Evidence review	Mental health and primary care
Integrating care for people with co-occurring alcohol and other drug, medical, and mental health conditions (Sterling et al., 2011)	Journal article	Addiction and mental health with physical health
Integrated care framework - integrated care competences (NHS Health Education England, n.d.)	Competency framework	General health

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