
Toolkit for Primary Mental Health Care Development: Effective services for a sustainable future

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Toolkit for Primary Mental Health Care Development:

Part 1: Navigation Guide

Introduction

Welcome to this Primary Mental Health Care (PMHC) Toolkit.

The overall aim of the Toolkit is to support your PMHC development work, whether you work in policy, service management, or are a clinician.

Time is probably the most precious resource in the health service, from policy to clinical levels. People who work in the health sector in New Zealand are generally time-poor. We find it difficult to juggle the competing demands of clinical work, mandatory reporting, contract management and service review and planning. Usually it is the most immediate deadlines that are prioritised, and time for thorough review and planning is limited or absent. This tension is perhaps even more pressing in the primary care environment, where many activities need to be paid for directly. Given this, we recognise that you may not be able to work through the Toolkit systematically. If you integrated it into your regular planning this would be beneficial, but you might only be able to use it on an acute 'problem solving' basis, and you can still gain from doing this.

A request and encouragement: Someone set aside two hours to examine this Toolkit fully

The basic idea of the Toolkit is to enable you to do more structured problem solving and planning independently of consultation and advisors.

If you are to gain maximum benefit, someone in your service will need to allocate two hours to explore all the Toolkit components and think about how it might best be used to start with. For an overview of the Toolkit it is best to start with this Navigation Guide.

This Toolkit is a collection of items intended to be combined in ways that you decide are suited to your planning needs. The Toolkit is neither a prescriptive map telling how you should prioritise or plan in your service, nor a description of an ideal or perfect policy environment or service. It is organised into five parts, each of which provide links and direction to other material in the toolkit. Each part of the Toolkit has a variety of contents. This part, the [Navigation guide](#), is intended to support your use of the rest of the Toolkit. You will notice that the Toolkit is different to others you may have seen, in that it is not simply a list of things you 'should' achieve with your service, such as equity of provision, using evidence-based treatments, or achieving better primary-secondary care integration. We were asked by our research partners not simply to re-state known goals, but to produce something that would acknowledge the challenges and help them achieve these goals.

This Navigation Guide:

- ❑ [Outlines some principles](#) that will help you get maximum benefit from the Toolkit;
- ❑ [Lists the Toolkit components](#) – the Toolkit includes a range of components that you can use in any way you wish;
- ❑ [Includes a suggested process outline for using the Toolkit](#) components to develop solutions for your planning or service issues. After the introductory phase of your first workshop, we suggest referring to the Navigation Guide to ‘ground’ your workshop discussions on the basic principles you have prioritised for this particular decision-making/planning process.
- ❑ [Can be used to choose your entry point](#) to the Toolkit if you want to bypass a workshop process for problem identification and prioritising. For example, if you are a service manager and you know you must find a way to provide Primary Mental Health Care (PMHC) for children and young people;
- ❑ [Includes an appendix with some single page ‘jump start’ sheets](#) to help you focus on key process issues in planning. Some of these reiterate material in the Navigation Guide but are easy to pull out or copy to have them on hand.

Accompanying the Toolkit is the Research Report. The report is an account of the research process we used to generate the Toolkit. It contains some additional general background information so that it can also be seen as a stand-alone document. You do not have to read the Research Report to use the Toolkit. The elements of the Toolkit are summarised in the Research Report, as the Toolkit is the main research ‘output’.

Principles of Toolkit development and for its use

The Toolkit was developed using several basic principles. In a general way, these relate to a systems framework. If you incorporate these into your thinking as you work through your planning and decision-making you will have a better opportunity to work towards a more coherent policy, strategy or service.

In addition, the principles will be useful for the inevitable occasions when you feel your planning has got 'stuck' or a problem seems insurmountable. In these instances, you can use the principles as 'anchors' for your thinking. This can be most useful when you arrive at a sticking point of some kind. Remember also that the work is yours: you can introduce your own principles to your planning process, or you can choose to make one principle your priority. The principles are also included as a pull out page in Appendix 1 to this [Navigation Guide](#).

Principles

- ❑ **Focus on the 'service user' journey.** Critique the service/plan/policy from the perspective of someone who is using the service to get help for their mental health problem. Ask what the result of your work would be like from that perspective.
- ❑ **Use a quality improvement frame.** Service development and improvement is an iterative process, or journey. As trite as it sounds, the process/journey is as important as the destination. Make sure you value to opportunity to review and reflect.
- ❑ **If it's possible it's perfect (or at least 'good enough').** Be pragmatic. Do what you can this month and this year but don't stop aspirational planning.
- ❑ **Form follows function.** View all your choices and decisions in the light of an ideal where the form of the system serves its function.
- ❑ **Population versus person: the creative tension.** We recognise a tension between management at a population health level and the care of an individual patient and encourage you to be creative in the management of this tension. Using this idea means you accept the apparent contradictions

between the prioritisation of a population or individuals. Through discussion and trying out ideas (for example, as scenarios in the Systems Model software, testing ideas with stakeholders, and in real life practice) you will move to a position where one perspective overcomes the other, a synthesis or combination of the perspectives is accommodated, or there is a change in the focus of the discussion.^{1,2} The quality framework, where change moves in a spiral rather than a straight line, is consistent with the dialectical framework.

Toolkit components

This section outlines the contents of the Toolkit. These are the Navigation Guide; Knowledge Bank; Guides to tackling issues with illustrative vignettes; workshop plans and population based system modelling.

Part 1: Navigation Guide (this section)

Part 2: Knowledge Bank

The Knowledge Bank contains four perspective papers. These are drawn from the research process, our knowledge of the literature and experience in the sector.

The topics are:

- Where next for Primary Mental Health Care? - current issues and opportunities
- Diagnosis and management in Primary Mental Health Care: a paradox and a dilemma
- Quality in Primary Mental Health Care
- Towards the future Primary Mental Health Care: Optimal Model II

It contains copies of the following guidelines:

¹ Quinton, A. (1999). The new Fontana dictionary of modern thought. Bullock A & Trombley S (eds); London, UK: HarperCollinsPublishers Page 222

² Ayer, A. J., & O'Grady, J. (1992). A dictionary of philosophical quotations. Oxford, UK: Blackwell Publishers. Page 484

- Identification of Common Mental Disorders and Management of Depression in Primary Care (2008)

It also contains a list of other useful website links.

Part 3: Guides to tackling issues, with illustrative vignettes

This section contains guides to tackling specific issues in PMHC. Each of these is linked to a corresponding vignette which provides a fictional (but drawn from research partner experience) example of the problem to be worked through. The guides and vignettes are grouped together as: ways of working together; using your resources; making the system work; population groups.

The guides are:

Ways of working together

- Teamwork
- Leadership for Primary Mental Health Systems
- Relationships and communication

Using your resources

- Prioritisation and establishing the boundaries of Primary Mental Health Care
- Time and time management
- Financial sustainability of Primary Mental Health Care services
- IT and systems
- Eligibility to receive Primary Mental Health Care
- Connecting with the consumer

Making the system work

- Coordination of care
- Mental Health and chronic conditions

- Integration across the continuum of primary, community and specialist settings
- Models of care
- Future proofing Primary Mental Health Care
- Mental health promotion

Population groups

- Specific issues for child and youth Primary Mental Health Care
- Issues in alcohol and substance use
- Primary Mental Health in the elderly
- Primary Mental Health Care for Māori
- Primary Mental Health Care for Pacific Peoples

Part 4: Workshop plans

The workshop plans provide two options for supporting your use of the primary mental health Toolkit. Other parts of the toolkit provide examples of the way that primary mental health care is being developed and offer questions and suggestions about the decisions we think you should be considering for your own organisation. You can use these as material for your workshops. By the end of your workshop(s) you should have a clear set of plans for your own development work over one to two years and hopefully a strategic direction beyond that. This section also includes some suggestions for 'jump-starting' a stalled process.

Part 5a and 5b: Population based system modelling

The [Systems Planning Guide](#) (Part 5a) and [Dynamic Systems Model](#) (Part 5b) are designed to help facilitate planning conversations about PMHC in your region, so that you can design solutions that best fit your particular circumstances. To facilitate the conversations we have designed a system model of the key elements within PMHC and how those elements link together. The model focuses on common knowledge derived from our extensive conversations with planners and providers

within the partner DHBs, and our combined knowledge of the literature, health system design and planning, and clinical practice.

Process outline: pathway to Primary Mental Health Care development

[Figure 1](#) on the next page is a visual representation of the kind of process you will probably use to apply the Toolkit. It will be useful to refer to Primary Mental Health Care (PMHC) [Optimal Model II](#), and the [Planning Principles](#) outlined earlier in this section, during the whole planning and development process. However, be aware that you can use the Toolkit in any way you think it will support your PMHC development work.

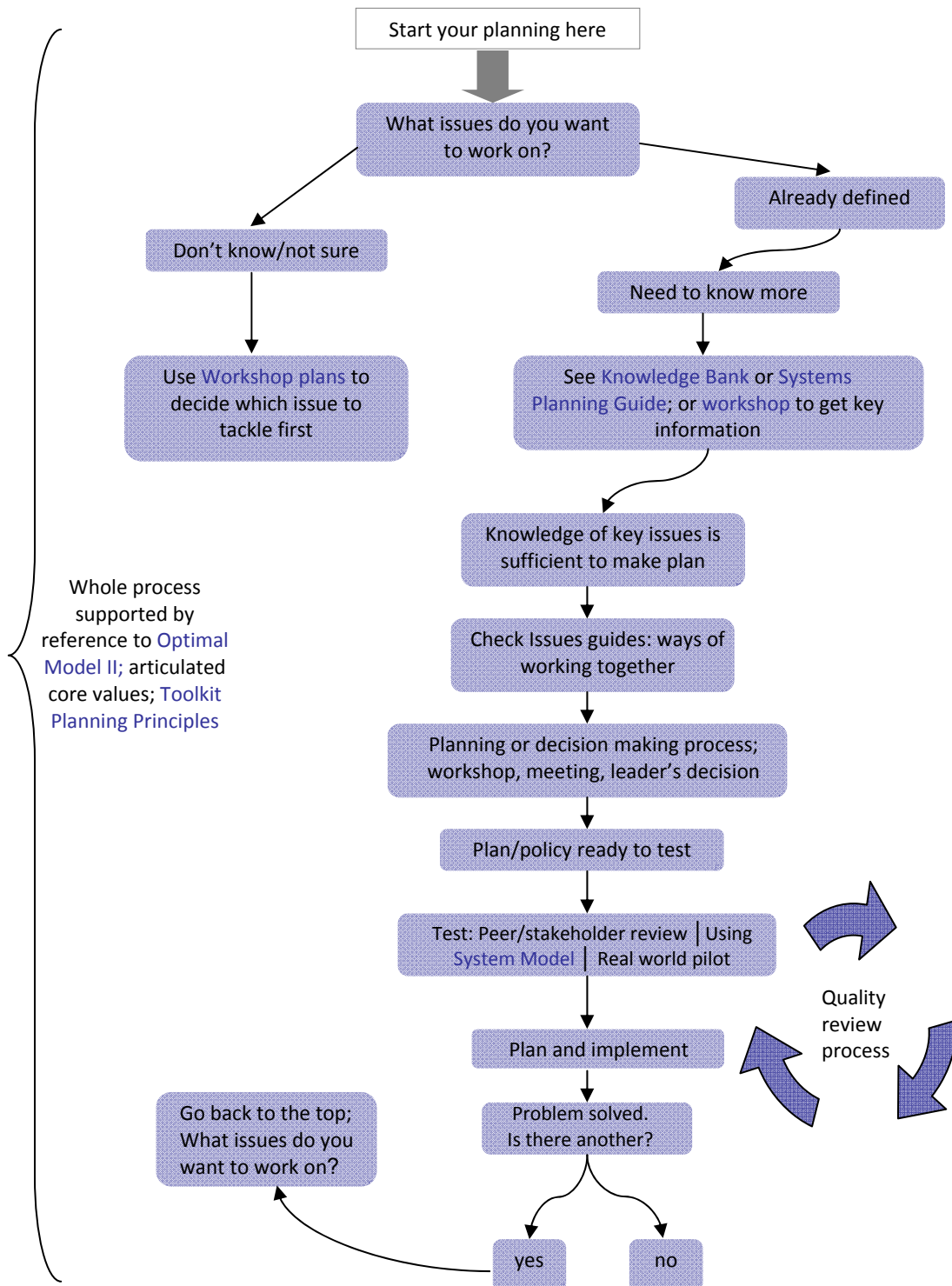


Figure 1: Pathway to Primary Mental Health Care development

The first step is to identify the issue you want to explore or the problem you want to solve. If you have several things on your agenda or you are not sure where to begin you will need to do some work, perhaps structured as a [workshop](#), to determine your priority and/or decide on a key task.

Having done this, or even before this, you may decide that you have insufficient knowledge to proceed in an evidence-led goal directed way. In this case, check the contents of the [Knowledge Bank](#), or the [Systems Planning Guide](#), as there is likely to be something there that will help. You can also ask local experts and stakeholders to help you get the right information. Depending on what you need you might try direct enquiry from an individual inside or outside your organisation, the web or your DHB library, or else use a workshop to identify the key information.

By now you have sufficient knowledge and you are deciding what sort of process you want to use to plan or make your decisions. Some decisions need to be made quickly, or there is no need for stakeholder engagement, in which case you might use a manager or lead clinician's decision, or you might possibly use a brief meeting of a few key people. Other decisions need to take longer because it is recognised that the process is important if the decision is to have credibility, stakeholder buy-in, or because you simply need many different perspectives to contribute. In this case you might choose a [workshop](#).

Once you have your decision, plan or policy you will need to test it in some way. Depending on its nature, you can do this by asking peers or stakeholders to comment, using the [System Model](#) to examine the possible system consequences, or trying a pilot in the real world. Often in health services, especially when there is pressure to deliver on outcomes or there is financial constraint, it is not possible to use real-world pilots, and this is where the System Model can be a great support. You will review your decision or plan in the light of the outcomes of testing and preferably within a quality review process that will continue to be used as you plan and fully implement the change. At this stage you may want to move on to another issue.

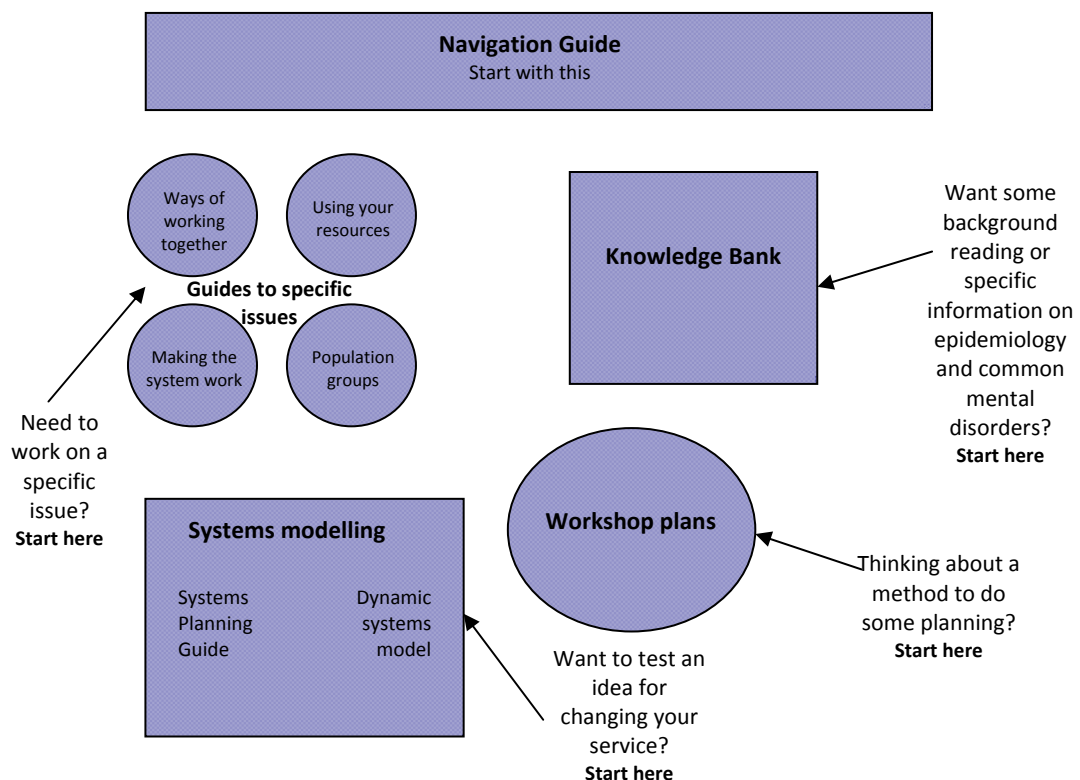
Working through the pathway

If you are not clear about using the pathway see examples in Appendix 2 to Navigation guide. These two examples are based on our work with the four research partners and should assist with your understanding of the ideas in the pathway.

Choose your own entry point to the Toolkit

We are acutely aware that you are likely to have limited time. Because of this it may be most efficient for you to choose your own entry point to the Toolkit. There are several ways to do this. For example, the person leading primary mental health care service development, planning or policy in your service could simply choose a problem to work on or the choice could be made using a workshop process for identifying and prioritising key issues.

Figure 2 below is a visual representation of the Toolkit components that shows another way they relate to each other, and possible entry points. Always start by reading the Navigation Guide.



Jump start your planning

If you are struggling and need a jump start to help your planning get off the ground, see the short cut sheets in Appendix 3 to this [Navigation guide](#). These examples are based on our work with the four research partners and should assist you.

The jump start short cuts are:

- There is too much to do and it is overwhelming: where do we start?
- We have lost our way and can't seem to agree again on the overall goal
- A powerful person is blocking or sabotaging the plan
- Bullet-proofing

Appendix 1: Planning principles

- ❑ **Focus on the 'service user' journey.** Critique the service/plan/policy from the perspective of someone who is using the service to get help for their mental health problem. Ask what the result of your work would be like from that perspective.
- ❑ **Use a quality improvement frame.** Service development and improvement is an iterative process, or journey. As trite as it sounds, the process/journey is as important as the destination. Make sure you value to opportunity to review and reflect.
- ❑ **If it's possible it's perfect.** Be pragmatic. Do what you can this month and this year but don't stop aspirational planning.
- ❑ **Form follows function.** View all your choices and decisions in the light of an ideal where the form of the system serves its function.
- ❑ **Population versus person: the creative tension.** We have used the idea of the dialectic to support acceptance and creative management of this tension. Using this idea means you accept the apparent contradictions between the prioritisation of a population or individuals. Through discussion and trying out ideas (for example, as scenarios in the Systems Model software, testing ideas with stakeholders, and in real life practice) you will move to a position where one perspective overcomes the other, a synthesis or combination of the perspectives is accommodated, or there is a change in the focus of the discussion. The quality framework, where change moves in a spiral rather than a straight line, is consistent with the dialectical framework.

Appendix 2: Examples of working through the pathway in Figure 1

Example 1

Karys is a social worker appointed as the Mental Health Coordinator for a PHO that includes 10 practices. She quickly identifies the longstanding split between primary and secondary mental health services as a key problem. If it is not solved, she cannot see how other aspects of PMHC can be improved.

Karys main task is to bring people together and try to foster a sense of a common goal to work towards. She reads the materials on [ways of working together](#) in the issues guides. As part of her orientation she also makes a point of identifying and talking individually to the key players and people of influence in mental health and primary care. She takes a non-critical approach to this information gathering, assuming that people have their own good reasons for behaving the ways they do. Next Karys searches the web for some ideas on how to bring people with differing agendas together. She enlists a local influential GP and psychiatrists to work with her on a plan to facilitate better communication, with a medium term aim of more shared care arrangements. She has to use some of her budget to pay for the GPs time but considers it well spent as his involvement enhances the credibility of her role with the GPs. When she reflects on what she gained from the Toolkit, it was very simple- it gave her permission to take time to plan and reflect, build relationships, and confidence to take a risk by engaging senior people.

Example 2

Eru is the manager of mental health services at Central Heights DHB. He manages the clinical service. Over the past few years it has been difficult to sustain the secondary care community-based Maori Mental Health Service as there has been major staffing issues. The problem has been getting skilled staff and the service has been at the mercy of a few staff with political agendas that are not consistent with that of the DHB. He has been increasingly worried about the quality of that service. The main local PHO is iwi-based and runs an excellent service for PMHC. Eru is thinking that if he put the community care resources from the Maori mental health service into the PHO perhaps they could run the service as part of the primary care service. He also

knows his knowledge of PMHC is limited. To increase his confidence he gets some reminders on identifying key stakeholders from the issues guide on [relationships and communication](#). Eru then decides to discuss the problem with others and meets with a few key DHB staff to explore and define the issues. They decide to use the [Dynamic System Model](#) to look at different possibilities for increasing the numbers of people going through the PMHC service. He is primarily looking at what services he might be able to get for the available funds, acknowledging that the consumers he is focussing on have secondary care kinds of problems. Eru hypothesises that it would be possible to have people seen in primary care by using the extended GP consultations, if he puts a psychiatrist in for one day per week and locates a fulltime secondary mental health nurse at the PHO. He then invites the relevant PHO staff to a workshop where they bring their knowledge of their local population and use the [Dynamic System Model](#) again to gain a more precise idea of how this could work. He is quite anxious that the workshop could be hijacked by the political issues so he prepares very carefully and ensures it is well contained and managed. He uses a skilled facilitator from another part of the DHB to manage it so he can participate and so there is a sense of neutral guidance of the process. The PHO staff are concerned that the quality of what they do will be undermined but as they share the concern about Maori having access to an effective service they are willing to try the new approach. In the workshop they use [Optimal Model II](#) as an aspirational benchmark. They identify that they may be able to link with aspects of a new social services programmes under Whānau Ora. A six-month pilot is planned after which, if it is successful, the Maori Mental Health Service will be wound down and all resources transferred to the PHO. A joint quality review process is agreed.

Appendix 3: Jump start your planning: shortcuts

Shortcut 1

There is too much to do and it is overwhelming: where do we start?

You don't have to do everything. Many small things together can make a difference. Agree on 1-3 things you can start this month, and agree to review them. This can be as simple as a counsellor phoning the GP of a patient to let them know of progress. It could be asking a patient for feedback on the mental health care you offered, or starting regular contact with the person in the DHB who arranges your contracting, to build the relationship.

Shortcut 2

We have lost our way and can't seem to agree again on the overall goal

Go back to the original basic principles of the Toolkit, or the one you valued most highly. These are useful anchors. Alternatively, you might have developed some of your own, so go back to them.

Principles

- ❑ **Focus on the 'service user' journey.** Critique the service/plan/policy from the perspective of someone who is using the service to get help for their mental health problem. Ask what the result of your work would be like from that perspective.
- ❑ **Use a quality improvement frame.** Service development and improvement is an iterative process, or journey. As trite as it sounds, the process/journey is as important as the destination. Make sure you value to opportunity to review and reflect.
- ❑ **If it's possible it's perfect.** Be pragmatic. Do what you can this month and this year but don't stop aspirational planning.
- ❑ **Form follows function.** View all your choices and decisions in the light of an ideal where the form of the system serves its function.

- ❑ **Population versus person: the creative tension.** We have used the idea of the dialectic to support acceptance and creative management of this tension. Using this idea means you accept the apparent contradictions between the prioritisation of a population or individuals. Through discussion and trying out ideas (for example, as scenarios in the Systems Model software, testing ideas with stakeholders, and in real life practice) you will move to a position where one perspective overcomes the other, a synthesis or combination of the perspectives is accommodated, or there is a change in the focus of the discussion.

Shortcut 3

A powerful person is blocking or sabotaging the plan

This can be challenging and frustrating. Sometimes people are not doing this deliberately, but are fixed on their own agenda and this gets in the way of yours. However, sometimes it is deliberate (it may still be well intentioned). It may not be personal and often isn't. In any social system there are power differentials, so the first step is to recognise and accept that. The situation does not necessarily reflect on you as an individual. In order to be able to examine the scenario from the "outside", seek some supervision, advice, or collegial conversation with a trusted colleague. Someone outside the service may be best if it is a sensitive issue.

Shortcut 4

Bullet-proofing³

Although bullet proofing is best built into a planning or change process from the beginning, it can be used at any time, such as deciding on the next step especially if a block has occurred. The process of working through this should be done by the person leading the planning or change, supported by appropriate team members and stakeholders. Brainstorm what could possibly go wrong in your project, areas

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http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/creativity_tools_-_bullet_proofing.html

that could cause problems, or possible consequences of whatever has caused it to be stalled. For each item in the list, consider how likely it is to occur and how serious it would be. Then prioritise according to the consequences for your continued progress, and move to problem solving mode. Perhaps you need to build time for solving some of these potential problems into your timeline. Who do you need to work with to get commitment or compliance?

One exercise that can be really useful is the 'simple rules' exercise. Often we are stopped from doing things differently by simple unspoken rules that we all adhere to because 'that's the way it's done around here', and we just don't give it further thought. Once you have identified your problem, consider some ordinary occurrences in relation to the problem, in your system. Ask the questions: what is the underlying mental model for this instance of the problem, what unwritten rules support it? Once you have identified the rule(s), you can re-write it (them). Try an experiment by purposefully breaking the rule(s).

"Like lots of breakthroughs, the Fosbury Flop looked strange the first time you saw it. Really strange."

Tom Kelly IDEO Design

Toolkit for Primary Mental Health Care Development: Part 2: Knowledge Bank

Knowledge bank

This section of the Toolkit contains four perspective papers on the following topics:

- Where next for Primary Mental Health Care? - current issues and opportunities
- Diagnosis and management in Primary Mental Health Care: a paradox and a dilemma
- Quality in Primary Mental Health Care
- Towards the future Primary Mental Health Care: Optimal Model II

It contains copies of the following guidelines:

- Identification of Common Mental Disorders and Management of Depression in Primary Care (2008)

Other useful links:

www.primarymentalhealth.org.nz (Ministry of Health's primary mental health and addiction website)

www.nzgg.org.nz (see Guidelines for Identification of Common Mental Disorders and Management of Depression in Primary Care)

www.hiirc.org.nz (Health Improvement & Innovation Resource Centre)

www.tepou.co.nz (New Zealand's National Centre of Mental Health Research, Information and Workforce Development)

http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/creativity_tools_-_bullet_proofing.html (NHS Quality and Service Improvement Tools)

<http://www.thelowdown.co.nz/> (The Lowdown - Youth depression website)

<http://www.depression.org.nz/> (National Depression Initiative, featuring John Kirwan and the Journal)

Where next for Primary Mental Health Care - current issues and opportunities

Organised primary mental health care (PMHC), in the form of structured services and programmes, is a relative new-comer to health services with a range of issues and challenges in its development. This perspective paper explores these issues through the lens of an action research partnership across four districts, undertaken during 2009- 2010. Details of the research process and analysis that underpins this essay can be found in the main report.

The issues identified through the research range across a spectrum from practical service operation, requirements of service management, inter organisational systems to more fundamental questions about the purpose of PMHC and its fit within a continuum of care. Taken together they describe a service that is in its adolescence with some substantial stages and developmental transitions to address before it achieves a sustainable maturity.

The context of today's concerns

Organised PMHC has largely emerged since the establishment of the Primary Mental Health Initiatives (PMHIs) funded by the Ministry of Health in 2005 (Dowell, Garrett, Collings et al. 2009). Until the introduction of the PMHIs there had been no central funding to specifically support PMHC, with this kind of activity limited to a small number of primary health organisations (PHO) or District Health Boards (DHB) projects. The PMHIs included extended consultations and packages of care for patients with 'mild to moderate' conditions, together with training for practitioners and primary mental health coordinator roles to support local operation and integration.

While PMHIs were successful in establishing a primary mental health capability with clear benefits for those people gaining access to services, the pathway of development to date has clearly had its limitations:

- ❑ It has been established using a PHO level bottom-up process. Consequently the strategic context for PMHC and its purpose and function within wider primary care or within the continuum of mental health care has generally had little attention. As a result there is substantial variation in focus, approach and equity of access across PHOs, and lack of connection with the wider primary care and DHB services.
- ❑ The PMHIs have had relatively modest funding. While this has supported the development of a basic level of service in most PHOs or districts it has not been sufficient to develop a broader infrastructure of relationships, leadership, service development and integration that is capable of addressing sustainability issues.
- ❑ Limited and centrally driven funding has meant that there have been pragmatic choices made in each PHO over targeting their services. Comprehensive population planning and outcomes targeting has been limited. There are unresolved challenges in managing both access criteria and model of care trade-offs between breadth and intensity of services.
- ❑ The programmatic, 'packages of care' nature of the initiatives means they are not well integrated horizontally with 'business as usual' primary care (including self care and care for long term conditions), nor vertically with DHB supported community and specialist mental health services.

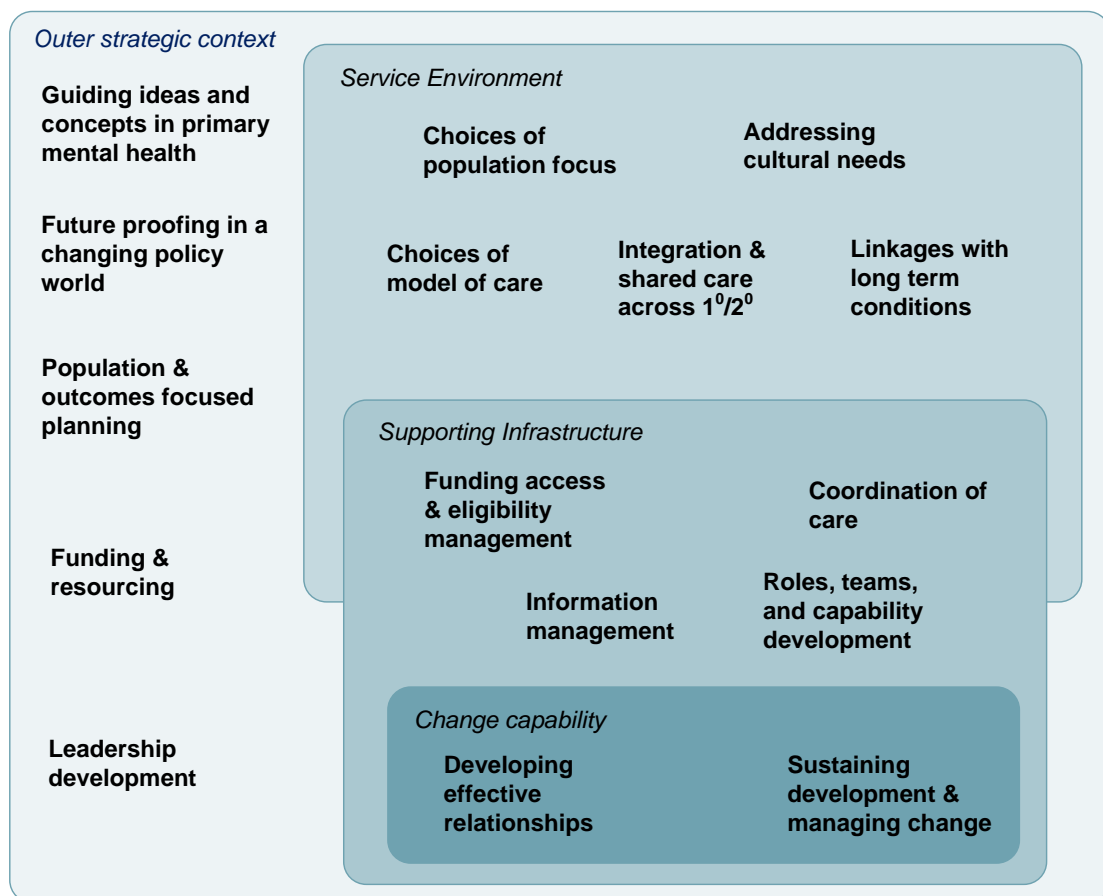
The future development agenda for the sector, as described by the Ministry of Health (Ministry of Health 2009), draws on the stepped care model with integrated interventions at different steps of intensity with linked monitoring of service user outcomes to achieve a coordinated 'least intensive, most effective' system of care across primary, community and specialist settings. The Ministry guidance paper describes thirteen areas for development but not how to operationalise this direction within the current operating environment.

In a partial response this paper articulates the nature of the issues facing clinical leaders, service managers, planners and funders in developing a sustainable primary

mental health capability, with pointers to further development contained in a series of issues focused guides within the Toolkit.

A framework for current issues

The diagram below provides an overview of the issues covered in this essay. From issues that shape the strategic context to those that create the service environment, and, within this the supporting infrastructure need to maintain the service environment and develop that change capability needed for sustainability.



Developing the strategic context for primary mental health

The emergent nature of structured PMHC has been described above. What is clear from our research is that the pathway of its service development has not been accompanied by the development of a powerful strategic context. In most areas centrally driven funding has stimulated service and capacity development in isolation from the broader streams of care system development. Without this context there is little which integrates the guiding ideas, trends in care systems, and policy and priority outcomes in a way that can mobilise the resources and leadership for its ongoing success. This perspective paper discusses five issues, aiming to help leaders and the workforce across multiple organisations in a geographical area create this context. The aim is to stimulate structured inquiry, dialogue and thinking towards an over arching framework for sustainable development.

1. Understanding the guiding ideas, purpose and function of PMHC

Mental health as seen in primary care is not simply a less severe version of the cases seen in specialist mental health practice. The broader range of presenting issues seen in primary care, their interrelationships, causes, consequences and relative priorities mean that primary care is more concerned with relative distress and functionality within a social context than diagnostic category or severity.

The concepts of mild, moderate and severe conditions which has dominated efforts to focus specialist services on the '3% severe' has tended to define the purpose of PMHC as being to address the 'non severe'. This arbitrary and implied dichotomy runs counter to a person centred view which would see all people with mental health conditions needing primary care, supported by specialist assistance as required.

Taking this starting point the Toolkit explores the function of PMHC in terms of effective responses to episodic distress and impaired functionality within the person social and cultural context. This provides a strategic platform to engage people and their whānau, clinicians, service managers and funders to ask questions about the

role of primary and specialist services in mental health and how to best utilise the resources and capability used across the whole continuum.

2. Future proofing in a changing policy world

The policy context that gave rise to structured primary mental health is continuing to evolve.

- ❑ Long term service trends are simultaneously increasing the specialisation of care and emphasising greater shared care; between specialists and wider primary care, and between health services and people and families as co-producers of care. These trends will drive greater integration e.g. the development of mental health services in integrated family health centres and the adoption of variants of stepped care. Similarly there will be pressures for further development of supported self care through e-therapies, peer support and mental health capable community health workers.
- ❑ Changes to funding pathways: The tight ring fencing of mental health funding (particularly for secondary and community services) is loosening. This is a challenge in that it will require mental health to justify its priority against competing demands. It is also an opportunity in that it provides greater freedom for rethinking how best to deploy capacity across the continuum of mental health care. Funding pathways in primary care are changing as flexible funding pools, alliance contracting and Whānau Ora funding models will blur the hard boundaries of existing funding streams and place more onus on providers to prioritise and manage resources to achieve better health outcomes.
- ❑ Workforce skills shortages and pressures for much higher levels of productivity will generate pressures for developing models of care that make finely tuned use of scarce, expensive resources and that facilitate use of new workforce roles, including those of patients and families.

- ❑ The same productivity pressures are generating a search for scale and efficiency across health organisations; whether this is PHO amalgamation, regionalisation of DHB services or national shared services.

Taken together this represents a substantial challenge to a relatively new and emergent PMHC subsector. The existing model of relatively independent PHO service direction and decision making will need development into larger scale integrated thinking and development across area wide mental health networks. The PMHC infrastructure of leadership, workforce, information and clinical knowledge and skills will need attention. As an example few, if any, areas currently have the capacity to operationalise the thirteen key areas of the Ministry of Health's 'Towards optimal primary mental health care in the new primary care environment guidance essay' (Ministry of Health 2009).

3. Developing population and outcomes focused planning frameworks

The emergent pathway of development of the PMHIs shows that few areas have developed effective planning frameworks for PMHC. The issues that any area faces are varied and complex. There is no one solution that can be applied across the country and because of this it is important that each area comes to grips with its own population, needs, and the characteristics of the people and resources who can respond to them. However, from a national perspective it is important not to have too much variety or fragmentation, so that similar service standards can be maintained everywhere, and so that services are provided within a coherent strategic framework.

The Toolkit provides a [Systems Planning Guide](#) designed to help facilitate conversations about PMHC, so that districts or local areas can design solutions that best fit their particular circumstances. It takes a systems approach that explores the linkages and relationships across population profiles, service need, models of care and service provision. The [Systems Planning Guide](#) provides a prompt for the discussion needed to understand the issues in more depth and develop answers relevant to a particular region.

4. Funding and resourcing

The PMHIs are currently supported by \$22.5m p.a. of ongoing funding (Ministry of Health 2009). The evaluation of PMHIs identified all up costs of \$580 - \$930 per patient treated (Dowell, Garrett, Collings et al. 2009). Assuming a NZ population of 4.3 million people (including children and young people) and the 16% with mild to moderate common mental disorders represent 688,000 people. At a nominal standard costs of \$750 per person, we can help 30,000 people per year that is, 4.4% of those potentially eligible.

Within this funding bucket, improving allocative efficiency through ensuring the funding reaches high need populations is important; however its relative small size means it is unlikely to stretch to cover the high need populations. Increasing efficiency, particularly through using models of care with brief interventions can potentially increase the reach of the existing funding substantially.

Finding pathways to provide leverage for the impact of the dedicated PMHC funding will be critical to future development. One pathway could be to increase the impact of 'business as usual' primary care; increasing the synergies between mental health and programmes for long term conditions, utilising low cost options such as e-therapies or green prescriptions and utilising low intensity brief psychological interventions within the primary care team.

The other potential opportunity is to leverage the \$1b spent on specialist and community mental health. The shift in focus and function described above provides an opportunity to think differently about how the capacity of the system as a whole is used. Some thinking suggests that segmentation by need could better differentiate severe and enduring (0.6% of the population consuming perhaps 50% of the resources) from episodic care needs, opening the door to a collaborative shared mental health model of care between primary, community and hospital based services (Kates 2002).

To explore the possible impact of these changes the guide in this Toolkit describes approaches to planning, the development of leadership and approaches to primary/secondary integration.

5. Creating effective system leadership for primary mental health care

Creating an effective leadership environment is essential for sustainable PMHC. Inevitably because of the nature of PMHC this will involve distributed leadership, that is, a network of leadership across organisational and disciplinary boundaries.

While each PHO service or programme has their own management structure we found leadership to be highly variable within PMHC with few districts having the functional leadership capability to think through or direct the development of a sustainable system. This is not to devalue the leadership capability we observed or the individuals acting as champions who promote service development. However, if we think of leadership as a system function it should have some form, processes and capabilities. The focus of the guide on [leadership](#) in the Toolkit is on these functions of leadership - seeking to support localities in assessing their existing capability and how to improve it.

Developing the service environment

Our image of the current service environment is of a demonstrably capable service that is operating in a very small corner of a huge and dimly lit room, providing high levels of benefit to those who walk through its door but with no surety that it is effectively contributing outcomes within a system as a whole. The five issues explored in the next section aim to focus our PMHC capability and generate maximum impact through synergies within the wider sector as an integral part of a whole system.

1. Choices of population focus

Not surprisingly for a service that has emerged from a pilot capability development background few PMHC services are founded on a comprehensive view of population need. For pragmatic reasons most have taken a condition focus, (e.g. depression or

anxiety), and within this established eligibility requirements that further define the population who can access services. This generates substantial questions of equity and effectiveness, for example;

- ❑ The original priorities for the PMHIs included a focus on Māori, Pacific and high needs populations and while substantial progress has been made, service utilisation for some populations (e.g. Pacific) remains low.
- ❑ Age based exclusions when evidence suggests equal benefits for both younger and older patients at similar levels of severity.
- ❑ Little focus on child or youth when the evidence clearly shows the lifelong impacts at individual, social and economic levels, of mental health problems early in life.
- ❑ Complex co-occurrence of stressful life circumstances, mental health problems and physical illness; where the evidence is clear that people in these circumstances suffer excess morbidity.

The Toolkit [Navigation Guide](#) leads you through an inquiry into the potential issues and opportunities of rethinking the population focus of PMHC. Better choices could both improve the impact of the current investment in services and help support the business case for further investment.

2. Choices of models of care

While there is a building of knowledge and an evidence base of effective mental health care in primary settings there is a wide range of variation in the models of care used in practice. For example, the evaluation of PMHIs found nine distinct models in use. These differed considerably in terms of type of capability, workforce and resource required. In many cases the model of care has been driven by availability of providers or therapeutic tradition and differs substantially across PHOs within each area.

Since choice of model of care can have a substantial impact on outcomes, population reach and resource usage, developing consistent and coherent approaches is a critical issue for future sustainability.

Future sustainability will require integration of the newly developed structured PMHC services within a wider set of responses. These will include better support for the majority of mental health needs that are currently met by the GP or practice nurse in the context of existing consultation times; and alongside the competing demands of other health issues. There will be a need to integrate e-therapies and support for self, whānau and peer supported care within the community. At the more intensive end, shared care responses with specialist services will be required to make better use of limited resources across the sector as a whole.

In parallel, Whānau Ora, kāupapa Māori and Pasifika models of care are emerging as essential components of the total service mix to meet the needs of specific populations.

Policy direction points towards use of stepped care as a framework for development, yet the pathway for development is unclear and may be different for each area. The Toolkit proposes a process for planned evolution, building from the [Population Based Planning Guide](#), to explore, define and prioritise the important steps and transitions required.

3. Addressing social and cultural needs

The broader view of mental health in a primary care context described earlier places emphasis on both distress and impaired functionality within people's social and cultural context. This perspective focuses attention on the potential of interventions that reduce symptoms and stress, and those that enhance the social strength of the community, family and whānau to support the individual.

Some services, particularly Māori, are investing in the engagement of a wider circle of whānau within a cultural approach to develop social strength and collective family capacity. Our observation is that effective services using this model tend to require

more time and longer duration of engagement, and therefore require care in the design of programmes, effective targeting and the ability to utilise multiple funding streams. It is important that there is continuing evaluation of services that require intensive funding.

The challenge for PMHC in the short term is to understand the trade-offs between the less immediately tangible but potentially more enduring benefits of this more intensive model of care, and the more readily demonstrable benefits of less intensive brief interventions with greater reach for lower cost.

The challenge in the medium term is to integrate PMHC with effective and efficient ways of mobilising the social context through self care, health promotion and family/peer support.

4. Primary/secondary integration and shared care

The sector has seen a number of steps towards greater levels of integration of mental health care across primary, community and specialist settings. In the past these have been driven by deinstitutionalisation and the establishment of care in community settings. Previous primary/secondary shared care developments have used mixes of consultant/GP liaison, shifted outpatients and shared care models (Nelson, Fowler, Cumming et al 2003) with the goal of de-burdening limited specialist resources, but focusing on the moderate to severe cases.

The emerging opportunity is to develop shared care from a whole of system perspective, drawing on the emergent strength of primary mental health services as part of that whole.

A number of separate influences are potentially converging to make this a possibility:

- ❑ Previous shared care initiatives were largely specialist driven, with implicit assumptions that specialist knowledge and skill transfer was critical. The development of structured PMHC is building a primary care knowledge and skill base that is effectively handling complex mental health needs. This

different, but complementary, primary practitioner capability opens new opportunities to organise care across the continuum.

- ❑ Better understanding of the nature of the population and health needs currently served by secondary and specialist funded community services is highlighting that many are not receiving appropriate high quality care. Lessons from initiatives such as 'Knowing the People Planning' highlight that many people with severe diagnostic categories are relatively stable with only episodic need for more intensive support. Similarly many people with complex and enduring mental health needs are not receiving comprehensive bio-medical care.
- ❑ Ministry of Health policy direction supports the implementation of stepped care and the greater role of integrated primary/community based health services. Stepped care requires a coherent approach to mental health services across the continuum. A critical functional element will be acceptance that responsibility for certain aspects of care remain with the primary team, and that specialist care, including shared arrangements, will be integrated with this.
- ❑ Potential of greater flexibility in mental health funding with the relaxation of funding ring fences that could facilitate a whole of system view about how mental health resources and capacity are used.

5. Linkages with long term conditions

Within primary health care settings the co morbidity between physical and mental disorders is a reality that makes separation of responses within artificial clinical boundaries less effective in terms of care and inefficient in terms of duplication of resources and capabilities. This is especially true with the overlap between mental health and long term conditions where co-occurrence is the norm and exacerbates the morbidity burden of each in isolation. On this basis alone PMHC cannot be divorced from services for physical health.

However, responses for mental health and long term conditions have similarities and difference that are important to balance in model of care development and service

design. By definition long term conditions are enduring and are likely to require sustained and increasing intensity of support over time. In contrast mental disorders are very largely episodic, needing interventions during periods of relapse or stress combined with support to enhance resilience and capacity for self care.

From a pragmatic perspective the future evolution of both streams of healthcare are likely to have much in common; motivational development, simple cognitive and behavioural strategies such as problem solving, self care and resilience development are examples of common shared best practice.

Similarly, at the level of service development and infrastructure an alliance of primary mental health and long term conditions development could provide a combined critical mass and scale that primary mental health struggles to achieve on its own.

The [Toolkit issues guide on Mental Health and Chronic Conditions](#) provides a set of prompts and ideas to encourage better linkages as a key part of sustainable primary mental health development.

Developing a sustainable infrastructure

A major concern arising from our research is that the infrastructure for PMHC is relatively embryonic and limited in its development to service management within PHOs. To develop sustainable PMHC, able to address the future demands of policy and service changes, a more capable infrastructure is needed.

1. [Aligning funding, service design, contracting and service prioritisation criteria](#)

Structured PMHC, at current funding levels, meets only a small fraction of the population need estimated to have mild to moderate needs. Options to leverage a wider range of resources within the system may lift this level but will not change the fundamental challenge to align funding for specific population need, allocation of resource to and across services and individual clinical treatment decisions. To date most PMHC services have addressed these issues in a relatively simplistic fashion;

condition based population targeting, service allocation via 'packages of care' and individual treatment decisions based on eligibility criteria.

While this has been adequate to support relatively limited scale, discrete PMHC initiatives it has significant limitations; areas of high need have been ignored, the range of service options and intensity used does not allocate resources efficiently and the eligibility threshold approach risks both overspends and inequity of access.

Developing a sustainable PMHC system with more complex care models will require a more sophisticated approach and capability in service management.

This will need to address issues such as:

- Which populations? (See the [Toolkit Systems Planning Guide](#) and [Dynamic System Model](#))
- What balance of need and ability to benefit is to be prioritised for funding?
- What service models best match need with a range of service intensity (e.g. steps in care), so as to use the least intensive, most clinically effective resource available?
- What funding streams are available to support the mix of service intensity and capacity? How will these individual funding streams work together?
- How will this be managed and coordinated through contracts across a network of providers?
- How will individual clinical prioritisation decisions be made to ensure the resources available are directed to those with highest need? How will ongoing access prioritisation decisions be made across the network of services? (e.g. how will referral, step up/step down, and exit/re-entry decisions be made using common criteria?)
- How will the dynamic connections between clinical responsibility for resource spending decisions and service management accountability for budgets be managed?

The Toolkit issues guide on 'Eligibility Criteria' picks up the issues of prioritisation and clinical leadership required for responsibility and accountability.

2. Coordination of care

The system for providing PMHC is fragmented across many organisations, funding streams, business models and professional groupings. At all levels from service user experience of care, managing and maintaining clinical services or managing costs, this fragmentation presents considerable challenges. The advent of structured PMHC initiatives has kick-started the development of coordination functions in various clinical and non clinical forms.

As PMHC is maturing, with moves towards larger groupings of practices and PHOs, and greater attention on the opportunities of primary/secondary shared care, there is an opportunity to pay greater attention to the types of functions involved in coordination and consider how these are most effectively deployed as part of a sustainable infrastructure. For example:

- ❑ Service user focused coordination; needs assessment and service access, case management and advocacy
- ❑ Information coordination; common assessments, referral and shared care information exchange, self care support and follow-up
- ❑ Network focused coordination; interdisciplinary team development, community liaison, cross boundary clinical governance
- ❑ Service coordination; training, service quality improvement, financial management and contracting

Currently many of these functions are mixed up with a few individuals fulfilling all aspects because of the small size and the discrete nature of most PMHC initiative based services.

Sustainability will require more coordination capability than this approach provides, with requirements to mainstream and integrate some aspects of PMHC coordination

for scale and effectiveness, while increasing focus on the specific aspects that more integrated clinical model will require.

The Toolkit issues guide '[Coordination of Care](#)' provides a process for inquiry and design for this critical component of service infrastructure.

3. Roles, teams and capability development

PMHC is dependant on the continuing development of a number of complementary clinical and service roles with increasing capacity to function as a team in a complex model of care.

There are a number of barriers to formation of effective team based care. In many programmes GP engagement is very variable with some not seeing themselves as part of a PMHC team. This can be exacerbated by the development of specialised primary mental health teams of psychologists and counsellors operating at arms length to practices and also not acting as part of that team. There are also substantial wider issues such as achieving strong working relationships with specialists and practitioners operating in the NGOs.

Building team environments that support good working relationships, the establishment of knowledge, trust and confidence in respective skills will be a critical part of the future sustainable PMHC infrastructure.

While some of this can be created at a service operating level it will also need a more strategic view of the workforce and capacity needed across the mental health system as a whole. For example what type and level of workforce will be needed to operate an integrated stepped care model? Could the existing workforce capacity be utilised more effectively by shifting roles and functions or where their work is carried out? For example, utilising specialists to provide assessment and advice in primary settings or utilising existing community based mental health workforce as part of the PMHC team.

4. Creating an effective information environment

The current information capability of PMHC has emerged through a combination of standard Patient Management Systems, embedded templates to support service usage and referral decisions, and some custom built tools to monitor PMHC packages of care utilisation.

As with many other domains in health, PMHC lacks effective means to share information across a distributed team and with service users to support self care. This capability will need to be considerably developed to enable stepped care or shared care models to work effectively.

In parallel information accessibility is rising for people with mental health concerns or conditions; Google search, the ability to do on-line K10s, use of 'The Journal' to support self care and provide access to evidenced based e-therapies are current or very near future tools to support PMHC.

One of our partner DHBs has an integrated data resource for both individual care and population level analysis. However, most districts do not have the capability to gain a population wide view of service delivery or performance. Without this service development and quality improvement is constrained and clinical leadership is operating without a firm foundation of knowledge to guide practice.

At a national level there is a substantial investment in developing an information environment to support outcomes oriented service development for secondary care mental health consumers. However, there is little visible connection of this work into primary settings.

A critical concern therefore is the development of an evolutionary pathway for the PMHC information environment. Much of this needs to happen at a larger scale than PHO based services, at district, region or national level. However, this should not stop the local development of an information environment that supports quality of care and service development using the resources available.

Change capability

Across our research partners we observed a wide variation in change capability, from areas with well established structures for leading and supporting change through to areas that were so busy that change management was essentially reactive and ‘following the dollars’. In the area of sustainable infrastructure we are advocating two aspects for particular attention; actively supported processes to establish relationships across the sector and more structured investment in a base level of learning, development and change capability.

1. Developing effective relationships and communication

A major challenge for the newly emergent service structures in PMHC is the many unconnected or loosely connected agencies, organisations and people across the continuum of care. From a change capability development perspective a critical task is navigating the complex environment to engage these diverse stakeholders in developing a sustainable primary mental health system.

- ❑ There are challenges in establishing a strategic context for PMHC that is strong enough, so that stakeholders see this as a priority for attention amongst their other competing demands.
- ❑ There are substantial differences in paradigms and concepts across practitioners, professionals and managers operating in wider community, primary, NGO and specialist mental health settings, that will need to be integrated into a sustainable PMHC system.
- ❑ There are organisational and professional interests and investments in particular service configurations that will require adaptation and change as PMHC evolves.
- ❑ Building engagement and trust takes time and there are practical issues of enabling participation of key stakeholders where their time is highly committed and where participation is a financial burden on small organisations whether private businesses or not for profit agencies.

An effective change and development infrastructure will require more investment by localities in developing their relationship infrastructure. A clinical leadership network, with a service development role mandated by the key stakeholder organisation in an area, will be an essential component of a change infrastructure.

Since only a few areas currently have this capability in PMHC, the [Toolkit issues guide 'Relationships and Communication'](#) provides a process for stakeholder analysis to guide the design of an effective relationship capability.

The experience of areas with locality wide clinical steering groups already in operation should also be sought as a guide to establishing terms of reference, composition of the groups and design of effective operational processes.

2. Sustaining development and managing change

Finally the issue that almost governs all else in developing sustainable PMHC is the limited development resources for people, and limited time available.

Across the country there is almost no reflective time or structured learning ability designed into the operation of PMHC. This will have to be addressed through the creation of protected time that is invested into cross organisational leadership, steering groups and service development. Of all our suggestions, this is probably the most critical.

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Diagnosis and management in primary mental health care: a paradox and a dilemma

In this perspective paper we examine the issues associated with the diagnosis of mental health problems in primary care in relation to treatment and service provision, concluding that we are moving to formal acknowledgement that problems presenting in primary care are commonly mixed clinical pictures with associated social issues and that purpose designed refinements of current low-intensity treatments will be necessary.

Why do we classify and diagnose?

Diagnosis serves several purposes in all areas of clinical practice. Making a diagnosis requires classifying the clinical problem and gives the clinician a 'short hand' way of understanding the clinical problem, in particular what features the patient has in common with others with similar problems, what treatments are most likely to work, and what the prognosis is likely to be (Kendall 1975). Having a diagnosis enables health professionals to communicate with patients about the nature of the problem, and also with each other.

While clinicians have used diagnostic constructs for thousands of years, more recently diagnoses have also been used as part of sophisticated systems to determine what services people should have access to, and how services will be funded. The two main classifications in use, The World Health Organisation ICD system and the American Psychiatric Association Diagnostic and Statistical Manual (DSM), were both initially developed from systems which counted hospital statistics. They are now used not just in public health and research settings, but particularly in the case of the DSM, for health insurance and billing purposes.

Problems with classification and diagnosis

Although classification of psychological problems is important for research and service provision purposes and has become an important part of psychiatric practice, in clinical practice, it can be problematic for several reasons. Psychiatric diagnoses may be unstable over time within an individual (Baca-Garcia E et al 2007; Ghazan-

shahi et al 2009). The psychiatric diagnostic categories themselves are also unstable – for example, in the change from the DSM III (265 disorders in 1980) to DSM IV (279 disorders in 1994), 14 new disorders were introduced, with some new disorders being constructed and others disappearing. In ordinary psychiatric practice many of the treatments are not specific to existing diagnostic categories. Finally, having a psychiatric diagnosis is associated with the experience of stigma and discrimination, with some disorders being stigmatised more than others.

In the primary care setting, diagnosis is associated with these problems but additional issues add to the complexity. The diagnostic systems in common usage (i.e. the ICD and DSM systems) are largely derived from specialist psychiatric practice, and reflect the kinds of sign and symptom patterns that are seen in that setting. Over the years the diagnostic categories have been refined to better reflect the presenting problems and what is increasingly known about their aetiology and underlying pathophysiology. In this process the number of diagnostic categories has increased and the inclusion and exclusion criteria have become more precise. This process has also led to increasing use of the ‘not otherwise specified’ categories as even psychiatrists find the categories cannot accommodate the problems people present with. It led the classification system further away from what is commonly seen in primary care: for example until its current version the DSM system did not have a category for ‘mixed anxiety and depression’, the most common presentation in general practice settings. Furthermore, there has to date been a focus on *categories* rather than considering symptoms and functioning in various domains as *dimensions* of experience and observable phenomena. In relation to treatment, there have been increasing attempts to tailor treatments to the more specific diagnostic categories, although observation suggests that this is usually short-lived and that after a period the indications for new treatments tend to broaden out to include more diagnoses (i.e. the treatment becomes less specific).

Alongside all these issues, a fundamental problem for primary care practitioners is that the syndromes that reflect some aspects of problems presenting in psychiatric practice quite well, do not suit primary care practice. This is because primary care

patients usually do not present with such clear cut patterns of signs and symptoms. People often present to primary care with mixed clinical pictures, and syndromes evolve over time. Furthermore, in primary care settings, people commonly present with non-specific psychological distress, i.e. with syndromes that do not meet the diagnostic threshold. Just over one quarter of primary care patients are considered by GPs to have diagnostic sub-threshold problems. These 'sub-threshold' problems are common, and are associated with significant suffering and impaired functioning (Collings et al. 2006; Martin et al. 1996; Wagner 2000). For example, many patients in primary care with problem drinking would not reach the threshold for alcohol dependence, but nevertheless create significant problems for themselves, their families and society.

Medically unexplained symptoms (i.e. a combination of psychological and persistent physical problems with no detectable underlying pathology) often represent psychosocial distress and are common presentations in primary care. Many of these symptoms may come to be diagnosed as part of recognised medical conditions such as irritable bowel syndrome, but when the symptoms persist or become multiple in their nature it may be helpful to label them as a psychological problem. These can be challenging to manage as it is not clear which aspect to prioritise, and practitioners are fearful of 'missing' a treatable medical condition while also often experiencing frustration in the clinical relationship (Woivalin 2004).

Presentations of non-specific psychological distress associated with psychosocial complexity (e.g. welfare, housing or family/whanau issues such as violence) are common and do not lend themselves to simple diagnostic frameworks or responses (Dowell, Garrett, Collings et al. 2009).

These issues mean that both the diagnosis and treatment options for patients presenting in primary care are less clear-cut than in secondary care. From a classification perspective primary care does not fit well with the existing diagnostic systems. From a prognosis perspective, there is less evidence about the course of these mild-moderate mixed picture syndromes, but it we do know that a high proportion are eventually self-limiting (Jackson 2007).

Mental health problem identification in primary care

Most management of mental health problems takes place in primary care settings (Hornblow et al. 1990). Despite the problems with the utility of psychiatric diagnosis, primary care practitioners manage mental health problems frequently as part of their day-to-day work: over one third of adults attending primary care are likely to have met the criteria for a DSM disorder over the previous 12 months (MaGPIe Research Group 2003). How are the complexities outlined above resolved in practice?

We suggest that GPs are more interested in *detecting* psychosocial problems than *diagnosing* them. Although it has been suggested that GPs fail to *diagnose* mental health problems, we suggest that this claim is an oversimplification. GPs are effective at *detecting* mental health problems. The MaGPIe study showed that GPs identified psychological issues in the past 12 months in 70% of people who had already presented within the 12 month period and who had a diagnosable mental disorder during that time, but in only 33% of those who had not been seen in the previous 12 months. That study also showed that higher frequency of consultation was associated with problem detection (MaGPIe Research Group, 2005; Bushnell and MaGPIe Research Group, 2004). This suggests that continuity of care is an important element of problem detection. The same study showed that GPs consider functioning as well as symptoms when detecting psychological problems (Collings and MaGPIe Research Group 2003), suggesting that GPs do not use the same diagnostic frameworks as used in secondary care.

The clinical practice context is an important determinant of whether a primary care practitioner will decide that a psychological problem is present, and whether a decision to actively manage it is appropriate at any given time. For example, having detected a psychological problem, the practitioner may choose to address other more pressing problems in that consultation if the patient has minimal functional impairment (Klinkman et al. 1997). Furthermore there are almost always other constraints such as time and resource issues (Klinkman 1997).

Links between problem identification, diagnosis, clinical management and service provision

Because health resources (both money and skilled staff) are finite, there is a need to systematically determine what problems 'qualify' for treatment and what treatment options will be made available. The use of clinical diagnoses to determine access to treatment and other services is widespread in health services internationally, and ranges from tightly prescribed options such as those common in Managed Care settings in the USA, to clinician determined options which are common in secondary and tertiary mental health services in New Zealand.

Funding and service delivery in New Zealand primary mental health care (PMHC) is currently predicated on being able to define clinical problems using the general diagnostic fields offered in the DSM and ICD systems, and on being able to distinguish 'mild-moderate' from 'severe' problems. However, even outside mental health, GPs are known to use widely varying practices in relation to diagnostic coding (Brown et al. 2003). Add to this what is known about the specific frailties of psychiatric diagnosis, and the uncritical use of a purely diagnostic approach in day-to-day primary care clinical practice must be open to question.

Although the DSM and ICD diagnostic systems themselves are probably rarely used in PMHC in New Zealand (Dew et al. 2005), the screening instruments that have come into common usage as part of the process of determining eligibility for primary mental health services (e.g. the PHQ-9 and the K-10) are strongly linked to these diagnostic frameworks (Kessler et al. 2003; Kroenke 2002). The choice to use these instruments was a consequence of the thinking that simple and brief tools were needed to determine eligibility for treatment.

We contend that this was easy to adopt in the PMHC setting because PMHC development in New Zealand was already being driven in part by secondary mental health service thinking and philosophies. Two simple examples support this assertion. The first relates to the default and even articulated age limits on most of the PMHC programmes running in New Zealand at present. Very few cater for

children or people over the usual working age, replicating the age-based service divisions seen in secondary mental health services but not primary care. The second example is that most PMHC services essentially replicate the secondary care model, where people with certain kinds of problem, in this case mental health problems, are referred out of the practice to be treated or managed by a person with 'specialist' skills such as a counsellor or psychologist. Associated with this are potential barriers to treatment and good clinical management, including waiting times, possibly having referrals declined, having to locate and attend an unfamiliar treatment setting, poor communication between treating and referring clinician and administrative problems (Mathieson, Collings & Dowell 2009).

We know that in New Zealand GPs take a very pragmatic approach to problem classification and management (Dowell, Garrett, Collings et al. 2009). Diagnosis is not always (or maybe even often) seen as a necessary step in arriving at a clinical management plan. Many GPs have been reluctant to 'pigeon hole' their patients with psychiatric labels, particularly if there are, for example, insurance company implications (Dew et al. 2005). Primary care practitioners will more often use generic labels such as anxiety/depression. They tend to be 'lumpers' when it comes to classification rather than 'splitters' who create multiple sub-categories. Practitioners are aware of the impact of psychosocial issues and are prepared to classify accordingly. In some parts of the country service provision is dependent on a psychiatric or DSM diagnosis, and where this is the case then GPs will tailor a diagnostic category to ensure access to treatment. In other cases, the practitioner only has to provide a 'diagnosis' of 'mild/ moderate mental health problem, to obtain services for a patient.

The apparent paradox of PMHC is that while most mental health care is provided in primary care settings and this is usually done without a formal psychiatric diagnosis, treatment can be very effective at reducing symptoms and improving functioning (Dowell, Garrett, Collings et al. 2009). This brings with it a significant dilemma for those working in policy, planning and funding, for whom the accurate estimation and forecasting of clinical activity and associated budgets is critical. While funders may

recognize the reality of primary care practice, they find it hard to commit funding to programmes that appear loose in their prescription.

Figure 1 on the next page illustrates the elements of the primary care practitioner's process for detecting and characterising mental health problems. This is adapted from our previously published work (Dew et al. 2005) to highlight the introduction of screening for the determination of eligibility to receive services. During the course of a consultation, the clinician weighs up the options around focussing on one problem, or one aspect of a problem, over others. Note that the determination of eligibility to receive primary mental health services outside the routine consultation can occur at any time and is not contingent on a formal diagnosis being made. In some cases the practitioner will have decided early on that additional help for the psychological or psychosocial issue is warranted and will construct the diagnostic or other eligibility criteria to ensure the person receives help.

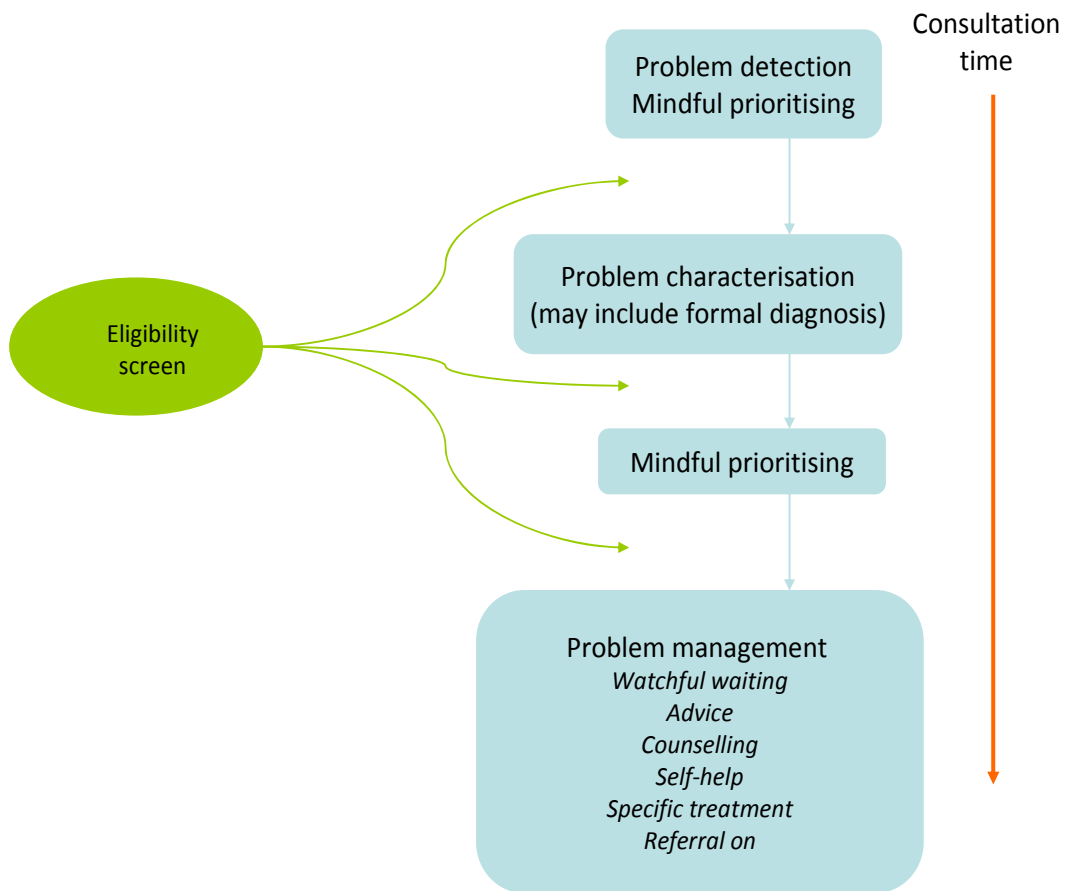


Figure 1: The primary mental health assessment process, which is reiterated over multiple consultations: mindful prioritising between multiple competing issues

An interesting aspect of PMHC development in New Zealand is that there is an upper threshold for eligibility. The original Primary Mental Health Initiatives were required to be designed so that those with 'severe' disorders were not seen but were referred on to secondary care. This created some interesting scenarios where it was known by GPs that the local secondary services would not accept the referral. As although screening scores (e.g. K10 scores) were at the severe end, the person was neither psychotic nor at risk of suicide. These people were commonly kept in the PMHC service and often managed effectively.

The dilemma around treatment provision in primary care is compounded by inconsistent links between the type of clinical problem and treatment. In primary care there appears to be a lack of a tight linkage between problem type (or diagnosis) and clinical management. At the high level of the Primary Mental Health Initiatives Evaluation, it appeared that brief non-specific treatment approaches made a clinically important difference for most people (Dowell et al. 2009). Even at a more specific level, treatments for mild-moderate depression are effective for patients with mild-moderate anxiety. There was no real difference in the proportional benefit between patients with anxiety or depression and those in whom social factors were prominent in their assessment. Regardless of the combination of problem and treatment, up to 80% of patients showed some overall improvement and 58.1% showed an improvement of at least 20 percentage points on their outcome following intervention (equivalent to a change of 8 points on the K10).

However, for problems which are mainly characterised by depressive symptoms of mild to moderate severity, both drug and psychological therapies are effective (NICE 2004; De Rubeis et al. 2005; de Mello et al. 2005). This makes the dilemma more acute for service planners and funders, as while psychological therapies may be better tolerated (NICE 2005) and may have a more sustained effect (Ma & Teasdale 2003; Teasdale et al. 2000), they may be less accessible due to cost and skill availability. The patient with moderate depression could be treated for six sessions of CBT or given a prescription for an SSRI with very similar treatment outcomes, and significant difference in health care costs. This scenario needs to be tempered with

the knowledge that there is some suggestive evidence that for mild-moderate disorders, talking therapies may be better than medication and that medication is definitely more effective with more severe than with moderate disorders.

Towards a resolution

The fundamental purposes of diagnosis are to ensure the patient has the most appropriate effective treatment and can be given an account of how they can expect to be in the future, so they can actively participate in the management and prevention of future episodes where possible. It is therefore important that primary care practitioners portray an accurate picture of the way they themselves are framing the problem. For example, it is quite appropriate not to give, say, a simple diagnosis of depression, but tell a patient that a particular presentation is a common kind of psychological problem where depression and anxiety are mixed.

Both assessment and management should be pragmatically geared to the working environment of PMHC and the kinds of problems that present. At the international level the ICD and DSM classifications are currently being revised, and both will address general practice and primary care working practices. The outcome is likely to be a smaller number of broader groupings that cover the main problems seen in primary care.

For planners and funders at DHB and PHO level, funding and management needs likewise to be geared to broader groupings and not tied to specific diagnostic categories. Funding and services need to be inclusive of the wide range of problems seen in primary care and to fund the social components of management options.

Because of the large numbers of potential patients services need to be tailored to relative efficiency. This means that we may see a reduced range of specialised psychological therapies being offered within the PMHC frame, accompanied by the development of more available generic low intensity interventions specifically designed to be delivered in primary care for problems as they present in primary care (Collings, Mathieson, Dowell et al. 2009). Such interventions will fit in between

self-help and more specialised therapies in the treatment menu, and are likely to become one of the standard treatment options in New Zealand PMHC.

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Quality in Primary Mental Health Care

Introduction

This Primary Mental Health Care (PMHC) Toolkit is intended to help organizations and professionals consider the most effective ways to deliver quality care and achieve quality outcomes. Quality in PMHC is challenging to measure and assess although it is possible to determine some of the elements of a 'quality' service. With this in mind, all the content of the Toolkit could be described within a quality framework. In this essay we define aspects of quality as they relate to PMHC and encourage you to develop activities within your organization or role which will evaluate the quality of care provided to those who use PMHC. We build on the Primary Mental Health Initiatives Evaluation and use our recent refinement of our 'Optimal Model' for PMHI (Dowell, Garrett, Collings et al, 2009) to develop a quality framework to support New Zealand PMHC development into the future.

Quality in health care

The Institute of Medicine in the USA defines Quality in Health Care as *"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"*.⁴

There is an extensive literature both internationally and locally on this important topic and while definitions may vary in different settings, some themes, mainly relating to the clinical domain, such as safety, effectiveness and patient experience, are common to most quality frameworks.

Other themes such as efficiency, capacity and value for money are less common in quality frameworks but are all associated with the economic or resource allocation aspects of services. As such they are linked to service integrity and sustainability, and are also important elements to consider from a DHB and PHO perspective.

⁴ www.iom.edu/Global/News%20Announcements/Crossing-the-Quality-Chasm-The-IOM-Health-Care-Quality-Initiative.aspx Medicine

The processes and activities involved in establishing and maintaining quality in health care fall into two broad and overlapping groups: Quality Assurance (QA) and Continuous Quality Improvement (CQI) (Berwick 1989). The first Quality Assurance (QA) developed out of time and motion and efficiency study and has at its heart monitoring and the measure of performance. The second, Continuous Quality Improvement (CQI) had its origins in production line industries and the belief that quality can be improved if all those involved in an activity look at ways of improving the overall quality of the system they are working in.

The most enduring model or framework for understanding quality in health care was developed by Donabedian (1998), who divided quality processes, activities and measurement into structure, process and outcome domains with each component having an effect on the next. We will use this framework for our discussion of PMHC quality. Structure refers to provider attributes (e.g. therapist /patient ratio, Number of clinics in a given locality), process refers to the care given to the patient (e.g. the type of psychological or drug therapy), and outcome is what happens to the patient (e.g. improvement in psychological rating scale). These three types of measures have their unique strengths, but each is also associated with conceptual, methodological and practical problems. The choice often falls between process and outcome measures.

Quality in Primary Mental Health Care

While the central role played by primary care in the recognition and delivery of care for people with mental health problems is now widely acknowledged, ensuring the quality of primary mental health care remains a challenge in both developed and developing countries (Shield 2003). There has thus far been little formal assessment of service quality in PMHC settings. Within the UK Quality and Outcomes framework (QOF) there are a number of measures relating to mental health care, though as will be discussed later some aspects measuring performance and outcome in this area are challenging. Valid indicators of mental health care are important in assessing and improving quality of care as they can show variations in care, including suboptimal care (Seddon 2001). However, there are few indicators available for quality

assessment of primary mental health care, and few that can be applied at the system level—for example, practice or primary care organisation—rather than at the level of the diagnostic group (such as depression or anxiety) or that reflect the views of key stakeholders in the primary mental health setting, particularly patients and carers (Shield 2003).

General Practice and primary care inherently include service attributes that would usually be considered as indicators of high quality health care provision. The personal contact and continuity of care offered in primary care means that there are many opportunities for mental health issues to be addressed and many opportunities for a bio-psychosocial approach that supports good clinical outcomes. Moreover the family oriented perspective of primary care is enabling as far as mental health care is concerned.

In practice however a number of factors potentially compromise quality. In many countries including New Zealand the time allocation for individual consultations is brief and the competing demands in each consultation mean that mental health issues may not be prioritized. While the MaGPIe study demonstrated that GP's were more likely to recognise mental disorder if they knew their patients well, recognition and management were less likely to be optimal if the patient was seen in an acute care setting (MaGPIe 2004). There has also been much debate about disparities in recognition and outcome with some evidence that the mental health care needs of Maori and Pacific people are less well addressed (MaGPIe 2005). In addition there are widely acknowledged quality issues to be addressed at the primary-secondary care interface including appropriate communication and referral pathways.

As has been discussed elsewhere in the Toolkit, there are major gaps in PMHC service provision for some groups such as children and adolescents, and people over usual working age (Dowell et al. 2009). While those with problems of extreme severity may be able to access some services at times, an underlying lack of service provision means that there are very likely to be important quality issues when services are provided, as there is essentially no infrastructure in terms of organizational or professional capacity to support the work.

In the last few years the introduction of targeted funding for PMHC through the Primary Mental Health Initiatives has provided new imperatives to assess the quality of the care being provided.

Different perspectives on Quality

In any organization quality improvement can be seen from a variety of different perspectives, and activity on a number of different scales or levels. At DHB or PHO level the planning, implementation and assessment of mental health quality could potentially be focused on systems efficiency within the DHB, efficacy of PHO initiatives, the training needs of primary care teams and so on. There are many aspects of care and service delivery that contribute to overall quality and hence a 'mixed economy' of different quality initiatives will be appropriate. In theory, quality measures can drive improvement in a number of ways. One model described by Don Berwick is the 'change' 'selection' and 'reputation' pathways (Berwick 2003). In the change pathway, quality measures act on the intrinsic professional motivation of clinicians and organisations to improve in areas where they see potential for improvement. In the reputation pathway, the publication of quality measures that compare performance between individuals, teams and organisations drives change through a desire to protect or improve reputations relative to others. Particularly in a North American context the selection pathway suggests that patients drive improvements by using measures to make choices between providers, incentivising providers to improve quality.

There are key quality issues in primary care, which can be explored within a mental health service context. These will include issues of access to care, workforce development and training and the use or otherwise of indicators of quality in a mental health care context.

In terms of the primary health sector engaging in quality initiatives the first and most important measures of quality are generic and challenging.

Time: There is no protected time in General Practice and much of primary care for anything other than patient care and contact. The single biggest improvement that organizations could make to further quality work is to fund time for quality activities.

Teamwork: There is a strong evidence base for the presence of good teamwork being linked to improved quality across a wide range of aspects of primary care clinical activity (Crampton et al. 2004). In addition there are effective means of measuring teamwork such as the Team Climate Inventory. We suggest that at DHB and Primary Care Organisation level, consideration is given to the measurement of teamwork effectiveness and promotion of effective teamwork in mental health care.

Information technology: Present primary care information systems were developed through small vertical markets with a focus on billing and prescribing functions. There were not designed for audit, evaluation or population health assessment. Moreover secondary care IT systems in many DHBs are idiosyncratic and isolated from other DHBs or primary care.

Primary/secondary care integration: Many quality issues present across the primary care interface including problems in communication and referral pathways. An important function of DHBs is to assess the effectiveness of work across the interface and support quality initiatives in this area.

We realize that working on these issues carries resource implications and that any quality indicators in this area are aspirational. The success or otherwise of other more specific indicators is dependent on them.

In addition there are other quality themes that apply to the primary mental health field.

As a starting point we suggest the DHB should have considered the following:

- ❑ Overall access to primary mental health care and to what extent there are disparities within local areas.
- ❑ The local working arrangements for primary mental health teamwork, together with training needs.
- ❑ The patient journey and some assessment of the patient experience.

As will be discussed below, for quality to be appropriately built into the work of the DHB and PHO there must be measurement of quality activity. How formal or incentivized this measurement becomes is a trade-off between trying to get accurate measures of quality activity and the compliance costs of data collection and follow up.

Use of Performance indicators and measures of quality

There is ongoing debate about the appropriateness or otherwise of performance indicators in primary mental health care (Crampton et al. 2004). Considerable work has been undertaken internationally on the development of mental health indicators, particularly in the United States. However this work is focused on addressing issues related to discrete disorders. In primary care the focus is appropriately centred on the concept of a group of less well defined Common Mental Disorders (CMD). For indicators of quality to be successful and accepted they must be able to reflect the complexity of the primary care environment, and avoid creating perverse incentives.

As those working in DHBs and PHOs are aware the current performance indicators in primary care stem from the PHO performance management programme (PPP). Until now mental health indicators have been absent from this programme, and it has been difficult to see how relevant indicators could fit into the current incentivized framework.

Some of the challenges in indicator development include a lack of agreement over illness terminology, lack of consistency of data collection and uncertainty over the

meaning of any outcome measure trends. Antidepressant prescribing rates provides a good example of the difficulties in developing an indicator in this area. A low rate of prescribing might mean a prudent use of pharmacotherapy and access to psychological therapies. Conversely it might mean under recognition and under treatment for patients who would benefit. The local and regional variation in prescribing added to the lack of a gold standard for appropriate prescribing rates mean that while this indicator would be excellent for stimulating debate it should not be used for benchmarked target setting.

Despite these challenges there is the potential to utilize indicators of primary care quality and performance which could have significant educational value in peer group discussions to raise quality of care.

We emphasise again the need for a strong element of 'aspiration' in any mental health quality indicator development. There has been a great deal of enthusiasm in the last few years to promote primary mental health care, and it is important to retain the positive commitment of the sector. Many quality initiatives fail in their potential because the bureaucratic demands of monitoring overtake the initial professional desire to improve quality in a particular area.

The indicators described below are examples of potential quality themes for primary mental health care identified as a result of discussions between the College of General Practitioners and the Ministry of Health (Perera et al. 2010).

a) **Measurement of the Prevalence of common mental disorders in (i) adults and (ii) children.**

This indicator is frequently suggested in the international literature. The overall aim is to capture the extent of practice level activity in relation to mental health. Exploring this issue with practice teams brings up the question of avoiding recording a diagnosis of CMD (as a result of a patient request or health professional choice), and the fact that current coding systems do not capture well the complexity of mental health presentations in primary care.

b) Referral to other primary care providers for the management of common mental disorders.

One of the challenges in primary care practice is enabling access psychological therapies for patients at a cost they can afford. Exploring referral pathways for psychological therapies is a good high level systems indicator of quality.

c) Prescription of selective serotonin re-uptake inhibitors for the management of common mental disorders.

As described above exploring patterns of prescribing is a useful marker of quality because there are no gold standards of prescribing rates.

These indicator themes and others would fit well within an educational framework of peer review. They do not lend themselves well to benchmarked target setting.

As well as the important generic indicators of quality and the more technical potential indicators above, we believe that organizations should support and promote the identification of quality initiatives and indicators that are important to primary care teams and practices. Getting practice teams to identify the aspects of quality that 'make the heart sing' from the provider perspective is likely to be both empowering and helpful in creating constructive relationships between practice teams and DHB/ PHO.

Evaluation of the New Zealand primary mental health initiatives: a step towards quality

In this section we consider the main outcomes from the primary mental health initiatives evaluation in relation to service quality. The evaluation of the first wave of 41 initiatives identified a number of major themes which provide 'lenses' through which we can consider and debate the quality of PMHC (Dowell et al. 2009).

Most notably, there were nine different models of care, each deemed to be appropriate for the local context and each of which had features often associated with quality health services. The evaluation team defined an 'optimal model of care' (which we refer to here as 'Optimal Model I') based on all the observed facets of

care and service provision. No single model or organization contained all the elements of optimal care or service provision, although the majority included access to a wide range of mild to moderate mental health problems, a focus on mental health workforce development and the use of both psychological and pharmacological therapies.

Other issues relating to the 'typical' conception of service quality were:

- targeting of services to high-needs populations
- having both Kāupapa Māori and mainstream options available
- the use of clinical outcome measures was encouraged as a clinical tool

While there were many examples of effective interdisciplinary teamwork, the involvement of practice nurses was not always facilitated. In addition, there was no structured training or education programme for PMHC that included all disciplines.

Observations relevant to a broader conception of service quality included: the observation that no service delivery model offered inherently superior value for money, or an inherently more cost-effective service compared to others; up to 80% of service users benefited from the variety of interventions offered; and well-defined criteria for determining clinical eligibility for care are important.

In relation to access for the whole population, the initiatives provided access to Māori in excess of their proportion in the enrolled population. Although, given the higher prevalence of some common mental health conditions among Māori, it is likely there was still some under-utilisation of services by Māori. There was under-utilisation by Pacific peoples and significant under-utilisation by Asian people. The mental health needs of children and young people overall were not sufficiently met, and over half did not offer services to this group; and few PMHIs offered services to service users over 65 years of age.

Based on these observations figure 1 summarises the main structural elements that could potentially be markers of quality at DHB or PHO level. It might be an advantage for example that there is congruence between DHB and PHO mental health

initiatives and that there are clearly identified markers of integration between primary and secondary services.

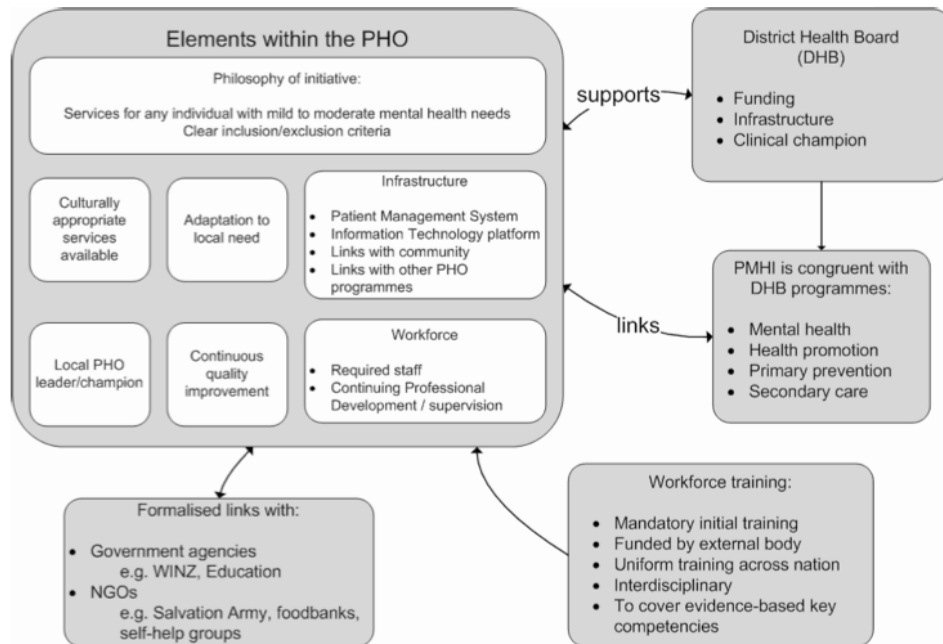


Figure 2: Optimal model for Primary Mental Health Initiative (PMHI) Source: Evaluation of the Primary Mental Health Initiatives; Summary Report (Dowell et al. 2009).

Further markers of quality can be identified by looking at process components of primary mental health illustrated by patient pathways through the health system (figure 2). Quality issues might be identified for example in identifying the rationale for the use of particular psychological therapies and the deployment of particular types of staff.

Figure E2: Service-user pathway (in the context of the structure of Figure E1)

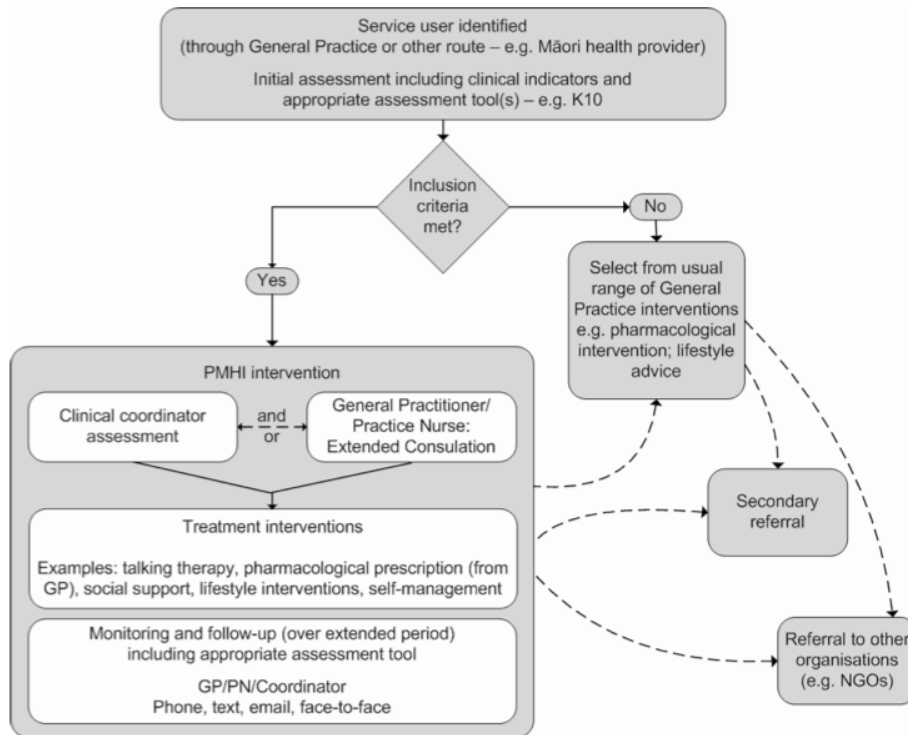


Figure 2: Service user pathway (in the context of figure 1) Source: Evaluation of the Primary Mental Health Initiatives; Summary Report (Dowell et al. 2009).

***** A task for you *****

Looking at the diagrams above – write down which elements of quality you think are most prominent in your service.

What elements are missing from the diagrams?

The evolution of Quality frameworks

It is important that quality evolves. As a result of our work on this Toolkit project we have reviewed and revised some of our previous perspectives on what would constitute the optimal delivery of quality within a primary mental health care service. We have refined our thinking from the original optimal model and created a new version – Optimal model II.

One significant omission, for example, from the previous optimal model was absence of specific services for children and young people. This is particularly important if a service is taking a long term perspective on quality.

Further discussion about this evolution of quality is found in the next perspective essay titled '[Towards the future Primary Mental Health Care: Optimal Model II](#)'.

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Optimal Model II for Primary Mental Health Care

As part of the evaluation of the Primary Mental Health Initiatives, some of us developed a conceptual scheme for an effective 'generic' initiative. This became known as the 'Optimal Model' (Dowell, Garrett, Collings et al. 2009). This model was based on the positive features of the nine different models of service provision we observed during the evaluation. Because it was limited to observations made about very new services, and because it was untested, it was in a sense a draft model. Nevertheless it achieved a significant degree of traction because it was highly congruent with the services that existed, and it provided overall guidance to new services setting up as the primary mental health care (PMHC) programme was rolled out across the whole country.

One of the aims of the current project was to refine this draft optimal model to enhance its relevance to sustainability and quality improvement in New Zealand's PMHC environment, and to embed the idea of building on existing capability and capacity. Specific issues highlighted for future consideration in Optimal Model I included primary care practitioners developing a new skill mix better orientated to PMHC. Particular skills that required development or reorientation included: clinical assessment, motivational interviewing, self-management support, brief psychological interventions, understanding of medication and use of outcome measures.

Synthesising these points with the lessons from the research partners, insights developed within the research team and consultation with the stakeholders engaged by the research partners, we have produced Optimal Model II (see Figure 1). [Optimal Model II](#) has retained some of the key features of the first version.

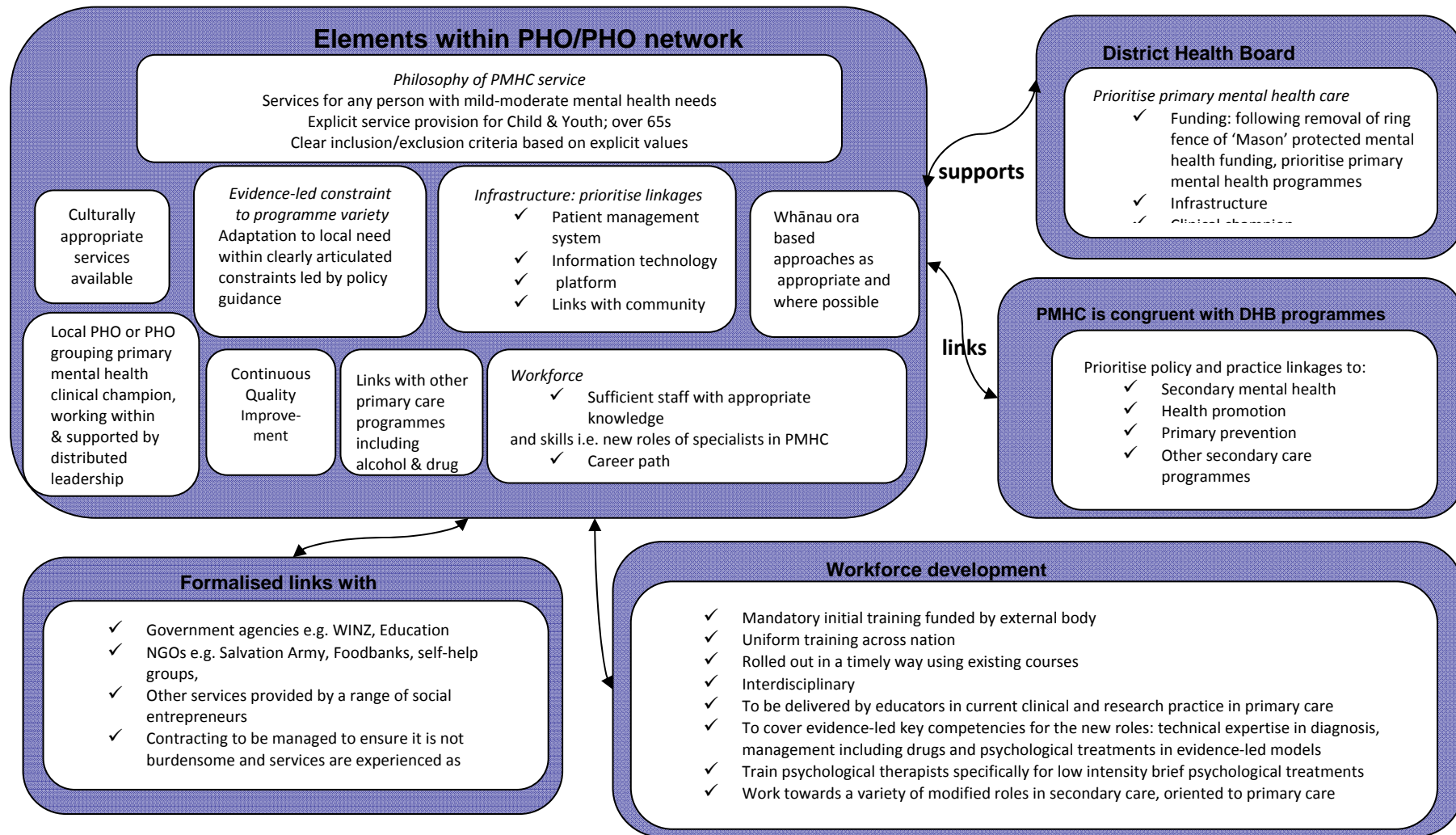


Figure 1: Optimal Model II

Specific points of difference are:

[The addition of Whānau Ora based approaches to the core elements of PMHC.](#) As specific Whānau Ora programmes are not yet rolled out, we could give more detail about this. However, it is clearly a potentially important development of major scale and high relevance to PMHC for Maori and, in some cases, non-Maori. One of the key attributes of the Whānau Ora programme is that it puts the social context of the person (specifically but not solely whānau) in the foreground of consideration of their problems. Giving priority to the relevance of context is an important aspect of mental health practice which is commonly neglected as services come under increasing pressure. Whānau Ora programmes are an opportunity to embed this into PMHC practice so that it becomes the norm. This approach is entirely consistent with the general philosophy of primary health care.

[Evidence-led constraint to programme variety.](#) This is a modification to the broad promotion of adaptation to local need as seen in Optimal Model I. While it is important to have some flexibility we have concluded that it is essential to have a degree of consistency in services across the country. There is already a good deal of variation introduced by the availability of skilled staff. For the next steps in PMHC development in New Zealand it is important to have policy guidance on what are the expected core elements of PMHC. We suggest this should be evidence-led and cover broad types of treatment as well as general service structure and functioning.

[Links with other primary care programmes.](#) We have increased the status of this in the revised model, and included alcohol and drug explicitly. There are two main benefits (of equal importance) to this. First, it is an opportunity to increase the effective resource available to PMHC (see issues guide [Mental Health and Chronic conditions](#)). Secondly, the high prevalence of co-morbidity between mental health problems and chronic conditions such as diabetes and heart disease means that quality of care and overall clinical outcomes would be improved by better links across programmes.

Primary mental health (clinical) champion. This was a key feature of the original model but we have added the suggestion that it might be important for this person to be a clinician. The services in which we have seen most momentum develop and be sustained have been those in which a) there has been an effective champion, and b) often this has been a senior clinician. There are a number of reasons why this might be the case. Often managers have a faster turnover than clinicians, and while one manager may prioritise mental health, a new manager might not. Additionally, much of the change work to be done is actually with clinicians, and it is possible that change messages may be more palatable coming from another clinician. In our view, the primary mental health champion will be most effective if working in a distributed leadership setting (see perspective paper titled '[Where next for Primary Mental Health Care? – current issues and opportunities](#)').

Workforce. Optimal Model II emphasises the need for sufficient staff with appropriate knowledge and skills and focuses heavily on the training needs of these practitioners. During the evaluation of the first wave of initiatives we observed the emergence of a 'new' mental health professional. a nurse or other professional with a background in, say, secondary care, who re-positioned their career as a primary care mental health professional. It was common for these roles to end up running as a kind of 'parallel' secondary service, and this was especially the case when referrals for psychological therapies were out of the practice. While this increased access to services for people who would otherwise miss out, it was perhaps not a truly primary care model. There were problems with communication back to referring doctors, for example, which is a classic secondary care problem. It is our recommendation that the expanded workforce working in PMHC becomes better integrated with primary care practice so that it is a core part of it rather than an 'add on'. This can be achieved through via workforce development programmes that have this as a stated goal. The clinicians delivering treatment also need more support for skills development in low intensity brief interventions, and this should become a core component of all mental health and primary care professional training. Finally, secondary care professional roles need to be modified so support for PMHC is enhanced.

DHB level. The ring-fence around mental health funding has been formally removed, although prior to this DHBs had a variety of ways of undermining it. There needs to be a renewed focus on ensuring this mental health resource is protected so it can be channelled to PMHC services.

Links with other agencies. The key change here is that contracting needs to be done in a way that is less burdensome to NGOs and other agencies, and services are experienced as 'seamless' by those using them. Currently professionals in organisations are very constrained by contracts, and may be told by managers not to engage in clinical activities which are outside a specific contract. This contributes to people 'falling through the cracks'.

Regarding the service user pathway (see figure 2), we have made fewer changes. However, we would like to see the provision of psychological services brought more fully into the primary care setting rather than have such a strong focus on referral out of the practice.

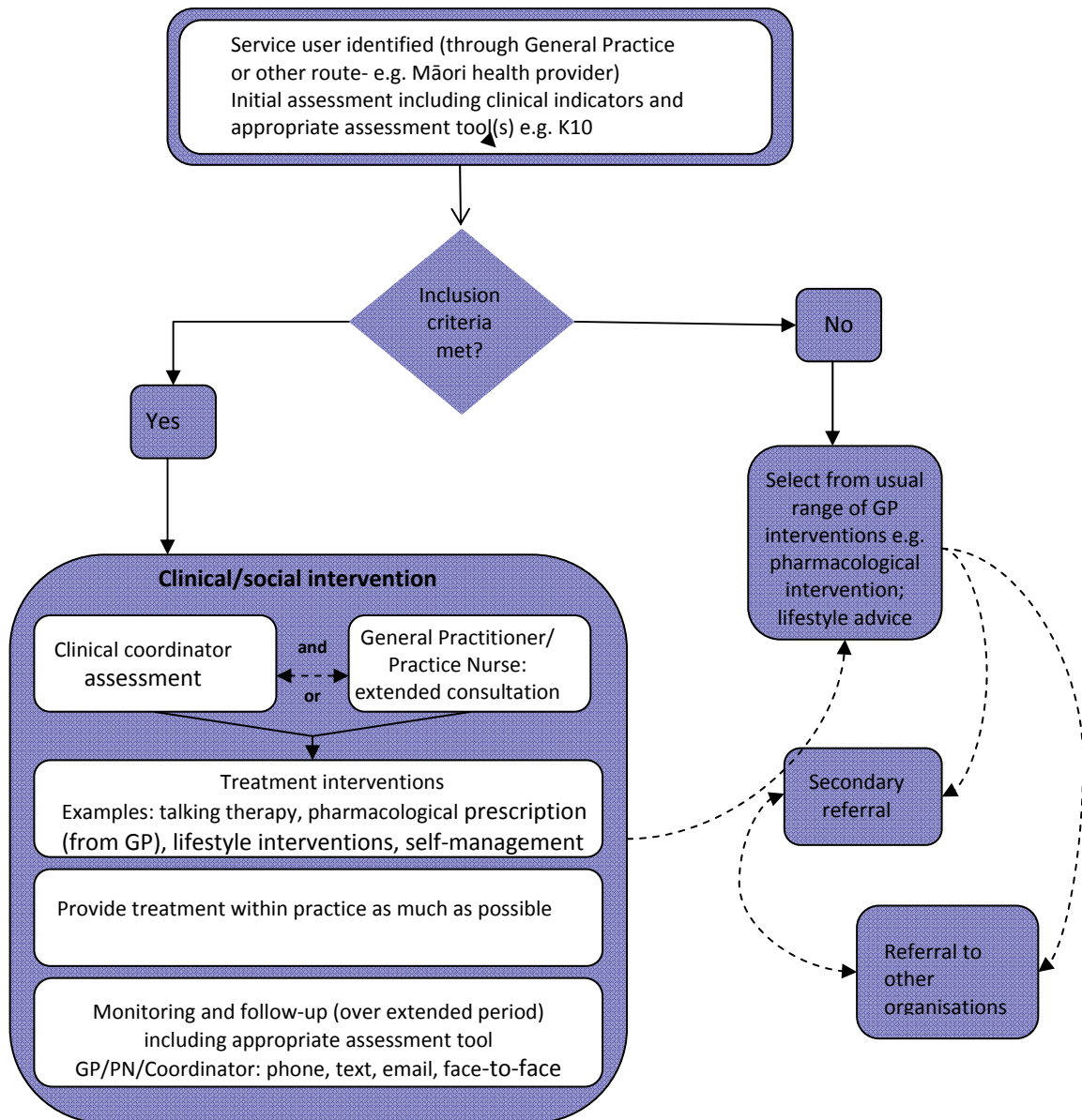


Figure 2: Service user pathway (in the context of the structure of Figure 1)
Adapted from Evaluation of the Primary Mental Health Initiatives (Dowel et al 2009).

Toolkit for Primary Mental Health Care Development:

Part 3: Guides to specific issues, with illustrative vignettes

This is a set of guides to tackling specific issues in primary mental health care (PMHC). Each guide is followed by a vignette which provides a fictional (but drawn from research partner experience) example of the problem to be worked through.

The following guides are included:

Ways of working together

- Teamwork
- Leadership for Primary Mental Health Systems
- Relationships and communication

Using your resources

- Prioritisation and establishing the boundaries of primary mental health care
- Time and time management
- Financial sustainability of PMHC services
- IT and systems
- Eligibility to receive PMHC
- Connecting with the consumer

Making the system work

- Coordination of care
- Mental Health and chronic conditions
- Integration across the continuum of primary, community & specialist settings
- Models of care
- Mental health promotion
- Future proofing PMHC

Population groups

- Specific issues for child and youth PMHC
- Issues in alcohol and substance use

- Primary Mental Health in the elderly
- Primary Mental Health Care for Māori
- Primary Mental Health Care for Pacific Peoples
- Asian Peoples Mental Health

Teamwork

This issues guide is linked to the vignette 'Sometimes talking is so hard' ([click link](#))

Successful teamwork is critical to creating an environment for sustainable change in health care. Depending on your stage of team development/evolution, you may need to set aside protected time in a team workshop to discuss these issues.

[Link to workshops \(click link\)](#)

Things to consider

The principles of teamwork and teambuilding are straight forward, but the 'devil is in the detail', and in developing trust in team relationships. Questions to ask when considering teams for PMHC are:

Team identity?

Who are the members of the team and do they have a common purpose? In PMHC team members may have been drawn from different disciplines and may not have worked closely together e.g. psychiatrists, GP's, primary mental health coordinators.

Team members' roles and responsibilities?

Are the members of the team clear about their roles? If previously the GP has been responsible for all aspects of the patient's PMHC, what should their new role be now that there are additional team members such as counsellors or clinical psychologists?

Role perception?

Defining each team member's perception of their role is as important as identifying the actual role that they play. There is little point in allocating 'counselling' to a practice nurse in a team if their perception is that they are solely responsible for monitoring and follow up.

Leadership?

Teams do not function well without good leadership. Leadership in PMHC is difficult because a new 'discipline' has been created, and there is little experience in effective leadership by either individuals or teams. It is important that leadership is allocated

to the person who can most effectively take forward the team objectives, no matter what their disciplinary background.

Communication?

Many problems in effective teamwork are due to poor communication or miscommunication. Teams cannot communicate well if team members do not know each other. Creating protected time for team members to communicate effectively with each other is challenging in primary care and must be specifically created.

Philosophies of care?

PMHC is being developed by professionals from a number of different backgrounds. Primary care and secondary care traditionally have different philosophies of care, as do professionals from nursing, medical and psychological therapy backgrounds. These different philosophies of care must be discussed and consensus reached on a common philosophy, if the team is to work effectively.

Conflict?

Conflict is inevitable in teams and protocols and contingency plans should be developed to enable conflict resolution. Protected time is necessary for effective conflict resolution.

The operation of the team?

Linked to the philosophy of the team is the way that team has been 'designed'. Many teams have been created as a response to workforce shortage or fiscal constraint. In this situation team members may be 'substituted' or delegated for each other e.g. nurses for doctors, counsellors for psychologists. The opportunities for team effectiveness in this situation are very different than if there is a deliberate strategy to enhance team effectiveness by combining the skill sets of different team members.

Stability?

The health sector in recent years has been characterised by rapid and constant change. Developing and sustaining effective teamwork in this environment is difficult. The more challenging teamwork feels in a rapidly changing environment the more it should be prioritised.

Sometimes talking is hard

This vignette is linked to the issues guides. [Click here](#) to go to 'Teamwork'.

Rory feels like he's telling his story for the fifteenth time, this time to the kindly psychiatric registrar, following on from the Emergency Department registrar and the admitting nurse, and the ambulance crew, and before that all the people who sort of listened and sort of didn't. Yes at the time he had meant to kill himself and the rope was round his neck and if Mahlia hadn't come in and found him, well who knows...

Six weeks previously Rory had started to fall apart after his girlfriend of four years had left him, his boss had threatened him with dismissal if his work didn't improve and his drinking had become problematic, particularly at weekends. His flatmates had escorted him to the local GP, when a skin infection had begun to spread the length of his arm. The GP asks questions about Rory's mental state after prompting from the accompanying flatmates and makes a working diagnosis of depression, with associated adjustment and alcohol use problems. (There is no suicidal ideation on direct questioning by the GP). With his low income Rory qualifies for free psychological support from the local primary mental health initiative (PMHI) and he is referred to the local mental health coordinator. The GP also prescribes antidepressants and arranges to see him again in a week. The GP has not met the mental health coordinator face to face, but has heard good reports of the way the scheme is working from the other doctors in the practice.

An appointment is made for Rory for the beginning of the next week, and he attends, accompanied again by one of his flatmates. The PMHI coordinator has a past mental health nursing background, and at the interview notes that Rory has been feeling more depressed and occasionally thought he would be "better off out of it". There is no definite suicidal ideation, and she refers Rory to one of the five counsellors with whom the PHO has a contract. The counsellor has a particular interest in alcohol problems. Rory attends the first meeting with the counsellor five days later. The counsellor finds him withdrawn and argumentative and is concerned that he is expressing definite thoughts of self harm. She feels that he is not a 'primary care referral' and says he should go back to his GP. She also phones the mental health coordinator. The coordinator phones the practice, and leaves a message for the GP, who is away on annual leave. She speaks to the duty doctor who suggests that the

coordinator contact the crisis intervention team, as routine referrals for psychiatric assessment usually take between four and eight weeks. The coordinator attempts to contact the crisis team, who say that the referral must come from the GP, and that in the meantime 'counselling might help'.

Rory fails to keep his appointment with the GP, but his flatmate phones the PMHI coordinator to say she is worried about him. The mental health coordinator felt disappointed at the previous response from the duty GP at the practice and leaves a message with the Practice Manager to say that Rory still has problems. Rory's GP receives the message and attempts to ring Rory. Failing to do so, the GP contacts the crisis team. The crisis team request that Rory is seen before they will accept the referral.

Rory has been alone in the flat for three days since Mahalia and the others went away for the party down South.....

Questions to consider

1. Who is the Primary Mental Health Care Team?
2. Who has responsibility for care at each stage of the story?
3. How might communication and teamwork have been improved?

Leadership for Primary Mental Health Systems

This guide is linked to the vignette 'District Led Primary Mental Health' and 'Valiant Champions' (click link)

This guide will help you to:

- Understand leadership in the context of primary mental health
- Explore the issues, challenges and opportunities for system leadership
- Develop a plan for strengthening the leadership capability in your area

Summary

Creating an effective leadership environment is essential for sustainable primary mental health. Inevitably because of the nature of primary mental health this will involve distributed leadership, a network of leadership across organisational and disciplinary boundaries.

While each service or programme has a management structure we found leadership to be highly variable within primary mental health with few districts having the functional leadership capability to think through or direct the development of a sustainable system.

This is not a reflection on the leadership capability of the individual people we observed acting as champions or the essential part their leadership style. However, if we think of leadership as a system it should have some form, processes and capabilities.

Situation

Primary mental health care (PMHC) is a component of healthcare that has emerged through combinations of local primary care champions and Ministry stimulated Primary Health Organisation (PHO) based initiatives.

Most PHO initiatives are relatively small scale and narrowly focused with perhaps one or two people in managerial roles supported by a generic (non PMHC dedicated) clinical leadership together with a wider network of clinical practitioners. The 'Valiant Champions' vignette describes a composite case that is typical of this situation.

Because of this pattern of development few District Health Boards (DHBs) have exerted an overall leadership role or framed up the contribution of PMHC within the wider systems of care. The 'District Leadership' vignette describes the leadership environment of one that has started to develop this functionality.

Complications

- ❑ PMHC as a structured service is new and still developing out of a pilot/initiative mentality, the story about its role, function and impact is still relatively weak.
- ❑ In PMHC the leadership function belongs to a distributed network of interdependent organisations and practices. In most cases there are only informal inter-organisational mechanisms and personal relationships to support leadership, which limits its capacity and capability. How could more sustainable, capable, cross-organisational leadership functions be developed?
- ❑ Clinical and multi-disciplinary practitioner leadership is critical to be able to tackle and resolve many of the core issues but this needs to be supported by protected time and funding, and complemented by a leadership partnership that includes service and funding perspectives.
- ❑ Individual champions for PMHC will always be important in leadership roles and it is important to find ways of using their knowledge and passion effectively. They are critical as relationship networkers, knowledge brokers and boundary spanners. Who are your champions? How do you support them now? How could you enable them to be more effective?

Most PMHC services are relatively new, small scale and fragmented across multiple PHOs. Developing leadership capability is likely to require resources and scale that is not easily achieved from its current small base.

Challenges

In thinking through how to create a fit for purpose leadership structure for PMHC we take a functional perspective on leadership rather than a structural or process view i.e. what is the capability that is needed. Our goal is to support you to engage with others to think through the leadership capability you have now and identify where and how you would like to develop.

A leadership agenda:

1. Developing a clear sense of purpose and role for PMHC

The leader's role is to maintain dialogue and debate about the nature and function of mental health in a primary care setting. This creates a sense of purpose and function of mental health in wider primary/community context and expresses this outwardly through ongoing communications and engagement processes with others.

2. Creating critical scale and mass

If most PMHC initiatives lack size and scale to develop and sustain effective leadership functionality how can this be overcome? How could a critical mass of leadership be developed that links and integrates the scarce skills and expertise that exist in different organisations but avoids the fragmentation that currently exists across PHOs? To maintain itself this needs to be able to have a recognised continuing function and support structures that facilitate this. Possible options include:

- ❑ More formalised networks across PHOs and providers with DHB funding and planning support
- ❑ Linkage across the mental health continuum, between primary, community and specialist mental health

- ❑ Linkage across the spectrum of primary care e.g. recognising similarities in capability with long term conditions

3. Supporting distributed, network leaders

A leader must cultivate champions across the spread of disciplines and organisations who are involved, as well as acting as a connection into board functions in DHBs, PHOs and regional/national policy functions.

4. Supporting protected time

How can this leadership function be sustained in the midst of people's busy working lives? In particular, how is participation supported when a large proportion of primary health provision is not included in salaries and individuals need to charge for their time?

5. Achieving an outcomes focus

Leadership is needed to balance management of today's service delivery orientation with an outcomes focus that considers if the resources are going to the right people, in the right place and in the most effective manner. This external focus needs to occur from 'inside' the distributed leadership network rather than be owned by one part e.g. DHB Funding & Planning.

6. Maintaining accountability for resources and performance

Leadership is needed to maintain an oversight of where resources are spent; the adequacy of capability development; the priorities for next investment; the monitoring of results and communication of implications or consequences through the network; overall productivity and sustainability.

7. Providing direction and boundaries to models of care and service delivery

A leader must provide direction about where the boundaries of a service will lie, and how much variation in service delivery is helpful to meet the needs of different populations and groups? Monitoring, challenging and resolving these issues calls for

an information, analysis and service governance capability as part of the leadership functions.

8. A design and realisation capacity

Leaders must have the ability to scope development projects and have them resourced. They must also be capable of self reflective & evaluative learning.

How strong are your leadership functions?

Match each of the 8 agenda items above with a self assessment of your leadership on a 5 point scale (poor, fair, good, very good, excellent).

District led Primary Mental Health

This vignette is linked to the issues guides. [Click here](#) to go to 'System Leadership for Primary Mental Health'.

Michael is the clinical leader for the District Clinical Primary Mental Health Steering Group that has oversight of primary mental health in the district. The form and shape of PMH developed out of an early decision to establish primary health depression management as part of the long term conditions programme. This provided programme funding for a comprehensive assessment, access to therapy and follow up by GP, nurse or coordinator. All practices involved in the programme share a common dataset so that utilisation, cost and outcomes are tracked, enabling a district wide view of the results that supports clinical oversight and quality improvement.

The focus on depression was decided early on based on its high prevalence and the clear evidence base for effective treatment in primary care settings. From this pragmatic base of agreement a common service framework, workforce, IT and funding were developed, all drawing on past experience of approaches developed for long term conditions. Individual PHOs have taken this common framework and adapted it to suit their own approach using the Primary Mental Health Initiative funding. Uptake in practices has not been uniform with higher levels of utilisation in some areas and lower levels in others, notably for Pacific people where there remains concern over the best model of care to suit Pasifika context and culture.

However as the experience has developed questions are emerging;

- Is the strict focus on depression appropriate? Depression and anxiety are often blended, are we excluding people with higher level of need and benefit by a single condition focus?
- What of other populations of equally high need that we are not addressing? Youth, elderly, substance abuse or a wider view of complex stress?

- ❑ Is the relatively single type and level of response still the best or should we allow more flexibility of response?
- ❑ Would this help increase uptake for Pacific peoples?
- ❑ While the programme started off as being part of a chronic conditions approach is this still appropriate? Should it be more focused on linking primary and secondary mental health services?

Since the wider programme was undergoing a process of rethinking and reshaping the Primary Mental Health Clinical Steering Group thought that framing up a project around a 'five year primary mental health development plan' would be a good contribution enable it to think proactively about where to target investment and development.

Since the group represented a wide range of expertise and variety of disciplines John was pretty confident that this could be achieved in a relatively tight series of working sessions provided the issues were well framed at the outset and the process was fed by good data and knowledge of the literature. A plan was put to the overall Clinical Steering Group and approval given to fund a collaborative planning process, including paying for the participation of the 15 people involved (this included GPs, Nurses, Pharmacist, community and Consumer Advocate). The DHB provided a project leader to support Michael as Clinical Lead with coordination, research and writing.

Questions to consider?

1. How would you have answered the vignette questions?
2. What are the key elements of the five year plan? Think: structure, process, outcome

‘Valiant champions’

This vignette is linked to the issues guides. [Click here](#) to go to ‘System Leadership for Primary Mental Health’.

Sharon is a passionate clinical champion for PMH in her district, busy immersed in developing her own practice which blends clinical psychology and kaupapa Māori approaches. She has exerted a strong influence on shape of the PMH service in her PHO and influenced the ideas of other PHOs around her through informal relationships, knowledge sharing and supporting the professional development of PMH coordinators for other PHOs. She is recognised as the knowledgeable inspirer and thought leader in the wider PMH community.

In essence the PMH services operate in a form similar to many around the country, GPs can access funding for an extended consultation (by them or a coordinator) and people meeting the access criteria are then offered a short programme of talking therapy. However, since each PHO service in the district has emerged from PMH initiative based funding there are subtle differences in the population focus, model of care, treatment intensity and costs patient of each service. Demand is substantially in excess of funding, especially in pockets of high deprivation and high prevalence of complex mental and social stress, especially amongst Māori.

A number of pilots have been established running alongside the original initiative funded services, utilising Services to Improve Access (SIA) and some intersectoral funding to support services for high needs groups. Funding for these pilots is not assured; in fact one source of intersectoral funding has recently ceased meaning that the PHO has had to dip into SIA funding to provide some level of continuity to meet community expectations.

While informal connections to specialist services are good primary mental health operates at arms length, interactions largely happen on a case by case basis, although a joint pilot for maternal depression is in start up stage. Specialist and community mental health services are under pressure but provide reasonably access if it is really needed.

Sharon is concerned that the current structure of primary mental health is vulnerable. Funding sources are fragmented and often restricted in what they will support. DHB Funding & Planning are well engaged with what is happening but the DHB is under severe financial pressure. Because demand is so much greater than capacity services are simply responding to the need that comes through the door. The variety of service approaches seems unsupportable yet different populations are in different situations and complex stress cannot be solved in one or two sessions of the existing brief intervention. With a fair amount of change likely in the PHO and primary care landscape now seems a good time to try and create direction and put PMH on a more sustainable footing.

However the current relatively informal process of sorting through the issues does not seem up to the task; people are too busy, no one has a clear role or mandate to do this. It almost seems easier just do good work, to stay nimble within each service, and react to what ever comes along, thinking “if some more money comes through we will make it work”.

Questions to consider

1. What are the leadership challenges in this story?
2. Where might Sharon find the leadership support to address these challenges?
3. What suggestions would you have for how she might go about generating this leadership support?
4. What specific suggestions would you have for Sharon to:
 - a. Establish a sense of purpose and direction?
 - b. Engage with the issues of developing sustainable funding?
 - c. Address the issues of differences in population need, variation in models of care and costs of intervention?
 - d. Approach the issues of primary/secondary integration?
5. What leadership infrastructure would you suggest to put primary mental health on a sustainable footing?

Relationships and communication

This guide is linked to the vignette “Involving Primary Care in Primary Mental Health Care” (click link)

Priority relationship, network member or interested party?

Fragmentation, crowding, diversity and change are key characteristics of the context in which primary mental health care (PMHC) is provided. At primary care and community level there will be multiple NGOs, government agencies and other stakeholders to collaborate with and work alongside, for the foreseeable future. We can also expect continued change processes in the configuration of organisations such as PHOs and DHBs, punctuated with relatively brief periods of consolidation.

A critical task in navigating this complex environment to achieve your goals is to identify the many relevant individuals and parties, and strategically decide how to approach your relationships with them. Not all are of equal significance in relation to your goals, and you cannot maintain the same level of engagement with all of them at all times.

Here is a simple three-step process to identifying, characterising and strategically managing your key relationships. To use this effectively you will need to have defined your organisational goals.

Step one: Environmental scan

- ❑ List all the agencies and individuals in your environment that are relevant to your goals, rely on you for services, or that consider you should pay attention to them. These might include local service providers, funders, professional groupings, consumer groups and the Ministry of Health. This list will include people inside your own organisation.

Step two: Prioritisation

- ❑ Sort and prioritise these agencies and individuals according to their relevance to your organisational goals. A useful classification is that of priority relationship, network member or interested party.

A *priority relationship* means you have some goals in common. Each party has a major interest in how the other achieves its goals. Some of your decision making processes and outcomes might be interdependent. The aspiration for this kind of relationship is partnership. For example, in an area where there are few psychologists and PHOs have been competing to secure their services, two PHOs might work together to develop specifications and contracting arrangements for a service and workforce capability building that they may wish to invest in jointly.

A member of your *network* needs you to achieve your goals because there is some dependence on the outcomes. For example, a counselling practice is contracted to provide a youth grief counselling service to two DHBs but for historical reasons the contract is held with only one of them. The non-contracting DHB needs the contracting DHB to manage this contract skilfully and appropriately and is dependent on this happening. The aspiration for this kind of relationship is consultation and information sharing, with an expectation of prioritisation of some of their needs, and possible partnership on occasional projects.

An *interested party* is more distant in terms of their influence on and expectations of you, and vice versa. For example, a provincial North Island DHB may have difficulty attracting sufficient GPs to cover the needs of the catchment population. The South Island medical school is developing rural training for undergraduate medical students but will not be placing students in the distant DHB. Nevertheless, the DHB is an interested party. This kind of relationship is characterised by keeping each other informed in a general way.

Once you have assorted the agencies and individuals into these categories you can use their status to determine the extent and nature of your relationship with them. For example, if you are a PHO, you may need to be able to work towards priority

relationships with some other local clinical service providers, a DHB may be in your network, and the local polytechnic that trains health professionals might be an interested party. It can be useful to consider that if other organisations used a similar process, you might be in a position you don't expect in relation to them. For example, if you consider that your PHO is relating to you as if you are an interested party, but you consider you should be part of their network, then you have the opportunity to prioritise re-crafting that relationship.

It is important to remember that agencies and individuals can change their status over time. An interested party might become part of your network if there is a major new funding initiative, and a priority relationship may become less intense if goal development diverges over time.

Step three: review the significance of agencies and individuals in relation to your goals

- ❑ Business and service provision cycles or policy and funding environment changes will mean you need to consciously revise the significance of other agencies, and your approach to the relationship.

Developing and nurturing working alliances

Having identified the key agencies and individuals in your environment and established their position in relation to your goals (i.e. priority relationship, network member or interested party), the key task is to develop and nurture the working alliances. The alliances may be defined or constrained by a number of things, such as contracts, funding flows, stakeholders in common, or shared goals. None of these things on their own will create a working alliance, and sometimes they can work against an effective working alliance. *A working alliance exists in the context of a relationship.* At an organisational level the nature of that relationship is defined by their position in relation to your organisation's goals (i.e. priority relationship etc). At a process level the nature of the relationship is determined by the relationships between individuals.

Working alliance in a priority relationship

The aim here is partnership, which means working together to achieve common goals. You have several goals in common and you each have a major interest in how the other achieves its goals. Some of your decision making processes and outcomes should be interdependent. This may still seem aspirational for some of your priority relationships e.g. between DHB and PHO. However, if you use this as a frame or model for your processes and how you think about them, you are more likely to move closer to a partnership model. To develop an effective working alliance in a priority relationship you will need to a) invest in the relationships between individuals; b) establish common values around the shared goals; c) agree on specific common goals; d) establish a social process that will support getting the work done (e.g. regular meetings, planned workshops etc); e) continue the investment in the relationships between individuals and f) regularly review progress towards the goals and set new ones.

Working alliance with a network member

A network member needs you to achieve your goals because there is some dependence on the outcomes. The aspiration for this relationship is consultation and information sharing, with an expectation of prioritisation of some of their needs, and possible partnership on occasional projects. In this relationship you will still need to establish a social process to support the work. The key items of work include: acknowledgement of their dependence on your success with the goals they depend on; acknowledging that they may be able to make a contribution to the achievement of those goals; sharing information about progress on specific goals and other relevant topics; regular review of progress and the state of the relationship.

Working alliance with an interested party

An interested party is more distant in terms of their influence on and expectations of you, and vice versa. This relationship is characterised by keeping each other informed in a general way. The key to managing this relationship is to ensure that

the interested party has the appropriate information at the right time. This should be managed within a systematic communication plan that includes maintenance of a list of key contacts, e-newsletters and presentations at existing and occasional meetings. Be ready to use face-to-face opportunities as interested parties may cycle in and out of network status from time to time

Summary

The keys to building and maintaining all these relationships are: ensuring you bring the appropriate attitude, and that attitude and the relevant information are communicated at appropriate intervals or points in work-plan evolution. Remember that agencies and individuals will change in relationship status and your management of the relationships will need to be modified accordingly. Finally, building and maintaining all these relationships in a thoughtful forward-planned way will ensure they are robust and sustainable.

Relationships and communication

This vignette is linked to the issues guides. [Click here to go to 'Relationships and communication'](#).

Ruth is a 43 year old clinical project manager in the local DHB mental health service. She has extensive experience as a mental health nurse in both secondary and primary care settings in Australia and the UK, and she has lived in New Zealand for a year. Ruth has a Master's degree in mental health services research from a prestigious institution in London. Following one year working as a nurse in one of the local mental health inpatient units, Ruth has been employed by the DHB to lead the development of primary mental health care services.

This DHB serves two quite distinct geographical areas: one with a socio-economically deprived urban and rural population with high unemployment, and a second, much smaller urban area that is relatively affluent. The more affluent area is better served by GPs, but across the whole DHB catchment area there is a significant shortage of GPs with a 'demand management' system in place for new patients. Partly due to this, the mental health service has tended not to refer patients back to GPs and is currently experiencing considerable pressure on clinical time due to changes in the distribution of funds now that dedicated mental health funding is no longer ring-fenced. Three-quarters of the secondary care patients live in the poorer part of the district.

For at least a decade, the relationship between GPs and secondary mental health services has been guarded. GPs feel secondary services are not responsive when needed and secondary services consider that primary care lacks the expertise to provide mental health care. The DHB wants to improve the liaison with GPs so that more patients can be referred back to primary care.

Questions to consider

How does Ruth:

1. Build a sustainable dialogue between GPs and secondary mental health services?
2. Support equitable distribution of primary mental health care across the DHB catchment area?
3. Use this as an opportunity to move towards the current preferred model of care?

Involving Primary Care in Primary Health Care

This vignette is linked to the issues guides. [Click here to go to 'Models of Care'](#).

Shane is the newly appointed primary mental health coordinator for Hillside PHO. The DHB wants to expand its mental health services and is partnering Ministry funding with some local mental health development funds. Previously there has been little primary mental health care activity apart from routine general practice services and the District has lagged behind in the coordination of psychological therapy provision accessed through primary care.

As a first step Shane has organised for some funded therapist time to be allocated to the largest Group General Practice in the District. He now wants to build on this initiative and, at the suggestion of the DHB primary care manager has organised a meeting directly with several other group practices.

The meeting is poorly attended and Shane is perturbed at what seems to be resistance to primary mental health development and criticism of both the PHO and the DHB. None of the other invited PHO or DHB staff were able to attend. After the meeting, Roberta, one of the junior partners in the practice Shane has been working with says that there is considerable dissatisfaction among the local GPs about workload. The area has a longstanding shortage of doctors and all the local practice lists are closed. A number of senior doctors have retired and there are problems staffing the local after hour's service. Roberta says that previous meetings with the PHO to discuss recruitment strategies have been unsatisfactory, and there has been little engagement with the DHB. There is also concern at the difficulties local GPs have in accessing secondary care psychiatric referrals. GPs also appear distressed at falling immunisation rates and what they feel is unjustified criticism from the local Emergency Department about ambulatory sensitive hospitalisations, particularly skin infections.

Shane reports these concerns to the Director Planning and Funding at the DHB and says he feels further progress in the primary mental health area is unlikely until the relationships between local General Practice and the DHB are improved. Over the

following nine months the DHB organises a rapid response community based IV antibiotic service for skin infections and works extensively with the Public Health Unit on a skin infection health promotion campaign. The DHB also organises a locum relief scheme enabling a number of doctors in smaller practices to take annual leave.

At the end of this time Shane arranges a further meeting with the local practices, the PHO and DHB to discuss primary mental health care. The local liaison psychiatrist and head of the crisis intervention team also attend. GP attendance at this second meeting is much improved and a steering group is formed to further define the extent of mental health issues in the District and how the Practices can be better coordinated with the PHO and DHB.

Questions to consider

1. Within your organisation how well represented are local General Practice and other health provider groups at discussions about primary mental health development?
2. What are the strengths and challenges in the current relationships between the primary care teams and the PHO and the PHO and DHB?

Prioritisation

This issues guide is linked to the vignette 'Who's in? Who's out' (click link)

Why use a guide to prioritisation?

It is often hard to select the most appropriate priorities from available options. Prioritisation Matrices are used to select priority initiatives from a range of ideas, to define the benefits and reach consensus. They enable people to lay out all the possible options available for a particular decision and then rank them (in a structured way) into an order, which puts the highest value (most important) options first. Their purpose is to narrow down the options before detailed implementation planning begins.

Ideas	Criterion 1	Criterion 2	Criterion 3	Criterion 4	Score	Ranking
Idea 1						
Idea 2						
Idea 3						
Idea 4						
Idea 5						

How to use it

1. Create a list of the ideas or options you want the team to consider.
2. Decide the criteria you wish to consider when selecting the preferred idea or option. Create a column heading for each criterion - select as many as you need.
3. Create a question for each Criterion that team members should ask themselves before scoring the idea. (see example)
4. Use a rating scale for each Criterion (e.g. 1,2,3,4) where 4 is a favourable indicator and lower ratings become less favourable. Use the same rating

scale (e.g. 1,2,3,4) for all the criteria. Create a definition for each rating to ensure that there is consistency when team members vote.

5. Team members allocate ratings.
6. Multiply each idea's ratings together to achieve a score.
7. Rank the ideas or options and discuss the scores.

Example: How do we extend mental health initiatives beyond current targeted population groups?

Ideas to be considered:

Idea 1: Reduce funding to present population groups.

Idea 2: Introduce clinical criteria alone for patient selection

Ideas	Impact on equity	Impact on costs	Focus on high needs	Difficulty	Score	Ranking
Idea 1	4	1	2	3	4X1X1X3	24
Idea 2	1	1	1	1	1X1X1X1	1
Idea 3	2	3	2	1	2X3X2X1	12
Idea 4	4	2	4	4	4X2X4X4	64
Idea 5	2	1	2	1	2X1X2X1	4

Establishing the boundaries of Primary Mental Health Care

In trying to plan any complex system and in this case Primary Mental Health Care (PMHC) we are always faced with the decision of what to include and what to leave out. What we choose to include within our plan for PMHC is influenced by what we know and see (facts) and what we value (norms). Our judgments about these determine what we consider to be relevant and inside the scope and what we consider to be less important or left out.

While we endeavour to take a ‘whole system’ perspective we cannot avoid the fact that our observations and judgments will always be partial. This is because, our knowledge of the facts and our norms will always limit our understanding, and secondly, any judgment we make will benefit some parties more than others. It is important therefore to make this process of establishing boundaries explicit so that there is a clear understanding of what the scope is and what needs to be done to address issues that may, as a result, be left outside.

The ‘eternal triangle’ of boundary judgements, observations and evaluations⁵ is a conceptual framework used to show how a specific claim is conditioned by boundary judgements. Whenever we propose a problem definition or solution, we cannot help but assert the relevance of some facts and norms as distinguished from others. Which facts and norms we should consider depends on how we define the reference system, and vice versa; as soon as we modify our boundary judgements, relevant facts and norms are likely to change too (Figure 1).

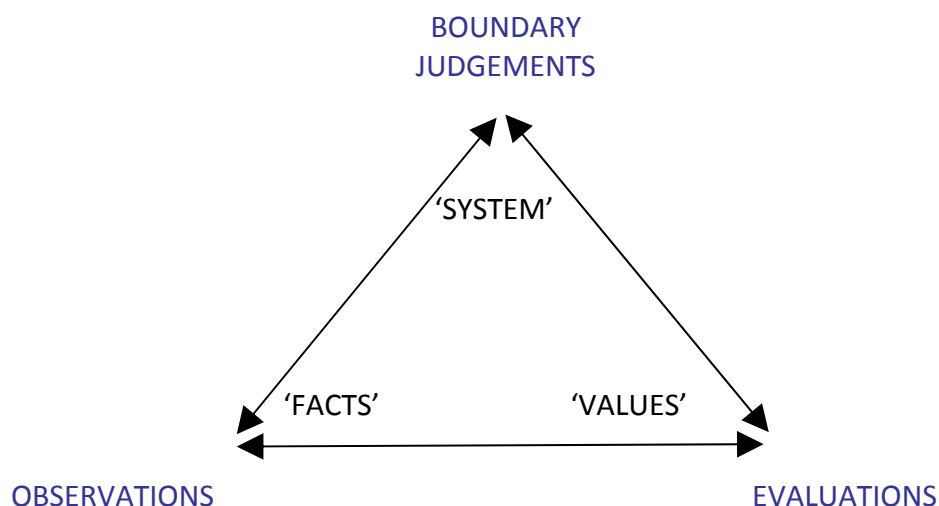


Figure 1: The ‘eternal triangle’ of boundary judgements

⁵ Ulrich, W., *Reflective Practice in the Civil Society: the contribution of critically systemic thinking*. Reflective Practice, 2000. 1(2): p. 247-268.

The 'eternal triangle' is a useful tool to guide discussions around what to include and what to leave out of PMHC. Any decision about the scope of PMHC asserts the importance of some 'facts' (observations) or 'norms' (evaluations) over others. So it is important to consider each corner of the triangle in the context of the other two. For example, what new 'facts' become important if we expand the boundaries of PMHC or change the predominant norms. For example, you decide to emphasise issues of equity. Does our current boundary do justice to the perspectives of different stakeholder groups? If new values, such as financial sustainability, become prominent then how does that affect the boundary and what new facts do we now have to consider?

The value of beginning your planning with a disciplined approach to boundary judgements is that you are able to explore the implications for all parties, regardless of whether or not their concerns have been included within the system boundaries you have set.

Who's in? Who's out

This vignette is linked to the issues guides. [Click here to go to 'Prioritisation'](#) and [click here to go to 'Establishing the boundaries of Primary Mental Health'](#).

Like all planners around the country Judith was trying to find ways of making the resources they did have access to deliver the best care to those in most need. But it wasn't that easy. There were advocates for a wide range of services and each was pressuring her for more investment.

There was an obvious issue around equity. Like many services, mental health services for Māori were inadequate for the task. Māori were not being served well and it showed in the health statistics. But what about children? Services that did exist were widely dispersed and poorly co-ordinated. Not only were children not being well served but it was well known that of those adults, Māori and Pakeha, with mental health conditions, many developed their first symptoms in childhood. In fact Judith had just read a recent report showing that 50% of people with mental health conditions were first diagnosed before they were 15.¹ At the other end of life older people were continuing to put great pressure on health services and dementia was surfacing as the big issue to be addressed.

There were a number of programmes operating in the District, and some of them were very good, but Judith wanted to 'take stock' and look beyond the effectiveness of any single initiative to engage people in the bigger issue of mental health in the region and what the priorities for action should be.

Questions to consider

1. Who should Judith engage with to develop a plan for mental health services in her region?
2. How do you think each of those involved would evaluate the effectiveness of any plan that was implemented - from their perspective?

3. What is the information you would want to 'bring to the table' to support discussions?
4. How would you decide 'who was in' and 'who was out', knowing that you can't do everything you want?

Time and time management

This issues guide is related to the vignette called “We’ve been trying to get this meeting organised for the last 6 months” ([click link](#))

Effective time management is essential to PMHC development, if no other reason than that there is no protected time in mainstream general practice or general practice team settings. The implications of this are:

- ❑ Time for project or initiative development must be resourced externally if General Practice is to be involved. This situation is different to secondary care settings where clinicians can expect paid non clinical contact time.
- ❑ At the individual clinician level it also means that strategies that involve general practitioners or practice nurses to attend for example case conferences will be challenging.
- ❑ Practices such as supervision that are standard in secondary mental health settings will not be present in primary care unless specifically resourced.

Principles of time management

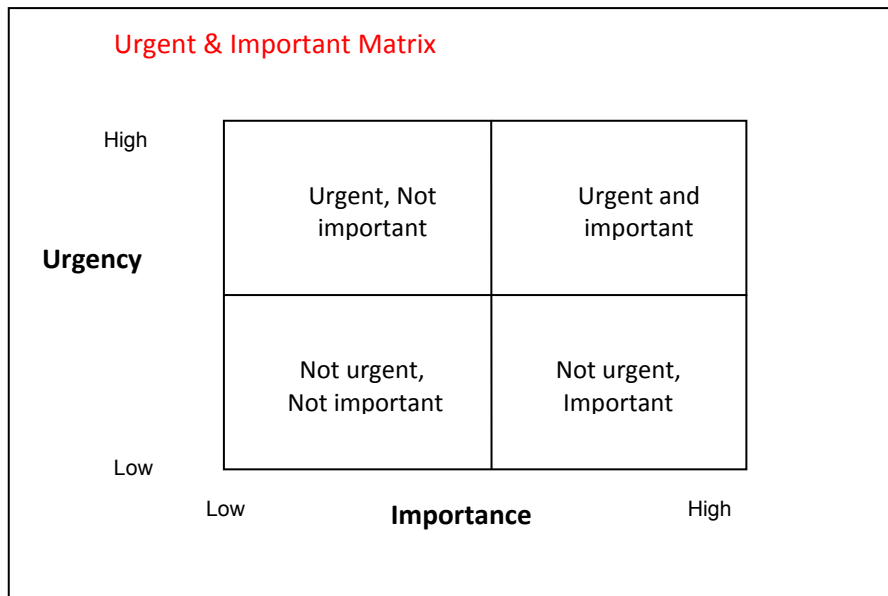
These are straightforward, commonsense and can feel virtually impossible to put into consistent practice. It is important that protected time and time management are discussed as a significant issue in primary mental health care development.

The following principles are important for teams and individuals.

1. Deal with operations separately from strategy in meetings and if possible during the team day. At the DHB level most time should be spent on strategy and strategic issues with operational issues delegated.
2. The focus should be on decisions and outcomes rather than discussions where possible and especially in meetings.
3. Information is vital for decision making. It is difficult to plan effectively for development or sustainability unless information is available; determine appropriate information sources before meetings where strategic decisions are to be made.

4. Don't get caught relitigating decisions.
5. If something is established policy go with it, don't waste time and energy fighting it unless you know it will cause real damage.

There is nothing more important than the following framework:



For both individuals and organisations it is difficult to appropriately prioritise which activities are addressed and in what order. In the primary care sector it is easy to be swamped by crises and the administrative demands of everyday tasks. Priorities will change depending on the phase of activity and evolution of your organisation. The urgent and important matrix can help you manage your time more strategically.

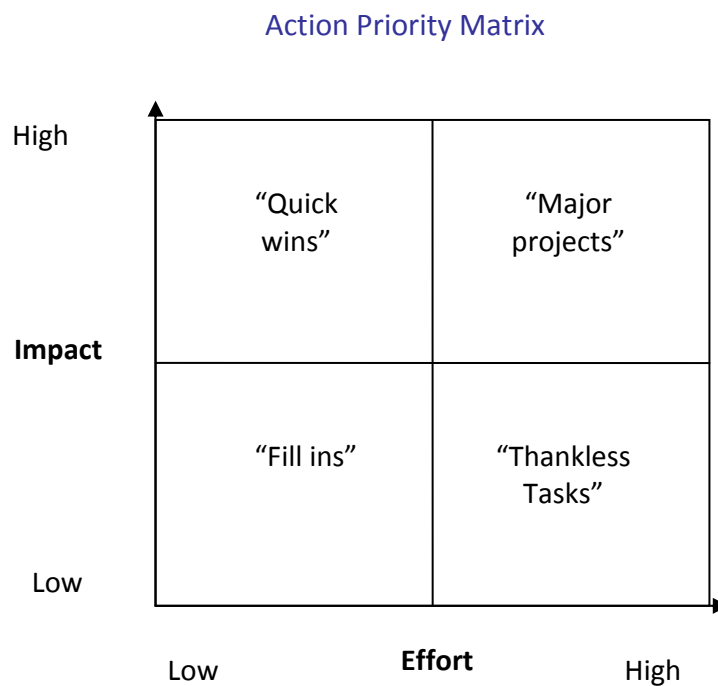
The following time management matrix⁶ highlights four quadrants where you can spend your time. Those who accomplish very little are probably spending a large amount of their time in the Quadrant of deception and the Quadrant of waste. It is important to make a plan to address activities in all of the four quadrants.

	Urgent	Not urgent
	I (MANAGE)	II (FOCUS)
Important	<ul style="list-style-type: none"> • Crisis • Medical emergencies • Pressing problems • Deadline-driven projects • Last-minute preparations for scheduled activities 	<ul style="list-style-type: none"> • Preparation/planning • Prevention • Values clarification • Exercise • Relationship-building • True recreation/relaxation
	Quadrant of necessity	Quadrant of Quality & Personal Leadership
	III (AVOID)	IV (AVOID)
	<ul style="list-style-type: none"> • Interruptions, some calls • Some mail & reports • Some meetings • Many “pressing” matters • Many popular activities 	<ul style="list-style-type: none"> • Trivia, busywork • Junk mail • Some phone messages/emails • Time wasters • Escape activities
Not important		
	Quadrant of Deception	Quadrant of waste

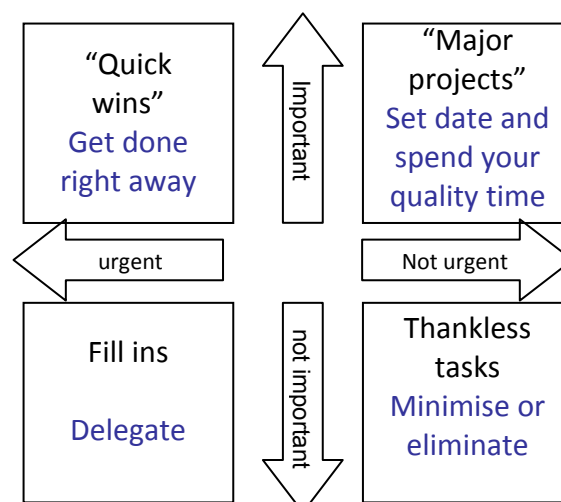
Adapted from Covey S (1994)

⁶ Covey S (1994). First Things First. To Live, to Love, to Learn, to Leave a Legacy. New York.

When making a plan that address activities in all of the four quadrants it is also important to create a mixture of achieving both 'quick wins' and work on 'major projects'. The action priority matrix below is a simple diagram that helps you choose which activities to prioritise (and which ones you should drop) if you want to make the most of your time and opportunities.



In your day to day work, decide how you can delegate things which need to be done, but not by you, and also which tasks should be minimised or even not done at all.



“We’ve been trying to get this meeting organised for the last six months”

This vignette is linked to the issues guides. [Click here to go to ‘Time and time management’](#)”.

Robyn is the planning and funding manager at the DHB responsible for the mental health portfolio. The DHB has three PHOs within its geographical boundary, each of which has been running primary mental health initiative pilots. As part of its strategic plan the DHB wants to align the working practices of the initiatives, and feels that there are additional opportunities to be gained from sharing training and some more specialized clinical psychologist time.

Relationships between the different PHOs have previously been challenging and in one of them there has been resistance to sharing a previously developed training module with others.

Robyn feels that the first step is a ‘round table discussion’ between the PHO clinical leaders, the mental health coordinators, the largest clinical psychology grouping and the DHB.

Robyn looks at her diary and discusses a possible date for the meeting with one of the mental health coordinators who was in the DHB for another meeting. They agree that two weeks should give people time to arrange diaries and Robyn asks her secretary to arrange the meeting for a Monday lunchtime.

Of the nine people invited to the meeting four send their apologies for the chosen date, and Graham, a GP clinical leader with one of the PHO’s sends a terse e-mail informing the DHB that ‘Mondays are busy.

Robyn asks for a rearranged meeting, this time six weeks ahead and offering two alternative dates and times.

Seven of the nine people invited agree to one of the times and a brief letter is sent explaining that the meeting is to ‘coordinate mental health issues across the DHB’.

Five of the attendees turn up for the meeting. Graham is absent, but Stewart, a GP from one of the other PHOs announces that 'he hopes the meeting won't go on longer than an hour'.

Robyn has prepared a briefing paper that she hands out at the start of the meeting and reads from. To her consternation she realizes that after the initial introductions and the briefing paper 25 minutes have elapsed.

She then asks for general comments. Stewart begins the discussion by elaborating on the history of separate development across the different PHO's and reminds the meeting that his PHO was the first to introduce a mental health pilot three years before the recently introduced Ministry funded initiatives.

The clinical psychology lead states that she is still unclear about the real purpose of the meeting, but is concerned that there is not sufficient DHB funded clinical psychology time to expand beyond current workload which is servicing referrals from predominantly one PHO.

The meeting finishes 45 minutes later with a provisional agreement to meet again in six weeks time.

That afternoon Robyn receives an e-mail from Stella planning manager from one of the other PHO's expressing concern that the meeting was dominated by the larger PHO in the district and that she hadn't been able to express her point of view adequately.

Questions to consider

1. What has gone wrong in these interactions and why?
2. How might have this process have been handled more effectively?

Possible solutions and issues

Clarity of purpose is one of the most effective tools for efficient time management. Any meeting should have its purpose clearly defined and any briefing materials sent out well in advance.

Managing a meeting well is an art form, and it is important that there is sufficient structure to enable each voice to be heard and to contribute.

There are significant issues to involving General Practitioners and other front line professionals in meetings. There is no paid protected non clinical contact time for those health professionals so attendance at meetings has to be incentivized or it will (or will not) be done as part of a 'goodwill subsidy'.

It is important to determine for whom a particular meeting is urgent and respond to their timetable.

Financial sustainability of Primary Mental Health Care services

This issues guide is related to the vignette 'Following the dollars' ([click link](#))

Our system model of PMHC, described in the [Systems Planning Guide](#), highlights the point that the adequacy of resources, in this case dollars, is dependent upon both the amount of resources available and the type and volume of demand on those resources.

Let us examine the scale of the issue. Currently, in 2010, specific PMHC activity across the whole country is supported by \$22.5 million of funding⁷. This modest amount has to support the 16% of the population estimated to have mild to moderate mental disorders, including substance use disorders, in any 12-month period.⁸ That is, assuming a population of 4.3 million, and that prevalence rates are similar for those under the age of 16, 688,000 people. Let us assume that half of these people will naturally remit⁹ or not want formal treatment, and continuing the assumption that people under the age of 16 are included, this represents 344,000 people in a year, with an allocation of \$65 each per year.

To put this into context, in the primary mental health initiatives evaluation, the additional cost (over the usual consultation cost) of a single extended GP consultation was \$60 per visit; and a standard package of care covering psychological treatment ranged from \$400-\$550, with all-up costs ranging from \$580-930 per person.

Of course, PMHC does not exist in a vacuum. There is now a matrix of services for the management of common mental disorders, including a range of self-help tools such as *The Journal*, which is a self-administered course of problem-solving therapy,

⁷ Ministry of Health. 2009. Towards optimal primary mental health care in the new primary care environment. A draft guidance paper. Wellington .Ministry of Health.

⁸ Oakley-Browne M, Wells J, Scott K. (eds) 2006. Te Rau Hinengaro: The New Zealand Mental Health Survey. Wellington: Ministry of Health.

⁹ Andrews, G 2001 Placebo response in depression: bane of research, boon to therapy. *British Journal of Psychiatry* 178:192-194; Kendler K, Walters E & Kessler R. 1997. The prediction of length of major depressive episodes: results from an epidemiological survey of female twins. *Psychological Medicine* 1997;27:107-117; Khan A, Warner H & Brown W. 2000. Symptom reduction and suicide risk in patients treated with placebo in antidepressant clinical trials. *Archives of General Psychiatry* 57:311-317.

and for younger people, the Lowdown programme which is also web-based. These programmes are funded from other allocations. There are also developments in new brief low-intensity psychological treatments that can be delivered from primary care by GPs or practice nurses without on-referral and without the need for extensive mental health expertise (e.g. Mathieson, Collings, Dowell et al. 2009¹⁰).

Clearly services will only be sustainable if you manage to match the demand to the available financial resources. There are three ways to do this: increasing the funding allocation, tightening the access criteria or decreasing the cost of providing the service. Figure 1 show the links between these three factors.

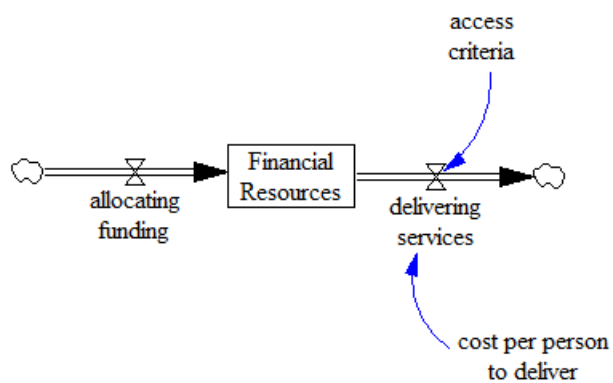


Figure 1: Factors affecting the financial resources available for PMHC

¹ Kim-Cohen, Julia, et al (2003). Prior Juvenile Diagnoses in Adults With Mental Disorder *Developmental Follow-Back of a Prospective-Longitudinal Cohort*. Archives of General Psychiatry vol. 60:709-717

¹⁰ Mathieson F, Collings S, Dowell A. 2009. Sub-threshold mental health syndromes: finding an alternative to the medication of unhappiness. *Journal of Primary Health Care* 1(1); 74-77

What can be done to match demand to resources?

Increase your effective funding allocation for PMHC

One of the features of funding for mental health services is that there are numerous funding channels. The millions that are spent on mental health as a whole, including secondary services, are separated out into different funding streams, often from different sources, themselves held in different budgets and often having different health outcomes to report on. While there is only just over \$22 million of sustainable funding for PMHC there is, for example, over \$1 billion available for specialist and community health. Even if you are unable to access additional dollars directly, bringing the relevant 'budget holders' together to explore common goals, overlaps, and ways in which each can support the other can be a valuable exercise. There is no doubt that the constraints on total funding limit the services you can offer, but there is also no doubt that within DHBs throughout the country; there are multiple budgets that are often managed separately. Finding ways to bring these together is an important step in increasing understanding and so being able to access more of the financial resource that is really available.

Explicitly managing access criteria

Demand is a reflection of both the need in your community and the criteria you set to control access. Accepting that we are unable to fund services for everyone who may benefit we make judgement calls about who will get those services. In some PMH services those judgements are made by the individual service providers and the resources are spent on those who present first. If the provider, usually a GP, considers that you are appropriate for PMHC service then you get the service, until a point is reached where the funding allocation runs out. In other PMHC services, decisions are made about where the money will be spent e.g. to focus on those with depression.

In both scenarios, the sustainability of the programme is determined by the access criteria that have been set. Claiming that a programme is sustainable or not simply on the basis of the dollars available, ignores the impact you have by establishing the

rules that decide who can and cannot access the programme. Being clear and transparent about those rules and ensuring that they reflect both the priorities of the community within the constraints set by the funder, and the financial resources available is essential.

Decrease the cost of the service

The cost of delivering PMHC services is highly variable. The all-up cost per service user for the original Primary Mental Health Initiatives ranged from \$583-\$934. This reflects the costs of different providers; for example, doctors, clinical psychologists, counsellors: different philosophies of treatment; the size of the programme (larger programmes had a lower cost per patient); and different set-up costs, as at the time of the evaluation the programme had been running only a year. For comparison purposes, the cost of a 6 month supply of fluoxetine is \$182 (at \$1 day/ 40mg), although this does not include the cost of assessment and monitoring which should add \$100-\$200. It must be remembered that for sub-threshold, mild and moderate common mental disorders the efficacy of psychological and drug treatments is similar, and patients will vary in their willingness to engage in these two options.

There is emerging evidence that brief therapies are effective irrespective of the professional background of the person delivering them, as long as they are experienced and treatment fidelity is maintained. Brief therapies by their very design enable more people to be seen with the same level of financial resource.

Decreasing the cost of PMHC services in the future will be challenging because as services become more embedded and also a core part of primary health care, there will be some additional costs associated with the need for career development opportunities and training, as well as the need to extend the reach of existing services. The most likely scenario is that costs will need to be contained with more achieved per dollar.

How to decide

We do not suggest one approach is preferable to others, but it is obviously critical that in your service design you consider the implications of that design for financial

sustainability. Every service design has implications, not only for the quality of the service provided but also for the numbers of people who can access that service. Quality and quantity do not necessarily trade off against each other, because, for example, reducing the number of psychological treatment sessions but making them more effective or retaining the same degree of effectiveness may maintain or even increase overall quality. It is important to consider the values and purpose of your service in the decision-making. We suggest that you work systematically through the three options outlined above and review your progress against them proactively as part of your service planning and review.

For those involved in policy and funding, the points about multiple funding silos are important. At the coalface of service delivery, the experience is that multiple programmes with their multiple sets of deliverables to report on can get in the way of doing the work, and can have high transaction costs especially in terms of professional time, which is the health system's most valuable resource. It is important for policy makers and funders to allow some latitude in the way funding streams can be used synergistically at the coalface and also to keep the reporting burden to a minimum.

Following the dollars

This vignette is linked to the issues guides. [Click here to go to 'Funding and resources'](#).

John is an experienced programme planner in a PHO. He has been working in mental health services in various roles since the mid 1980's. Originally trained as a nurse, John has become involved in planning as he feels he can have more impact on the type of services provided in his region. John is acutely aware that there is far more need in his community than they are currently meeting and he is always looking for new ways of delivering more and better services. He is determined to get programmes up and running, to capture any funding that is available. However, John is also concerned that the numerous funding streams that can be tapped into are not linked and are often 'ring fenced' to a particular population or service type. While 'following the dollars' means that services will be provided, and patients will be seen, John is concerned that it is resulting in a range of disparate initiatives that do not support and even possibly conflict with each other. He is concerned that the result will be a series of disconnected initiatives that may provide great care for those lucky and/or privileged enough to access them, but do very little to improve the health of the population in his region.

Questions to consider

How does John ensure that

1. The services respond to need and not just those lucky enough to be able to access them?
2. There are linkages built between each initiative, regardless of which funding stream is supporting it?
3. Consideration is given, especially in the case of time limited funding, to what will happen when the funding stops?

IT and systems

This issues guide is related to the vignette 'Much more than a computer' (click link)

Advances in IT and IT systems have fundamentally changed General Practice and Primary Care. The main uses of IT in relation to primary mental health are:

Patient information held on the Patient Management System (PMS). Most GP consultations are conducted using the PMS with clinical information retrieved and added as the patient is seen.

Referral to other providers: all referrals are prepared using the PMS. In some instances e.g. referral to private hospital specialist's electronic referral is possible either directly or through electronic fax. At DHB level there should be a focus on developing systems where electronic referral is standard. Some of the existing primary mental health initiatives have embedded templates to aid electronic referral. Many psychological treatment providers do not have computerised patient management systems at the present time.

Use of the Internet. The Internet is used to download useful information e.g. psychotropic drug prescribing information, or to provide patients with information about useful websites.

Current useful sites include therapy sites such as

Moodgym

<http://moodgym.anu.edu.au/welcome>

The Journal

<http://www.ndi.org.nz/index.php?q=content/journal-3>

The Lowdown

<http://www.thelowdown.co.nz/>

Population level data

The current PMS systems have not been designed to gather population level data or interrogate a patient list easily. There is the potential for general practice data to be collated and used for planning purposes in primary mental health, but this has not been realised so far beyond information collected through the primary mental health initiatives (PMHI).

The PMHI utilise a number of different scoring and rating systems which could be used to provide overall measures of prevalence and progress following intervention.

Much more than a computer

This vignette is linked to the issues guides. [Click here to go to 'IT and Systems'](#).

Sally, the IT manager at the PHO, has been asked to provide an update on current IT issues in Primary Mental Health to the DHB. She is aware of work being done for the Primary Mental Health Initiative in which referrals can be made to the mental health coordinator electronically and also that there is a DHB plan to try and have a single electronic medical record across the whole DHB, though this is some way off. She wonders how to proceed.

Questions to consider

1. Who do you contact in your organization when considering IT developments?
2. What is the best way of getting information from them?

Sally arranges to visit the mental health coordinator and the GP Chair of the Clinical Governance Group. Rawiri, the mental health coordinator tells her that there are two issues he has been trying to make progress on; the introduction of a guideline decision support tool (DST) and getting referrals and feedback letters organized electronically between the different primary care providers. Uptake of the DST has been low despite a CME evening at which it was introduced, and lunchtime meetings at two of the larger group practices in the District. He suggests that Sally contacts the largest counselling practice with whom the PHO has a contract.

When Sally discusses these issues with Tim, the Clinical Governance Chair, she is surprised to find that he is not overly enthusiastic about the introduction of the DST and says that most GP's in the district don't feel the need for electronic mental health guidelines; they only want increased access to psychological services and better discharge summaries from the psychiatric and crisis intervention teams. Further more he points out that the Practice Management Systems (PMS) in use are fine for individual patient management, but interact poorly with web based applications.

Questions to consider

How do you assess what is reasonable in terms of IT provision for clinical service delivery?

3. Who is driving IT developments locally and why?

Sally then meets with Siobhan, the lead practitioner of the counselling practice, to discuss electronic referrals between the primary care team. Siobhan says that although they use computers for accounting scheduling, they have not yet moved to electronic notes in the consultation. There is no funding to invest in additional IT within the counselling group or practice.

Question to consider

4. What would be your next steps to try and make headway on these issues?

Sally prepares a report to the DHB in which she outlines some of the barriers to further IT development, and is asked in return to provide a prioritisation plan. She and Rawiri decide that they should try and gauge more opinion about the barriers to introducing the decision support tool and that a meeting will be arranged between the PHO clinical governance group and the counselling group.

Three months later a third of the GP practices have trialled the DST and the PHO has streamlined the referral pathway using the DST hyperlink directly to the mental health coordinator and for secondary care referral.

The PHO has also managed to integrate a local directory of counselling services as a hyperlink from the DST and offered trial a direct electronic referral from the largest counselling practice back to the mental health coordinator, who can then pass them back to the GP.

Final questions to consider?

5. How much should individual PHOs or DHBs attempt to tailor existing PMS or other IT systems at a local level; or it is more effective to try and coordinate changes nationally?
6. How much are your current IT plans dependent on interacting within a PMS or local DHB software system, and how much on interacting with a common web interface? What are the consequences?

Why do we have eligibility criteria?

This issues guide is related to the vignette 'Eligibility criteria' (click link)

All New Zealanders are eligible to receive Primary Mental Health Care (PMHC) as part of the provision of primary care. The high prevalence of and morbidity associated with common mental health problems such as depression and anxiety, and their responsiveness to treatment, provide a strong argument in favour of case finding and management in primary care. However the relative lack of specific funding for primary mental health and the time and resourcing involved make case definition and the purpose for which cases are being identified two critical issues.

Case definition

Generally in health care, cases of a particular diagnosis are defined on the basis of signs (externally observable changes or problems) and symptoms (changes or problems the patient is aware of). Mental health problems in primary care often present as combinations of signs and symptoms that do not easily fit one diagnosis. This is one of the reasons GPs may not use strict diagnostic categories when identifying people who might benefit from treatment. In PMHC a case (i.e. a recognisable problem that can benefit from treatment) is more likely to be defined on the basis of symptoms and functioning than on good fit with traditional psychiatric diagnosis.

Purposes of case definition

Case definition is important because that determines how cases can be identified: once there is a definition it is possible to devise means to include and exclude people from case status. Case definition contributes to the decision about whether a person might benefit from a particular treatment, and in some instances may determine whether a patient is eligible for treatment. Access to services may be dependent on a DSM diagnosis for example or the result of a score on a psychological symptom severity rating scale.

Clinical eligibility criteria

Clinical eligibility criteria are the means to ensure that only 'appropriate' problems are defined as cases. 'Appropriate' in this context means likely to benefit from treatment. Clinical eligibility for pharmacological treatment in PMHC in New Zealand is based on the GPs usual clinical assessment, as for many other treatments available in primary care. When the primary mental health initiatives that included access to talking therapies were set up, it was decided that in some instances eligibility was determined on the basis of a combination of the usual GP clinical assessment and the outcome of an additional assessment procedure, as the desire was to ensure only people who really needed treatment were referred on. Because psychiatric diagnostic procedures can be time consuming and are often not a good fit with the combinations of signs and symptoms presenting in primary care, clinical eligibility criteria for talking therapies in PMHC in New Zealand are commonly based on simple sign and symptom checklists that have been calibrated against diagnostic instruments, usually for the purpose of screening. The K10 is an example of such a measure. It is a non-specific measure of psychological distress and does not indicate whether the underlying problem is, say, depression or anxiety. The PHQ-9 is a similar instrument developed for the detection of depression in primary care.

Policy-based eligibility criteria

The overall decisions about access to care are made at a policy level. The decision by some DHBs to ensure that only people with K10 or PHQ-9 scores over a certain level had access to the new primary mental health initiatives' talking therapies is an example of this. Other policy level criteria for access to the additional resources made possible under the initiatives were ethnicity and socio-economic status.

Rationing as a purpose of eligibility criteria

Eligibility criteria provide a mechanism for controlling how many people in certain groups (e.g. 'cases', ethnic or socio-economic groups) have access to services. The demand on services is determined by the eligibility criteria. The need to manage demand depends on where in the system the ability to allocate resources is located.

Some primary mental health services, such as access to antidepressants, are allocated on the basis of clinical decision making. Because the budget for medication is not held at PHO or practice level, there is no need perceived at that level to manage demand for them. However, for the psychological interventions that are part of the primary mental health initiatives, the budget is fixed at PHO or practice level, which means the demand must be managed at that level.

A fixed budget in the face of demand that might exceed it means scarce resources must be allocated across competing demands. In this situation, rationing or demand management is inevitable. Health service rationing can be applied in either an active or passive way.

Passive mechanisms of rationing are determined by structural elements in the health service and the consequences of policies set at Ministry and DHB level. Those with relevance to PMHC in New Zealand include financial barriers to care, workforce availability, time, distance and geographical location. In PMHC, the various kinds of service and treatment are distributed unevenly across the country, and on top of this, limited funding tied to specific services/treatments within PMHC means that some services/treatments will be rationed more than others. For example, drug treatments are less subject to passive rationing effects than are psychological treatments.

Active rationing requires decisions about how the resources are to be allocated and how demand is to be managed. This is 'priority setting' and occurs at DHB, PHO, practice and clinician level. Rationing or priority setting decisions are made explicitly and implicitly every day in health care, all around the world, by politicians, funders, service providers and clinicians.

Eligibility criteria for entry to a treatment programme serve three key objectives. The first is policy-related, that is, ensuring the programme is delivered to those who are identified in the policy as the target for intervention. This might be based on socio-economic status, ethnicity, age or problem type. The second is a clinical objective related to ensuring that identified cases are directed to appropriate evidence-based

treatments. Examples of this are diagnostic assessments. The third is an economic objective. This often relates to ensuring the service is delivered in a way that is within budget and is sustainable for the future. Depending on the economic criteria that are being prioritised, examples include ensuring the treatment is offered to those who will benefit most, to those with the greatest need, or that the treatment is the cheapest of effective available treatments. Determination of some of these depends on the nature of the outcome being measured, such as how benefits from treatment are defined. For example, outcome could be defined as a reduction in symptoms or an improvement in functioning, and then criteria would need to be set to determine what degree of change in these would be acceptable.

At PHO level, eligibility criteria are one of the few mechanisms available to manage demand for services. For example, symptom-based thresholds for entry to treatment programmes are easy to alter. At clinician level, symptom-based thresholds may mean that a person who the clinician considers would benefit or is badly in need of the service, would be ineligible. As it is clinicians who are providing the assessment i.e. screening for the eligibility criteria, they are in a position to reinterpret the criteria for the benefit of an individual patient.

Roles of DHBs, PHOs and clinicians in relation to eligibility criteria

The role of DHBs and PHOs is to be explicit about the implications of both national and local eligibility criteria and to communicate those clearly to clinicians. The role of clinicians is to understand the local implications of eligibility criteria and attempt to operate criteria in a way that professionally balances individual and population health needs.

Eligibility criteria

This vignette is linked to the issues guides. [Click here to go to 'Why do we have eligibility criteria?'](#).

Coastal Care is a collective of PHOs serving a mixed urban/rural population. The PMHC programme *Futurefocus* uses several private clinical psychology practices as a supplier of CBT-based brief interventions for depression. This is a longstanding successful programme dating from before the Ministry of Health-led primary mental health initiatives, for which Coastal Care received DHB funding as part of earlier DHB moves to 'outsource' a number of clinical and support services. Coastal Care won this DHB tender on the argument that this would reduce the burden on secondary care community mental health teams, who had difficulty recruiting and retaining clinical psychologists, and would also improve access to appropriate treatments for depression. The *Futurefocus* programme has some similarities to a 'managed care' approach. There are clearly articulated programme entry criteria which are adhered to as the programme manager, Bob, pays careful attention. The key criteria are that the programme is for those aged 18-65 years with a PHQ-9 score over 20 (severe). Patients are allocated up to 8 CBT sessions and the mean session uptake is 6.

The advent of the Primary Mental Health Initiatives brought an expectation of treatment of a broader range of common mental health problems. Furthermore, the initiatives were to focus on problems of mild-moderate severity, whereas the *Futurefocus* programme has focussed on moderate-severe cases. The initiatives would only offer a maximum of 6 sessions with the expectation of a mean of 4.

Bob is fielding a request from the DHB to ensure the programme is funded from the new Primary Mental Health Initiative allocation. However, the existing programme does not meet the criteria due to the high threshold for entry and the local psychologists are reluctant to reduce their possible number of sessions.

Questions to consider

1. What are the key steps Bob needs to take in terms of information and relationships?
2. Would you advise him to negotiate with the psychiatrist about numbers of services? If so what would the main argument be?

Connecting with the 'consumer'

This issues guide is related to the vignette "The service user's voice" ([click link](#))

The idea of the 'mental health consumer' is associated with the history of secondary mental health services. It originally arose from what was essentially a social activist movement, responding to the need for more self-determination for people with experience of mental illness. This emerged from a time when psychiatric practice dominated mental health care and most treatment or management was delivered in large institutions in which many people stayed or were detained for long periods.

Much of primary mental health care (PMHC) service development is based on assumptions derived from the clinical problems that present in secondary care, and one of the things we have focused on in developing this Toolkit is the importance of supporting a PMHC that emerges from primary care, based on primary care principles. So, given that, what is the relevance of the 'mental health consumer' in PMHC?

The key principles of good primary care, such as being an accessible first point of contact for health problems, continuity of care for the full range of health problems, the ability to understand the patient in their own context and as they develop over time (even a lifetime!), are of course relevant to working with people who present in primary care with mental health problems. Some of the issues highlighted by the mental health consumer movement, such as fears of the consequences of being labelled with a diagnosis, are also seen as problems for primary care practitioners.¹¹ Elsewhere in the Toolkit (essay titled *Diagnosis and management in primary mental health care: a paradox and a dilemma*) we have examined aspects of the problem of diagnosis in primary care, from the primary care clinician perspective. People attending their GP may not be aware that specific diagnosis is less of a preoccupation in primary care than for many secondary care practitioners, so this may be a potential point of reassurance for some.

¹¹ Dew K, Dowell A, McLeod D, Collings S, Bushnell J. 2005. This glorious twilight of uncertainty: mental health consultations in general practice in New Zealand. *Social Science & Medicine* 61(6) 1189-1200.

Another issue highlighted by the mental health consumer movement is the need for more self-determination in relation to treatment choices and general approach to problem management. Primary care practitioners are most commonly motivated by the need to find a pragmatic way to help the person manage their problem.

Supported self-care has long been an important aspect of primary care practice, so in this, too, primary care can be seen as aligned with the desires of many mental health consumers.

It is also worth noting that many people who are newly diagnosed with a serious mental disorder do not have experience of the kind of mental health care practiced in the 'old' psychiatric institutions. Little is known about these consumers as a group. Their illness-life trajectories may be quite different to those of people who have experienced long or multiple periods of hospitalisation. This group of consumers may have different ways of interacting with health professionals, and different expectations of them.

People with mental health problems may fear that they will be taken to hospital if they are open about a mental health problem. The reality from the primary care perspective is that GPs have no specific powers under the Mental Health Act, and often find it difficult to access secondary care services on behalf of patients. Furthermore, many GPs have experienced referring people to mental health services and not having care handed back after the consultation, something they find frustrating. Unless things are at crisis point, most primary care practitioners prefer to work with the person in the primary care setting.

Finally, primary care professionals work with people over long periods of time and do not focus on only one aspect of a person's health. They commonly know the consumer's family/whanau and other aspects of the life context. For people with mild-moderate mental health problems the primary care clinician is in a good position to see that these are part of the ups and downs of a person's life, as temporary disruptions that will be overcome.

It is important that these points are communicated to people who may seek help for mental health problems in primary care. It is no longer the case that GPs have very few options to help people with mental health problems, and it is also not the case that medication would always be the GPs preferred recommended treatment. There are now many public health messages communicating the availability of a range of services (e.g. extended GP consultations, guided self-help over internet, psychological treatments, medication), the benefits that can be achieved by seeking treatment, and countering the stigma associated with having a mental illness. These all support the uptake of PMHC services.

What can primary care practitioners do?

It is important that primary care practitioners take the time to listen to the concerns of people presenting with mental health problems, and communicate whatever is relevant from the points above as part of supporting therapeutic engagement.

What is the relevance of the ‘mental health consumer’ in PMHC?

The group of people using primary care is diverse in terms of prior experience with mental health services. Mental health consumers who have had difficult experiences in mental health care need to have this acknowledged. However, given that around 40% of us will experience a mental disorder at some time in our lives,¹² the ‘mental health consumer’ is relevant to primary care inasmuch as it can be any of us needing PMHC.

¹² Oakley-Browne M, Wells J, Scott K. 2006. Te Rau Hinengaro: the New Zealand Mental Health Survey. Wellington: Ministry of Health.

The service users voice

This vignette is linked to the issues guides. [Click here](#) to go to 'Connecting with the consumer'.

Alan is 42 years old, and was diagnosed with bipolar disorder several years ago. His mental illness has become more stable over time. He works as an accounts clerk in a small business. He has been using the services of the local community mental health team since moving into the area 5 years ago. Alan has a GP, but as he has no ongoing physical health problems, he rarely visits her. His psychiatrist occasionally writes to his GP with updates on Alan's progress in dealing with his mental health issues. When Alan does visit his GP, he is reluctant to say much as he fears she will treat his problem like a manifestation of his mental illness, rather than addressing the physical problem which he is concerned about. He feels, on occasion, that she 'talks down' to him and treats him like a child.

Sophie is 38, single, and is a primary school teacher of NZ European descent. Lately she has been feeling a bit low, is having difficulty sleeping, experiencing tension headaches, and is losing weight because she doesn't feel like eating much. She is finding it difficult to feel motivated about her job, even though normally she enjoys it. She has a good relationship with her GP, but is worried about discussing her symptoms with him because she suspects that she will be told she is depressed, and doesn't want that on her medical record. Even though she knows depression is nothing to be ashamed of, someone else she knows had difficulty getting income protection insurance when they wanted to buy a house because they had been on antidepressants. She visits her GP and only mentions in passing the headaches she has been having.

Questions to consider:

You are a primary mental health clinician:

1. How can you find out how Alan and Sophie are feeling?
2. How can you ensure Alan does not feel 'talked down' to?
3. Would it help if the GP knew Alan better?
4. How can you help Sophie get the help she needs?

Coordination of care

This issues guide is related to the vignette 'Coordination of care for Joe' ([click link](#))

The system for providing PMHC is fragmented across many organisations, funding streams, business models and professional groupings. At the level of managing and maintaining clinical services, this fragmentation presents considerable challenges. We suggest PMHC in New Zealand is now developed sufficiently to move towards differentiating administrative from clinical roles.

What needs coordination?

Key issues that require coordination at the clinical level are:

- Access to treatment programmes and services
- Systematic progress monitoring
- Responsiveness to clinical improvement or worsening
- Managing exits from and re-entry to the service

Research from across many realms of healthcare has shown that lack of coordination of care undermines the possibility of achieving good health outcomes.

What is coordination in the PMHC context?

Recent New Zealand evidence¹³ has shown that there are two kinds of coordinator role, clinical and non-clinical.

Coordination tasks commonly undertaken by a clinical coordinator are:

- Needs assessment and service access coordination for individual service users
- Advising primary care clinicians on referral options
- Mentoring practice staff and doing interdisciplinary clinical reviews

¹³ Dowell T, Garrett S, Collings S, McBain L, McKinley E, Stanley J. 2009 Evaluation of the Primary Mental Health Initiatives: Summary report 2008. Wellington: University of Otago and Ministry of Health.

- Building/strengthening networks between primary and secondary mental health services
- Advocacy for service users
- Case management
- Counselling
- Project management of service set-up

Non-clinical coordinators typically:

- Arrange/deliver mental health training for practice staff
- Liaise with and managing therapy providers
- Do financial management
- Liaise with practice staff and report on consumer progress

Is there an ideal?

The preferred model depends on the nature of practice arrangements, particularly when a service is new. However, a non-clinical coordinator may be more efficient where there are larger volumes.

As PMHC has matured in New Zealand, and with the move towards larger groupings of practices and PHOs, consideration should be given to moving towards separation of the administrative (non-clinical) and clinical coordination roles. This approach would mean the administration for PMHC programmes would be 'mainstreamed' and synergies between these and other programmes could be enhanced, and that clinical coordinators would become more clearly the 'clinical mental health lead' in PHOs and practices.

Administrative/non-clinical coordination would focus on:

- the infrastructure, administration and support for evolution of PMHC schemes, possibly combined with the administration of other programmes
- financial management

- ❑ enhancing links with other agencies e.g. NGOs and other providers of social services, including through contracting for services

Clinical coordination would focus on:

- ❑ Ensuring regular case progress review occurs and service exits and re-entries are managed with clear timely communication between health and social services professionals; using this as an opportunity to build links with secondary mental health services as appropriate
- ❑ Staff training and professional development, including professional supervision
- ❑ Contribution to the management of more complex cases, including linking with other agencies such as NGOs and social agencies; using this as an opportunity to build links with secondary mental health services
- ❑ Contributing to the uptake of emerging evidence on low-intensity and brief interventions in PMHC
- ❑ Developing and refining treatment options for mental health problems presenting in primary care, with a focus on those with social complexity

How do we move to a new model?

There are several steps:

1. Briefly describe your current roles and how the tasks listed above are achieved
2. Values check – what are the key values you want to retain in your service provision?
3. Identify up to three key strengths you would want to retain, and up to three weaknesses you would like to fix
4. Create a template for the new model, focussing on specific tasks to be undertaken, key relationships for each role
5. Check the strengths of your current model can be retained and weaknesses overcome, and check you have retained your core values

6. Identify financial re-arrangements that may be needed to support the new arrangement
7. Align with existing timelines for service developments, contracting, reporting.
8. Develop a detailed project plan to manage the transition
9. Develop a plan to review the new arrangement as part of quality review process

Coordination of care for Joe

This vignette is linked to the issues guides. [Click here to go to 'Coordination of care'](#) and [here for 'Mental Health and Chronic conditions'](#).

Moana is the diabetes nurse for Sunrise General Practitioners in Petersville, a regional town servicing a population of 60,000 people. She is responsible for managing diabetes care for between 400-500 people. Moana has worked in this area for many years, and is known by the GPs and other health professionals to operate at the level of an independent practitioner, although she has not bothered to try for Nurse Practitioner status with the Nursing Council. As an example of her level practice Moana routinely commences people on insulin and alters the doses of this and other hypoglycaemic agents.

Joe is a 53 year old man with type 2 diabetes poorly controlled with insulin. Joe's wife died of breast cancer 18 months ago and since then Moana has noticed a decline in Joe's general functioning and self-care. He is becoming more morose and slightly disorganised, although he is still managing his work at Repco where he works as a storeman. His children and grandchildren live in other cities and overseas and although they make a big effort to keep in touch frequently with Skype and Facebook he has not been able to easily master these since his wife died. Joe has become quite casual with his blood glucose monitoring and insulin dosages and has had several 'hypos' at work in the past three months. He has also started drinking whisky, a favourite when he was a partying young man, but which he had not touched for twenty five years, preferring a low intake of beer as a working man with a family. Moana is concerned Joe is becoming depressed and asks his GP to assess him and refer to the local primary mental health initiative. This is quickly done within an extended GP consultation and Joe is referred to a private counsellor who sees him within two weeks. The counsellor considers the main issue is unresolved grief and works on this with Joe over a period of four weeks. After two counselling sessions Joe has a serious hypoglycaemic episode at work and is taken by ambulance to ED, where he claims to have mistakenly taken too much insulin, which he admits he has

been careless with recently. The ED lets the practice know and Moana works with him to try and get better control. The counsellor is unaware of this event as Joe does not mention it in the third session. Joe does not attend the two final sessions with the counsellor and does not mention this to Moana who carries on working with him, seeing him every ten days to two weeks to support him to take better control of his diabetes. After three months, Joe has become significantly depressed and hands in his notice at work. However, his demeanour towards Moana has not really changed although the work towards better diabetic control has emerged as a 'battle of wills' between them. Five weeks after Joe leaves work, the letter from the counsellor arrives, addressed to the GP. The letter states that a unresolved grief is an issue they were working on, that Joe did not attend the full course of appointments, that in retrospect the counsellor wonders if Joe had been depressed, and recommends a trial of specific treatment for this.

Moana brings Joe to an appointment with his GP the following week and he is commenced on Fluoxetine. Moana monitors his mood as part of her work on his insulin management. She is able to check in with the mental health clinical coordinator if she is concerned, and they have set fortnightly dates to briefly (5 minutes) review Joe's progress. Eight weeks later Joe is doing much better, and admits that he had been thinking of killing himself and that an 'accident' with insulin would be a method that would cause least hurt to his family. Joe deeply regrets giving up his job and the economic decline means his chances of finding new work are slim. He is now struggling with social isolation which is probably contributing to a less than full response to his treatment.

Questions to consider

1. What might have been the first step a clinician could have taken to ensure everyone had the right information at the right time to do a better job for Joe?
2. Are there system issues that could minimise the risk of this kind of scenario?

Mental Health and chronic conditions

This issues guide is related to the vignette 'What about Johns' physical and mental health?' ([click link](#))

Can the ideas and systems associated with chronic conditions help in improving care for people with mental health conditions? For some conditions such as depression, co-occurring problems (i.e. medical and/or substance use disorders) are common. Programmes based on a chronic care model can be effective across the physical and mental domains¹⁴.

While the clinical issues may be distinct, for many patients the overlap between physical, mental and substance abuse disorders is simply the web of life within which they are meshed. As carers we cannot artificially create boundaries, especially when we know that one condition has an adverse effect on another. For example, people who have diabetes and also suffer from depression have greatly impaired functioning that can generate substantial barriers to implementing the lifestyle changes and adherence behaviours needed to effectively manage their diabetes¹⁵. For all these patients the key issue, from the point of view of care delivery, is that their illness is such that their participation in the design and delivery of care is crucial.

For many people with a mental health condition their experience is one of episodic symptoms that ebb and flow. Support, from a health professional, when it is required, is only for a short time and may simply be an acute intervention at a particularly stressful time of life and not something that is recurring or enduring. For others however their mental condition, while varying in its symptom severity, is an ongoing part of their lives, something that they have to deal with 7 days a week, 24 hours a day. In that sense it is very much a chronic condition.

¹⁴ Kilbourne, A., M., K. Biswas, et al. (2009). "Is the collaborative chronic care model effective for patients with bipolar disorder and co-occurring conditions?" *Journal of Affective Disorders* **112**: 6.

¹⁵ Piette, J., Richardson, C., and Valenstein, M., (2004). Addressing the needs of patients with multiple chronic illnesses: the case of diabetes and depression, *American Journal of Managed Care*, **10**: 152-162.

Looking at mental health through the lens of chronic care management is not to view all people with mental health conditions as having an ongoing condition that will gradually deteriorate over time. Planning the patient visit, rather than waiting for them to initiate the appointment however is effective practice as will be organising the practice team so that there is someone who can spend more than the allotted 15 minute slot with the patient. A chronic care perspective also focuses on helping the patient develop the knowledge, skills and confidence to become an active and effective participant in their own care. Furthermore it is a view that highlights the need for good links between the health care provider and community resources.

The experience that we have in designing chronic care programmes, usually for people with physical conditions such as diabetes, can be applied to improving care for those with mental health conditions. Much of what constitutes good care for people with type 2 diabetes also constitutes good care for people with mental health conditions. All categories, while being useful, often mask important differences. So focusing on whether or not mental health conditions can be treated the same as physical chronic conditions hides the obvious facts:

- For many people a mental health conditions is a short episode in their life and does not need ongoing care.
- For others' their mental health condition, despite varying symptom severity, is a long term chronic condition that can benefit from best practices in chronic care.
- For many co-morbidity is the norm, and trying to separate out their mental and physical conditions denies their integrated nature.

The key message is that mental health services cannot divorce themselves from physical health. Mental health should look to work closer with those who are funding and designing service to improve care for people with chronic conditions and get mental health issues and the specific needs of mental health patients' into the thinking about such programmes early on. Programmes should be designed so that they work for people with mental health problems rather than trying to set up alternative programmes in isolation.

Mental health and chronic conditions

This vignette is linked to the issues guides. [Click here to go to 'Mental health and chronic conditions'](#).

John is a 55 year old taxi driver. He was diagnosed with asthma 12 years ago which is gradually getting worse, and in the last five years the doctor has said he has Chronic Obstructive Pulmonary Disease (COPD). John is frightened of this diagnosis since his uncle had the same problem and John remembers him struggling to breathe with an oxygen cylinder at home. John's breathing is getting worse and he is short of breath even with the relatively little physical exercise he has to do while driving his taxi. He is afraid of losing his job and minimises his symptoms to both his employer and his GP. Even though his wife also works he is struggling to make ends meet.

John has been going to the same GP for over 20 years and knows him well. In addition to his GP he has seen a number of other clinicians over the last year; a cardiologist, a respiratory physician and the 'asthma nurse'.

His clinicians tell him that he must stop smoking and take more control of his condition. Although he tries, John cannot stick to any programme long enough to get results. He feels that he is getting very little support to do this and does not have the information or tools to succeed. John is worried about his future and often gets depressed. Full-time work is becoming more and more difficult. He is concerned that he may lose his job and it will make it even harder to cope and pay for the many out-of-pocket expenses he is incurring. He has talked to no-one, not even his wife, about these worries

Questions to consider: How do you ensure that

1. John's mental state does not deteriorate to the point that it makes it impossible for him to keep working?
2. The right services are brought together to ensure that John's mental and physical issues are addressed appropriately?

Integration across the continuum of primary, community and specialist settings

This issues guide is related to the vignette “A story of primary and secondary mental health” (click link).

The purpose of this guide is to help you do the following:

- ❑ Understand the different perspectives across the primary/ secondary care interface and the boundary between them.
- ❑ Explore the issues and opportunities for better integration of mental health services

Context

Prior waves of development in mental health have seen steps towards greater integration of mental health across primary, community and specialist settings. These were largely driven from a secondary care perspective with the main objective being to lessen the burden on specialist resources through the full or partial transfer of responsibility for care of selected patients to GPs with some transitional support.¹⁶ A number of local initiatives have developed with mixes of consultant/GP liaison, shifted outpatients and shared care models. For young people there are services that blur the boundary completely, with “Youth one-stop-shops”, or early intervention services that are primary care but with specialist staff available.

A number of separate influences are potentially converging to make further integration a possibility:

- ❑ Previous shared care initiatives were largely specialist driven, with implicit assumptions that specialist knowledge and skill transfer was key. The development of structured PMHC is building a primary based knowledge and skill that opens new opportunities to organise care across the continuum.

¹⁶ Nelson, K. et al 2003 Evaluation of Mental Health/Primary Care Shared Services

- ❑ Better understanding of the nature of the population and health needs currently served by secondary and specialist funded community services is highlighting that many are not receiving appropriate high quality care. Many people for example with complex and enduring mental health needs are not receiving comprehensive bio-medical care.
- ❑ Ministry policy direction supporting the implementation of stepped care and the greater role of integrated primary/community based health services.
- ❑ Potential of greater flexibility in mental health funding with the relaxation of funding ring fences.

Getting started

The rest of this guide provides a flexible pathway to develop greater integration and focuses on addressing five interrelated contributing issues:

1. Developing cross system leadership.
2. Understanding diverse viewpoints.
3. Building the case for greater integration across the continuum.
4. Understanding how to utilise the resources of the whole system.
5. Exploring options of integrated care models.

Developing cross sector leadership

Few districts have functional forums or processes to provide cross sector whole of system leadership yet experience strongly points to this being a critical factor for success. In the literature on shared care development there are some pointers to some of the success requirements:

- ❑ Champions with interest, enthusiasm, knowledge
- ❑ A clearly communicable sense of value and priority
- ❑ Early and sustained involvement of key partners with both representational and competency credentials

- ❑ Clear authority and responsibility mandates and terms of reference
- ❑ Strong processes for sustaining dialogue over purpose, scope and boundaries
- ❑ Mechanisms to facilitate development of partnerships, break through mistrust and conflict
- ❑ Clear, realistic, plausible plans with pathways for realisation and developmental evaluative learning
- ❑ Funding streams to support participation and a programme office

Questions to consider:

1. How can you engage and develop such champions?
2. How can you mobilise the arguments for this being a priority? Who does this need to be addressed to?
3. What alliances with other initiatives can you create?

Understanding diverse viewpoints

A critical first start to developing a more integrated model of care is to understand the differing view points, perspectives and values across the system as a whole. You should be ready to explore and facilitate dialogue on issues such as:

Primary care perspectives:

- ❑ Primary health is provided through small organisations where the clinical and business models are of necessity tightly coupled. Sustainable changes will only work if both clinical and business models are addressed together. There is limited free capacity for change; it has to be used wisely.
- ❑ Perceived lack of recognition for the extent to which mental health issues are addressed as part of business as usual primary care.
- ❑ Limited options and capacity of primary based services to address needs of those with moderate mental health needs.
- ❑ Awareness of the prevalence of quite complex, severe mental stress and impairment not addressed by specialist services that could well be addressed in primary settings.

- Isolation of many NGO community services from primary care.
- Difficulty in accessing specialist services when needed.
- Poor communication back from specialist services on the care being provided, loss of continuity of care with service users not being discharged back to primary care.
- Challenges in communicating, different perspectives, perceived lack of respect for skills in primary role.

Specialist service perspectives:

- Specialist services are generally stretched with competing demands on time and high case loads. Shifting resources can be achieved but needs to be done carefully.
- Specialist services perceive variability of primary care mental health capability and referral service utilisation. There is a lack of confidence primary capacity to handle mental health issues.
- Concern that once patients accepted into a specialist service 'they are ours for life'.
- Concern over poor attention to physical health needs of patients with complex, severe and enduring mental health but limited time and capacity to deal with complex shared care issues.
- Different paradigms between primary and secondary, especially attitude to risk
- Difficulty in forming relationships with GPs; busy, dispersed with wide variety of forms and structures in practices and PHOs

Questions to consider:

4. Who are the main stakeholders in your area and what are their issues?
5. How will you engage stakeholders in improving integration?
6. What process will you use to support an ongoing learning process?

Building the case for greater integration across the continuum

To develop the case for change we suggest the following areas are highlighted in your planning:

The mental health burden of your population that would be addressed through better care integration:

The [Systems Planning Guide](#) and [Dynamic Systems Model](#) in this Toolkit can help you translate national mental health survey data into information that is relevant to your locality (include link to Planning guide and systems model)

Opportunities for better match of care needs and services

Care should be organised to address complexity, (clusters of mental, social and bio medical needs), symptom severity, (impairment) and duration (episodic versus enduring). Models of care segmented to differentiate severe and enduring from episodic needs can provide much more effective care and better use of the combined resources of the system.

Critical question:

7. How could you develop a business case relatively quickly that would be sufficient to build support for taking the initial steps? e.g. Developing a leadership coalition and plan for a more comprehensive shared care development programme?

Understanding how to utilise the resources of the whole system

Formally structured primary mental health has developed in isolation from DHB supported secondary and community services. From a resource perspective business structured primary mental health is funded to \$22.5m, secondary/community services are funded to \$1b with business as usual primary care providing a substantial baseline contribution through standard consultations.

People with the most 'severe and enduring' disorders (approximately 0.4%) receive approximately 50% of secondary resources for care that could be better tuned and coordinated to support their needs; the larger proportion of people with moderate to severe but episodic needs currently treated within secondary care do not require the same ongoing structures of care and could be better served with a mix of intensive specialist intervention in conjunction with care provision that remains primary centred. A model based on use of specialist assessment, shared care planning and utilisation of existing community based mental health nursing and community worker resources could provide a lower cost per episode of care. There may be sufficient non doctor clinical resource already in the system to provide a shared care support worker at a ratio of 1:3 or 1:4 workers per GP.

Questions to consider

8. How could you explore the cost per capita of care for different model of care options in your area?
9. What data could you draw on to support this analysis?

Rather than confront the obstacles to doing shifting large blocks of resources head on could you work backwards from the 'ideal' structure to identify the how and where to start making small changes that would have a large and rapid impact?

Exploring options of integrated care models

In the 2003 evaluation of integrated care models in NZ there were three options identified as being tested or implemented; consultant/GP liaison, shifted outpatients and shared care models. The more recent Collins 2010 Milbank Foundation Review¹⁷ describes 8 models of care operating at differing levels of depth:

- ❑ *Minimal collaboration.* Mental health providers and primary care providers work in separate facilities, have separate systems, and communicate sporadically.

¹⁷ Collins C, Hewson D, Munger R, Wade T. 2010. Evolving models of behavioural health integration in primary care. Millbank Memorial Fund. New York.

- ❑ *Basic collaboration at a distance.* Primary care and behavioural health providers have separate systems at separate sites, but now engage in periodic communication about shared patients.
- ❑ *Basic collaboration on-site.* Mental health and primary care professionals have separate systems but share the same facility.
- ❑ *Close collaboration in a partly integrated system.* Mental health professionals and primary care providers share the same facility and have some systems in common, such as scheduling appointments or medical records.
- ❑ *Close collaboration in a fully integrated system.* The mental health provider and primary care provider are part of the same team. The patient experiences the mental health treatment as part of his or her regular primary care

While not all the models describe in the review are necessarily applicable in our NZ setting you are encouraged to explore the models and consider how aspects could be applied in your setting.

The Ministry Stepped Care Guidance model¹⁸, while focused on primary care, is inherently a model of integrated primary and secondary care.

¹⁸ Ministry of Health. 2009. Towards optimal primary mental health care in the new primary care environment: A draft guidance essay. Wellington: Ministry of Health.

A story of primary and secondary mental health

This vignette is linked to the issues guides. [Click here to go to 'Integration across the continuum of primary, community and specialist settings'](#).

It was after the second drink that the real stuff started to emerge.

“John, I hear all this mumbo jumbo about integrated family health centres and everything but it is just not reality. From where I sit you GPs are just all over the show. You have more patients than you can deal with. You can't afford the time to even understand a mental health issue when you see one let alone treat it. Apart from the odd one like you most of your GP colleagues only have a smattering of psychiatric skills so we at the specialist end have no confidence in the general level of skills out there... how on earth could we hope to build an integrated service when the base is so variable? There is no way I would want any part of it, shared care would be just too risky, as specialists we would always end up carrying the can when something went wrong.”

John sat quietly through this, he had heard it before and knew his friend meant well despite the sound off. Clearly everything Dave said had an element of truth to it. The district was short on GPs and they were busy. Different GPs clearly have a range of interests and capabilities yet here was the nub of the issue – every one of them was seeing and dealing with patients mental health issues every day. Lots of them with tough complex issues that GPs are handling already and could do much better if they had access to some advice and options that they could call in when needed.

“Dave, what are the options? You said yourself just a moment ago that you guys are way overloaded with cases but, according to the numbers, still under your expected access rates. Your budgets are tight. Something has to change somewhere.”

“Yeah it does John. If primary could step up and take on some responsibility for patients who don't need intensive support that would take the load off and maybe enable us to get out there and give you guys some more support, training or what

ever. But the last time we raised this we were accused of dumping patients and expecting unpaid time from GPs.”

“Some truth in that Dave, from where we sit there is a whole industry of community based support out there that is focused on those patients. Many of them are have episodic needs but are stable and frankly in much lower levels of need and distress than the people we see in our practices every day but can’t crawl through the CAT door to get access to any decent services. Then when we do get some one through that filter they disappear, we never hear anything about them until years later you say hey we don’t want them any more. I think most GPs would be happy to keep being the ‘home’ for their care but you can’t just ask us to do more. If the connection remains between us and the patient, with your guys help where needed, and we could have community mental health workers linked to our practices then that would be a totally different scenario.

Questions to consider

1. How come Dave and John seem trapped in the status quo? What are the constraints of the current system or the reinforcing systems of belief on both sides that contribute to this?
2. What would be the changes that could transform the situation?
3. Where would you start?

Models of care

This issues guide is related to the vignette "Can Zane work a 40 hour week?" ([click link](#))

Patient pathway, clinical decision rules, service model or resource allocation model?

'Models of care' is a phrase commonly used in contemporary Primary Mental Health Care (PMHC). In practice 'model of care' is an ambiguous term. It is used to mean: a patient pathway to and through services; clinical decision rules about what treatments to offer to whom, when and by whom; a model for conceptualising and organising services; and a high-level model for allocating service resources at population level. When you use the term 'model of care' to support any aspect of your planning or provision, ensure you articulate, record and periodically check the sense in which you are using it.

Form follows function

In all models of care, and in whatever sense the term is used, there are implicit structure and process elements that make up the *form* of the service provision. For example, in stepped care the steps are a structural aspect, and the routine progress assessment leads to a process of 'self-correcting' movement up and down the steps).

One of the principles of this Toolkit is that *form follows function*.¹⁹ When planning we often think about structure too early, and then develop processes that fit with the structure. We strongly recommend that when using the idea of any model of care, it is best to prioritise function and refer back to it frequently when developing/modifying processes and structures. At least be clear which of function or form (structure/process) is dominating in any application of the idea of stepped care.

¹⁹ Grumbach, K., *Redesign of the Health Care Delivery System: A Bauhaus "Form Follows Function" Approach*. JAMA, 2009. **302**(21): p. 2363-2364.

Models of care in contemporary New Zealand Primary Mental Health Care

Stepped care is the model currently receiving most attention in the policy context and there is pressure to move towards its more widespread adoption.²⁰ However the majority of the mild to moderate mental health needs of patients are currently met by the GP or practice nurse in the context of existing consultation times and alongside the competing demands of other health issues being brought into the consultation. This model which might be thought of as 'business as usual' contains elements of stepped care, when services are available or the patient's situation becomes more acute. For those who can afford it, business as usual includes referral to private providers of generic counselling, specific psychological treatment and psychiatric consultation. Another model is 'high intensity' care, which is more often seen in Kaupapa Māori PMHC. In this model, work may include the whānau, may occur away from the consulting room setting, and may allow for more frequent or a greater number of face to face sessions.

Within the stepped care model as currently interpreted in the New Zealand setting, there is considerable variety. For example, in many of the Ministry funded Primary Mental Health Initiatives, following an initial diagnosis of 'mild to moderate' mental disorder, the GP can manage the problem within the existing consultation framework, may apply to the PHO for funded extended GP consultation time, or move up a step (or two) and refer through the mental health coordinator for counselling or clinical psychology time. In other settings the steps are more proscribed with treatment pathways determined by a mental health assessment tool ranking, providing access to stepped care which provides access to clinical psychologist input after a course of drug treatment. These variations on stepped care appear different again from some Kaupapa Māori or Pasifika models where the steps involve initial engagement with community development workers who may then refer directly to psychologists or psychiatrists with specific cultural expertise.

²⁰ Ministry of Health. 2009. Towards optimal primary mental health care in the new primary care environment: a draft guidance paper. Wellington: Ministry of Health.

Moving from one model to another

Moving between models of care is best undertaken as a process of planned evolution. This can be challenging when compelling drivers of change (such as new funding allocations) are imposed from outside without regard to where you are in your process. Nevertheless it is important to have a medium to long term plan that you are working to. There is a series of important steps to ensure you can make a successful transition.

Steps for evolving a new model of care

1. Define and characterise your current model(s) of care
2. Define and characterise the model you are evolving towards

In these steps you will need to consider the following domains, some of which are listed in the Ministry of Health's guidance on moving to stepped care:²¹

- 1) How personalised is the care?
- 2) What are the inclusion/exclusion criteria and how are these operationalised?
- 3) What is the service user pathway?
- 4) What is the process for monitoring clinical outcomes?
- 5) What is the process for reviewing clinical management?
- 6) What is the process/mechanism for ensuring the needs of vulnerable groups are met?
- 7) How does the model ensure appropriate adaptation to local need while staying consistent with the need for regional and national consistency?
- 8) How does care provision coordinate between primary, secondary and social sectors?
- 9) Is the model supported by an appropriate IT platform?
- 10) What resources are dedicated to workforce capacity and capability?
- 11) How are DHB/PHO/social sector organisations supporting/undermining the model?
- 12) What are the funding mechanisms and do these support your model of care aspirations?
- 13) What processes are in place to monitor and improve service performance and quality?

²¹ Ministry of Health. 2009. Towards optimal primary mental health care in the new primary care environment: a draft guidance paper. Wellington: Ministry of Health.

3. Identify the five major steps in moving to the new model of care

This may include stopping some aspects of services, reconfiguring some and developing some new services or service components.

4. Identify, classify and manage your key relationships in relation to these major steps (*see Specific Issues Guide: Relationships and communication- create link*).

5. Develop a timeline

To develop the timeline identify the end point and work back. Then identify known internal and external related or unrelated issues that will impinge on the timeline. Adjust the timeline.

6. Identify the resources required, including personnel and funds
7. Develop the milestones under each major step, and the tasks associated with each milestone. This will include relationship management.

Not a panacea

It is important to remember that any model of care is a device that is used to shape services. No model of care can be a fully defining feature of service provision. For example, there are instances where stepped care may not serve some aspects of service requirements or resource allocation, such as underpinning values-based decisions. An example of this is where you may wish to prioritise service access for some population groups to make equity of outcomes more likely.

Can Zane work a 40 hour week?

This vignette is linked to the issues guides. [Click here to go to ''](#).

Zane (Kai Tahu, Ngati Toa, Rangitane) is a nurse employed by the PHO to set up a new Kaupapa Māori primary mental health service for people with mild to moderate mental health problems. He has worked in services around the country over the years in both inpatient services and community mental health teams. The PHO role gave Zane and his wife an opportunity to return with their young children to his local area, where his Scottish great-great-grandfather farmed, and re-connect with whānau.

Zane has observed how fragmented and uncoordinated services may mean substandard care for tangata whaiora and has made a personal commitment to providing more holistic, integrated care. He has taken a whānau-centred approach, meaning in practice that most assessments are done at the patient's home and may involve several visits so that a connection can be established with whānau and he can gain an understanding of the full story around the problem. Most of the referrals are for problems in the moderate to severe spectrum, with frequent substance use and physical comorbidity. He also fields requests to see other whānau members, even though they do not have referrals and the cases have not been triaged.

Zane has submitted a request to employ another staff member to work fulltime in his service, as the joint management and clinical role means he is regularly working 50-55 hours per week, and a waiting list is building. The PHO is running two parallel service models: Māori are entitled to extended GP consultations, medication and/or up to four sessions of brief talking therapy in the mainstream service, or extended GP consultations and medication/and or the Kaupapa Māori service. About a fifth of Māori patients using PMHC use the mainstream service and 2% of Pakeha patients use the Kaupapa Māori service.

Zane is about to attend a budgeting meeting with other service managers and Planning and Funding. He is concerned because Māori make up only 9% of the local population and his request will mean he is asking for 25% of the staffing budget for

PMHC in his locality. Planning and Funding take Treaty obligations seriously and acknowledge that Zane's work situation is untenable in the long term.

Questions to consider

1. How does Zane:

Argue that the model of care he is providing is good value for money?

Support equitable distribution of primary mental health care across the DHB catchment area?

Mental Health Promotion

Good mental health status is just as important a resource for the successful management of day-to-day life as good physical health status. This is why the protection and promotion of mental health is important as an end in itself, not simply as a strategy to prevent mental illness.

Any activity that has among its consequences the enhancement of people's psychological and emotional resources, resilience and strengths, and life competencies that are linked with social health and community participation, can be considered as mental health promotion. Mental health promotion activities can enhance the well-being of people with diagnosed mental disorders. A New Zealand example of this is the current anti-stigma campaign *Like Minds, Like Mine*. Attempts to prevent the onset of diagnosable mental disorders and their risk factors are also a domain of mental health promotion.

Mental health promotion encompasses many activities ranging from policy and legislation to opportunistic work with individuals. The latter includes such things as a GP working with a person to improve the amount and quality of sleep he or she is getting. Between these there is a wide range of activities that take place at programmatic level, such as school-based programmes and mental health literacy campaigns. Some programmes at this level also have what is essentially an opportunistic benefit for mental health, for example the green prescription programme, which aims to increase people's levels of physical activity, also benefits mental health status.

Over the past fifteen years New Zealand has had a rich and wide-ranging programme of mental health promotion activity, ranging from major programmes such as the *Like Minds, Like Mine* campaign²² to locality-based in-school programmes for the enhancement of well-being. One of the newer programmes is *MH101*, a mental

²² <http://www.likeminds.org.nz/page/5-Home>

health literacy programme aimed at professionals such as the police, who are likely to have contact with people with mental health problems.²³

Many of the concepts underpinning mental health promotion fit well with positive psychology, an emerging branch of psychology that focuses on researching, understanding and fostering positive emotions, individual strengths and virtues, and positive institutions.²⁴

Most of the ideas behind mental health promotion are entirely congruent with primary care philosophy and practice, and a good deal of mental health promotion already occurs in routine practice. This will usually be occurring following the kind of prioritising process that GPs and other primary care clinicians use to determine which issue they will deal with in a given clinical encounter, and often as part of the management of another problem.

However, primary care practitioners do not necessarily consider these activities as 'mental health promotion' as this term is not usually used in primary care. For this reason, any attempts to encourage primary care practitioners to increase their focus on mental health promotion at the individual level will require a re-framing of the activity so they see it as congruent with and enhancing what they already do. As practices amalgamate into larger entities that include a wider range of health professionals, it may be possible for primary care to take on more responsibility for mental health promotion in local communities, such as supporting classroom-based programmes in schools. However, these activities will have to be funded.

Mental health promotion

This vignette is linked to the issues guides. [Click here to go to 'Mental health promotion'](#).

John is a fifty year old public servant. He has made his way into senior management over a period of eight years and is highly regarded by his colleagues inside and

²³ <http://www.blueprint.co.nz/page/301-workshops+mh101>

²⁴ Seligman M & Csikszentmihalyi M. 2000. Positive Psychology: an introduction. *American Psychologist*, 55(1) 5-14.

outside his Ministry. Currently his workplace is undergoing a major restructure under a new CEO and all senior staff have to apply for the new roles. Redundancies are certain. There is much to do to get various policy tasks completed well before the run-up to the next election and work is getting busier as gradually middle level staff leave for new opportunities. New appointments are not permitted although external temporary project workers are allowed. These people require a lot of support to get up to speed as they usually do not have content knowledge.

John goes to his GP with a minor wrist injury from chopping wood. In passing the GP asks how things are and John mentions the work situation. The GP had been planning to keep this appointment short to catch up with the bookings, but instead asks John about his hours of work, sleep, his drinking and what support he has. He reminds John to schedule exercise, including during the week, and suggest John come back if his sleep has not improved in a months time.

Questions to consider:

1. Many of the patients at this inner city practice work for government agencies. Is there anything the practice could do to support the mental health of these people during this stressful time?
2. Are there roles for practice staff other than GPs in doing this?
3. Where can the practice get more information about approaches to mental health promotion that might work well in this situation?
4. What contribution could thinking from a positive psychology perspective add in this situation?
5. What steps could be taken to get this sort of work funded?

Future proofing!

There is no vignette for this guide

Primary mental health care (PMHC), as a structured service is still new, small in scale and resources and with a huge level of unmet need in population served and service gaps. To date service development has largely been reactive to initiative based funding. While very successful within this context future development is less clear cut.

The environment of primary care and mental health is continuing to change with a sense that the rate of change will need to pick up if both are to meet the challenges of rising demand, sustainability and affordability.

Ministry guidance documents²⁵ describe a comprehensive set of developments that will require a substantial lift in the resources and capabilities of primary mental health, yet the pathway to developing these is unclear.

Since the future is inherently unpredictable this guide focuses on suggestions in three areas:

- ❑ Helping make sense of shifting winds of policy and longer term trends in service direction – what are the uncertainties and what might they mean?
- ❑ Helping you to build your own sense of direction – how could you use the winds of change to help build your own pathway towards effective and sustainable services?
- ❑ Developing confidence - that today's decisions will build resources and capabilities useful in the future, despite the uncertainties that future may contain.

Shifting winds

In our research there are clearly strong shifts and changes that are seen to be on our horizon, including but not limited to:

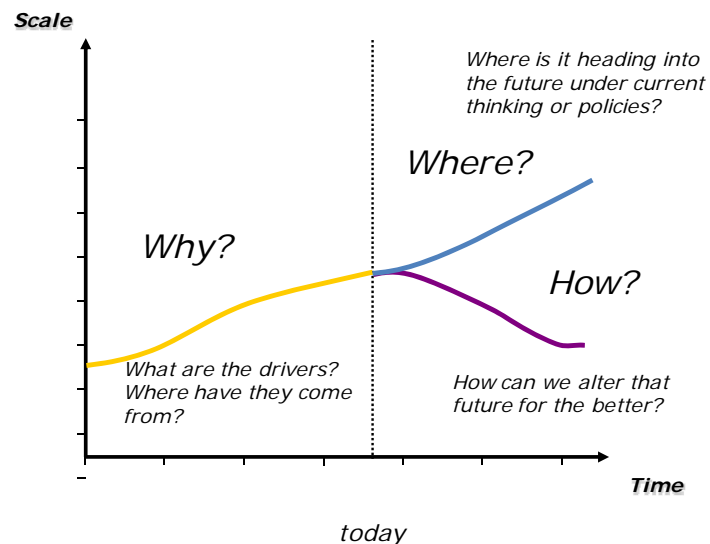
²⁵ Ministry of Health 2010, Towards optimal primary health in the new primary care environment.

- ❑ The wider sector challenges of rising demand, the changing demographic profiles of patients and workforce, affordability, sustainability and demand for productivity transformations.
- ❑ Shift in understanding of the purpose and function of primary mental health care; away from addressing diagnostic categories with specific services; towards addressing syndromes comprising stress, social complexity, and impaired functioning; more active integration with physical health services.
- ❑ Wide acceptance of the continued shift towards person, family/whānau centric care, with a co-production partnership rather than a patient or consumer relationship.
- ❑ Long term service trends, both in primary health care and health services generally that are simultaneously increasing the specialisation of care and emphasising greater integration, shared and supported self care. The recommended development of stepped care is an example. A wider view of these changes can be seen in the Ministry review.²⁶
- ❑ Changes to funding pathways to enable more flexible application of funding.
- ❑ Workforce skills shortages and pressures for new roles (e.g. 'coordinators') or new models of care.
- ❑ Productivity pressures are leading towards a search for scale and efficiency across organisations and services.

Drawing on the extensive practice and literature of 'Scenario Planning' could be helpful in understanding the implications of these changes. While full blown scenario planning is a substantial undertaking the approach can be useful even at an initial level of thinking, as shown in the following diagram.²⁷

²⁶ Ministry of Health. 2010 "Trends in Service Design and New Models of Care".

²⁷ Adapted from Warren, K. (2008). *Strategic Management Dynamics*. Chichester, John Wiley and Sons.



This diagram/tool lets you take an issue that is relevant and ask some basic questions:

- ❑ Why - What are the driving forces? Where have they come from? Why has it followed the pathway to date?
- ❑ Where? – Where is it heading to in the future? What might some of the critical events or alternative scenarios that we should anticipate? How could we describe the impact or consequences of those events in terms of their relevance to the sorts of decisions we may need to make?
- ❑ How? – What can we do to alter that future for the better? What would be our response under each of the different scenarios? What decisions of today would still make sense within each scenario? What scenarios would invalidate those decisions or make us change course? How would we know when to change course?

The ultimate value of this type of thinking is to help us understand the uncertainties in front of us and mentally rehearse what our response would be. Good plans should build in some of this anticipation of possible responses so that they are flexible and robust under a wide range of evolving circumstances.

Building your own sense of direction and confidence in the decisions you are making

The second part of the guide to future proofing is to develop a confident sense of your own direction so that as change occurs around you, you have a strong internalised direction about the sort of primary mental health system that you want to create. With this you will be able to make better choices about how and where you respond.

The [Systems Planning Guide](#) in the Toolkit provides a pathway for you to use to develop a strong sense of direction and confidence in the thinking and logic of your plans.

Specific issues for child and youth primary mental health care

This issues guide is related to the vignette “Children should be seen and heard” ([click link](#))

Consideration of Child and Youth mental health should be one of the most important elements of all your strategic thinking and planning. Some reasons for this are:

- ❑ The prevalence of child and youth mental health problems is high and underestimated.
- ❑ Recent developments in neurodevelopmental research highlight the importance of early psychological impacts on long term outcomes , both psychological and physical
- ❑ There is a strong long term economic argument for investing in child and youth mental health in terms of future productivity.

Prevalence

The most prevalent childhood and adolescent mental disorders among young people in New Zealand are anxiety disorders, mood disorders, conduct disorder and substance abuse. Among 11-year-olds there is up to 18% 1-year prevalence, rising to 35% - 40% in 18-year-olds. Childhood anxiety commonly precedes adolescent depression and studies comparing anxiety and depression have revealed a common genetic predisposition for these disorders. In the presence of both anxiety and depression, there is an increased risk of developing a co-morbid substance disorder.

Long term outcomes

Mental disorders in young people lead to emotional distress, impaired functioning, physical ill-health and increased suicide risk. They also carry a high risk of a pattern of recovery and recurrence (more likely in females) or unremitting persistence (more likely in males) into adult life.

Service delivery

Mental health problems in child and youth should be 'core business' for primary care and the young person with mild or moderate depression should typically be managed within primary care services. However young people often choose not to present mental health problems to GP's, and many child and youth services are situated within education, social welfare or justice frameworks. Nearly all existing child and youth mental health services are situated within secondary care delivery frameworks.

Liaison and integration of health with other services is the key to successful development of child and youth mental health.

In adult mental health it is common to take a problem based approach. In child and youth care a strength-based approach should be used in combination with problem solving and risk reduction.

Use of technology

When planning services for child and youth, DHB's and PHO's should consider the most effective ways of communicating and disseminating information. The internet and mobile phone technology are becoming essential tools in the delivery of child and youth mental health services.

Appointments and follow ups are more likely to be successful using mobile phone and there is increasing interest in the use of web based information and therapy.

There are a number of useful websites for youth including www.thelowdown.co.nz for information, self help strategies and support from peers.

Mental health problems in pre-school children and infants

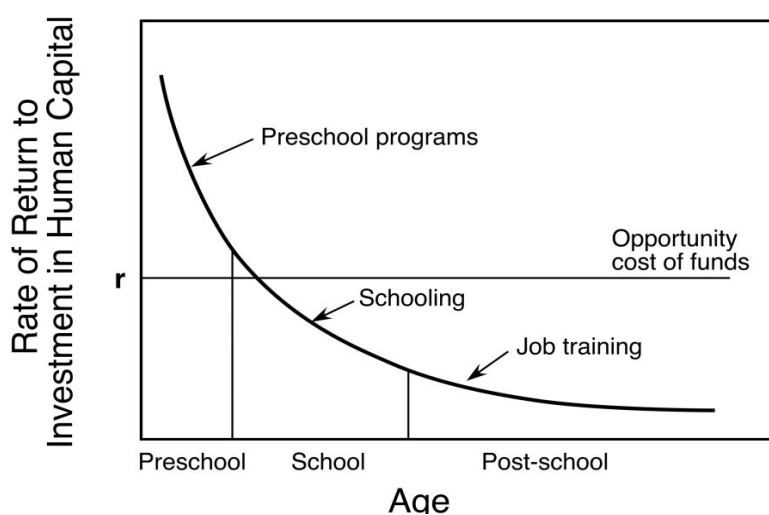
There is a growing awareness of the importance of psychological issues in the ante and post natal periods and early childhood. This has important planning implications. DHB's and PHO's should promote and integrated team approach between all those

caring for pregnant women and the infant and young child. This will include midwives and Plunket. The active management of maternal mental health problems will help the infant as well as the mother.

Some recent studies indicate that mental health problems can be present in pre-school children and infants. A Danish study reported a prevalence of mental health problems of 16 – 18% in children aged 1.5 years of age. The most common problems were emotional, behavioural and eating disorders. Psychosocial problems and parent-child disturbances appear to be risk factors for the development of a disorder in a very young child.

A long term strategic view

There is evidence that in health care, the best return on investment for future wellbeing is made between the years of 0 to 4 years. While it may be difficult for DHB's and PHO's to commit to a long term view, investment in early childhood is likely to provide the greatest gains in improving overall mental health outcomes.



Rates of return to investment in human capital as function of age when the investment was initiated. (Source: Knudsen et al. (2006) Economic, neurobiological, and behavioural perspectives on building America's future workforce. PNAS 103 (27) 10155-10162)

Children should be seen and heard

This vignette is linked to the issues guides. [Click here to go to 'Child and Youth'](#).

At the regular planning meeting between the PHO and DHB a new member of the PHO planning and funding team asks how much of the overall DHB mental health allocation should be devoted to spending on mental health issues in children and young people. She recently attended a seminar on population investment models in which it was suggested that 80% of any health sector budget should be invested in children and young people to get the maximum return on overall investment in health care.

This sparks a number of different questions and discussion points:

How much does the DHB currently spend on child and youth mental health services?

The question may not be as easy to answer as some might think. There are significant resources devoted to child and youth services, but it is fragmented across a wide range of services – child and adolescent mental health (CAMHS), social welfare, CYFS and so on. Some of these inputs the DHB may have direct control over and for others the DHB has working links with other services or sectors.

Any decision about reallocation of resources must be made after considering current allocation, and an assessment of the effectiveness of current allocation models.

Why does this DHB (and yours) allocate current resources in the way it does?

In many aspects of health care children are 'invisible' and have no voice. Adult services tend to be given the largest share of resource because illness and disease are already well established and management of established problems is seen as a higher priority than the preventive and pre-emptive focus of childhood.

Reorienting allocation priorities will mean debating strongly held opinions and traditions.

Why should your DHB consider reallocation towards child and youth?

The case for reallocation is strong. Firstly there is a growing appreciation of the high prevalence of illness and disorder in young people (18% of pre-adolescents with a 'diagnosable disorder and 40% of those in late adolescence).

Secondly there is increasing evidence of the long term harm of not treating symptoms in young people. Established mental disorders do not suddenly develop de novo in people in their late 20's. Tomorrow's depression has its origins in the anxiety of late childhood.

How could our DHB start this process?

The first step is to discuss and answer the questions posed above in relation to your own local area and district. Having identified needs or gaps it is likely that the immediate challenge will be to identify the existing stakeholders and arrange a meeting to discuss these issues.

"Many of the things we need can wait. The child cannot. Right now is the time his bones are being formed, his blood is being made, and his senses are being developed. To him we cannot answer 'Tomorrow,' his name is today."

Questions to consider

Work your way through the questions in the vignette.

Alcohol and substance use

This issues guide is related to the vignette “Alcohol and drug problems in primary care” ([click link](#))

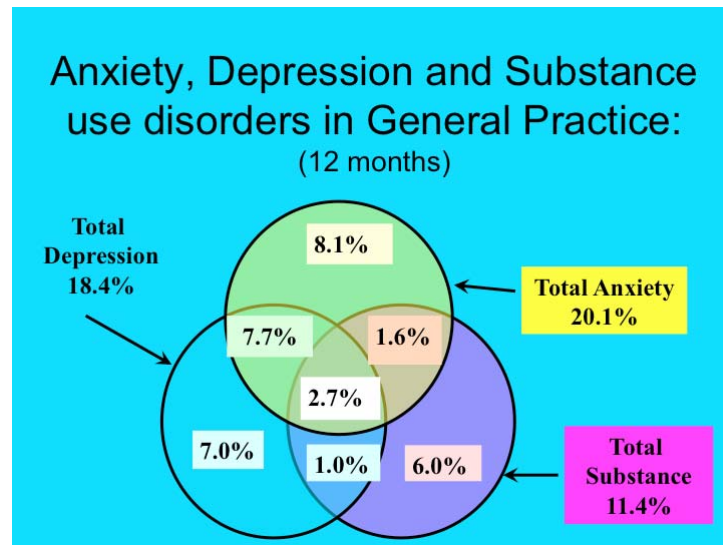
Within Alcohol and Other Drug services (AOD) we know

- ❑ That currently substance use services are fragmented and concentrated on specialist addiction services.
- ❑ There is little communication between primary and secondary care.
- ❑ That substance use treatment is focused on alcohol treatment and opioid substitution.

Alcohol and other drug use provide a number of opportunities and challenges for primary mental health services. There is evidence that General Practice and Primary Care services are in a good position to screen for and detect alcohol and other drug problems and that brief interventions provided by primary care teams can be effective at reducing these hazardous health behaviours. The challenges in addressing substance use issues lie in the high prevalence of disorder , particularly at ‘sub threshold level ‘ and the current ambiguity about how A & D services should be structured.

Prevalence and identification

There is a high prevalence of substance use disorders in Primary Care. The framing of this has traditionally been in terms of a focus on alcohol problems with a small number of other drugs, including cannabis and opiates.



The figure²⁸ above shows that about 12% of patients attending General Practice could be diagnosed with substance use disorder and that there is significant overlap with other conditions such as anxiety and depression.

There is evidence that using two simple screening questions will identify many of those with underlying A & D problems.

Screening questions for alcohol and drug problems:

- ❖ Have you used drugs or drunk more than you meant to in the last year?
- ❖ Have you felt that you wanted to cut down on your drinking or drug use in the past year?

If Yes to either question, ask Help question (below):

Help question: Is this something with which you would like help?

Options: no / yes, but not now / yes

²⁸ MaGPIe Research Group, *The nature and prevalence of psychological problems in New Zealand primary healthcare: a report on Mental Health and General Practice Investigation (MaGPIe)*. New Zealand Medical Journal, 2003. **116**(1171).

Tools such as the AUDIT tool (now available as part of the BPAC decision support packages) can then be used to further assess alcohol and drug abuse. However from an interaction point of view in the consultation it is more difficult for health professionals to ask routinely about alcohol consumption than for example cigarette smoking and it is still relatively uncommon for patients to be asked systematically about other recreational drug use.

Service delivery

Primary care and general practice could potentially be more proactive about identifying alcohol and other drug abuse. Various international studies such as the PRISM-E study showed that up skilling of the workforce to identify and manage alcohol abuse was relatively easy. There is evidence that those with at-risk drinking can substantially modify their drinking over time through face to face brief intervention counselling sessions.

The management of confirmed alcohol and drug problems has traditionally been the remit of secondary care services and with the development of primary care mental health services there is often ambiguity about whether A & D services should be included. There is also usually little liaison between primary mental health services and established A & D

Questions for DHBs and PHOS:

1. Do you have any data on the local prevalence of A & D problems at a population health level?
2. Do you have up to date information about new trends in recreational drug use in your area including cannabis and other drugs such as ecstasy and metamphetamine?
3. What is the protocol for managing A & D problems in primary care and what are the liaison arrangements with the secondary A & D service?
4. Is there any provision for proactive identification of 'sub – threshold A & D problems within the DHB / PHO?

Alcohol and drug problems in primary care

This vignette is linked to the issues guides. [Click here to go to 'Alcohol and substance abuse'](#).

John is the coordinator for the DHB Alcohol and Drug Treatment Service (ADTS) and presents a briefing paper to the DHB asking for clarity about service provision in primary care.

There have been several referrals to the ADTS from the mental health coordinator based at the PHO, and John wonders what his response should be. A meeting is called at the DHB.

Questions to consider

1. Who should be present at such a meeting?
2. What information is required to support the meeting?
3. What key themes might emerge?

The meeting is held with presentations from John and Wendy the primary mental health initiative (PMHI) coordinator.

John's perspective is that the present secondary service is operating at capacity, though there has so far been little waitlist for patients referred from psychiatric services and the local Emergency Department. John wonders what the potential range and number of referrals might be from primary care.

Wendy responds by stating that based on MaGPie study data, substance use is highly prevalent in primary care settings (up to 12% could be considered to have a diagnosis), with relatively few patients referred through to secondary care services.

Many patients will have 'sub-threshold' levels of a problem and she has been unsure whether to try and provide support for the small number of 'dual diagnosis' patients she has had referred.

All the referrals so far have been for alcohol problems with the exception of one referral for problem gambling and a patient with continuing cannabis problems who had previously seen and been discharged from the secondary service with possible early psychosis.

Questions to consider

4. For your organisation, what substance use is intended to be covered?
5. What is the overall strategic intent e.g. management of presenting patients or case finding to address unmet need?

It becomes apparent that existing services are mainly addressing known alcohol problems, and that there is little information about lower levels of problem drinking which might benefit from intervention and virtually nothing about other substance use. One of the GP's present with a special interest in substance use points out that in one of the communities in the DHB, cannabis use is very widespread and harvesting and marketing make a substantial contribution to the community economy. He also says that in a neighbouring DHB a recent 'P' Lab bust had resulted in a media campaign which had included a local General Practice helping to raise awareness of recreational drug use.

John restates the present structure of the local ADTS and emphasises his view that any expansion into primary care services would take time and resource away from existing secondary care service. On the basis of 'last in first out' he judges that the first casualty of any reduction in service would be a novel youth service focused on young recreational drug users showing signs of early psychosis.

From a primary care perspective Wendy says she has concerns that while the PMHI team can manage generic A & D issues with problem solving and motivational brief intervention approaches, she feels there are a lack of provider confidence and knowledge about more specialised management including any drug therapies and withdrawal regimes. John and Wendy agree that there is a lack of information and John says he will request some support from the DHB IT group to help explore the scope and scale of A & D problems in primary care. Wendy identifies one practice

where there is extensive coding of illness problems and where one of the doctors has an interest in A & D issues.

Questions to consider

6. What would be the next chapter in this narrative from the perspective of your own organisation?
7. To what degree is the likelihood of sustainable progress dependent on additional funding or a shift in existing funding from DHB to the PHO?

Primary mental health care for the elderly

This issues guide is related to the vignette “Mental health needs of the elderly” ([click link](#))

From a system perspective the elderly represent another ‘invisible population’ as far as the management of common mental disorders is concerned. There are many similarities in the presentation and appropriate management of common mental disorders between the elderly and the younger adult population.

Notable differences however include the higher prevalence of co-morbid chronic physical disease and the presence of dementia in older adult populations. The organisation of primary care must therefore have systems for assessing cognitive impairment. There needs to be the capacity to detect and manage increased prevalence of depression found alongside common diseases of the elderly, such as diabetes. There may well be conditions in this age group which are currently under diagnosed such as elder abuse.

Mental disorders have a lower overall prevalence among the younger elderly than in those over 75 years. In those over 65 years the prevalence of any common mental disorder in those attending their GP was 7.6 % for men and 12.1% for women.²⁹ Overall, the 12-month prevalence of depressive disorders among community-dwelling older adults aged 65 years and over in New Zealand primary care is about 2% for men and 5% for women. Older adults in residential care are at much higher risk of depression, with a prevalence of about 18% in low-level care residential facilities.

²⁹ MaGPIe Research Group, *The nature and prevalence of psychological problems in New Zealand primary healthcare: a report on Mental Health and General Practice Investigation (MaGPIe)*. New Zealand Medical Journal, 2003. 116(1171).

Service delivery

The following points are important to consider from a service delivery perspective.

- ❑ The psychosocial wellbeing of older adults can be assessed using the same approach as for other adults.
- ❑ Targeted screening for common mental disorders is indicated for older adults in groups with high prevalence rates, such as; older people in residential care, or those with a recent significant loss. Among older adults living in residential care, routine psychosocial assessment including screening for depression, anxiety and substance abuse should be conducted annually.
- ❑ Older Māori living away from their birthplace sometimes describe feelings of *moke moke*, a sense of loneliness or physical and mental displacement that may resolve when they return to their home environment.
- ❑ In many localities there is fragmentation between primary care and adult psychiatric and psychogeriatric services. It is important that there is sufficient clarity in terms of the specialist roles of psychogeriatricians and their teams, and that referral pathways are clear.
- ❑ Communication between primary care services and social services for the elderly is often not well developed and coordinated care between health and social services lacking. Relationship building in this area should be a priority.
- ❑ Services for dementia are increasingly important and largely fall within the broader remit of primary care. Caring for a person with dementia is stressful, and carers' needs are being increasingly recognised, particularly since carer interventions in people with dementia have been shown to be effective.

Questions to consider

1. In each locality you must decide whether the current configuration of services is appropriate for older populations.
2. How are mental health services for the elderly configured in your area?
Where does primary care fit in?
3. Are there regular opportunities for skill sharing and training between the relevant primary and secondary care clinicians?
4. What relationships does your organisation have with NGO's involved in the mental health care of the elderly?

Mental health needs of the elderly

This vignette is linked to the issues guides. [Click here](#) to go to 'Primary mental health in the elderly'.

Winifred B is 71 years old and retired last year from her job as a cleaner. She lives with Jonas, her partner for the last 15 years. Jonas recently went to their GP, concerned that Winifred was becoming 'a bit forgetful' and seemed more inclined to 'fly off the handle'. This is distressing Jonas, who had been looking forward to his retirement as an opportunity for them to take a more relaxed view of life. Simon, her GP, notes that Winifred has several long term health problems and uses her next review visit to explore her mental health. At interview Winifred is more withdrawn and irritable than Simon remembers her, and when with some reluctance she completes a mental health state assessment her borderline score makes Simon consider both depression and early dementia. Given current secondary care workload Simon knows Winifred would not get to see the psychogeriatric team for eight weeks. Because of their low income Simon discusses the situation with Jacqui, the primary mental health initiative (PMHI) coordinator to see whether Winifred might qualify for free assessment and therapy.

Jacqui would like to help, but the current PMHI initiative is only for adult patients up to the age of 65 years. Simon is concerned at this as he feels that Winifred would benefit from intervention and spends that evening 'Googling' the internet.

He finds out that international studies (e.g. IMPACT study on depressed elderly patients)³⁰ demonstrate collaborative care involving a psychiatrist, primary care doctor and nurse (the latter as the depression case manager) achieve better outcomes and that patients react better to treatment provided in primary care settings. Simon is also impressed that evidence suggests that this kind of approach encourages a large component of self management.

³⁰ Hunkeler, E.M., et al., *Long term outcomes from the IMPACT randomised trial for depressed elderly patients in primary care*. British Medical Journal, 2006(332): p. 259-62.

He relays his information to Jacqui who agrees to discuss this at the next PHO/ DHB planning forum. She also points out that there is little expertise in mental health problems in the elderly among the present primary mental health team and there would need to be significant up-skilling if they were to take on a lot of work with the elderly. Simon replies that the elderly seem to yet another 'invisible group' when it comes to primary mental health care.

At the DHB / PHO planning meeting there is overall support for the view that older adults would benefit by being able to access to primary care based programmes. It is also felt however that there is a resource issue both in terms of DHB funding (increased volumes) and general practice resourcing. The psychogeriatrician present points out older adults often present with physical problems and often have complex drug regimes, and it can be difficult to separate disorders such as depression or anxiety from reduced cognitive functioning.

Jacqui agrees saying that the complexity of these issues in older people is a very good reason for increasing service provision. She also feels that considerable linkage could be made with other long term condition management programmes supported by the DHB, such as Careplus.

The planning group meeting recommends that PMHI programme is extended to include older adults i.e. everyone aged 65 and over. It also agrees to support some additional training for general practice teams. The training would include how to identify mental health issues separate to cognitive functioning; polypharmacy; greater focus on self management and peer-support groups.

The DHB also requests some modelling of expected increase in workload volumes. Initial modelling on prevalence rates for 65+ year olds suggests there might be minimal impact on Depression volumes. Data from Te Rau Hinengaro shows the 12-month prevalence rates for >65 years old as 1.7% for depression, 6% for anxiety, 2% for both anxiety and depression and 7.1% with any mental health disorder. Rates for rest homes are higher at 18%.

Modelling cost increases for a large DHB suggests that extending the entry criteria to include everyone over 65 years would require an additional 750 volumes per annum. Using the current costs of \$400 per enrollee, this equates to an additional \$300,000 per annum. However, there is an argument that because the elderly are largely 'forgotten' in terms of utilisation data analysis, there is a risk that this estimation is based on suppressed demand rather than need.³¹

Jacqui reports back to Simon who is pleased that some recognition is being given to the topic.

Winifred is referred to the local psychogeriatric services. In the meantime she is found to have mild hypothyroidism and started on thyroxine and an antidepressant.

Questions to consider

1. How are the primary mental health care needs of the elderly addressed from the perspective of your organization?
2. How 'invisible' are the mental health needs of the elderly in your area? What sources of information do you have available and how accurate are they?
3. How could you improve the primary mental health services for the elderly in your district?

³¹ Figures courtesy of Counties Manakau DHB

Primary mental health care for Māori

This issues guide is related to the vignette “Kaupapa Māori mental health services”
(click link)

Māori perspectives on mental health and wellbeing

Traditionally, Māori have viewed mental health holistically, where the physical, spiritual, emotional and family aspects work together to contribute to optimal health and wellbeing. Several models of health have been proposed to this effect. One of the most commonly used models is Whare Tapa Wha. Health professionals working with Māori need a thorough understanding of Māori models of health so that they can apply these when delivering services to Māori. Health professionals also need to take into account the Treaty principles namely participation, protection and partnership when delivering services to Māori. Further, building strong relations with whānau is crucial given the central role they play in the Māori worldview.

Prevalence

Te Rau Hinengaro sampled 2,595 Māori from a wide range of demographic, social, economic and cultural backgrounds.³² Results of the survey revealed that the prevalence of mental disorders in Māori was 50.7% over their lifetime. The most common lifetime disorders among Māori were anxiety disorders (31.3%) followed by substance use disorders (26.5%) and mood disorders (24.3%). Māori aged 25-44 had the highest lifetime prevalence of any disorder while the lowest was in those aged 65 and over.

Kaupapa Māori service

Māori providers who deliver Kaupapa Māori services work from a range of holistic models based on Tikanga (Māori protocols and practices). The models are unique and are centred on working with whānau. Other elements such as whakapapa

³² Baxter J, Kingi T. K, Tapsell R & Durie M. 2006. Māori . In Oakley Browne M.A, Wells J.E. & Scott K.M. (Eds). *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.

(genealogy), Te Reo (language) and kaumatua (elder) guidance are also incorporated into the models. Māori providers usually work in a wide range of settings to deliver their services, including the marae and in the home. Working closely with Māori providers is imperative to ensure Māori can be offered early intervention, treatment and follow up.

Factors crucial for success

Several key factors need to be taken into account when providing mental health services to Māori. These include:

- ❑ Recognising that the Māori population is diverse. Māori live in urban and rural areas in both extended and nuclear family households. Some Māori are comfortable using mainstream services even if they have the choice of mainstream or Kaupapa Māori services, however, it is important to provide the choice as much as possible.
- ❑ Māori tend to be seen by secondary and tertiary services at a much later stage in their illness. This means that they present with more severe forms of illness and may also have a number of chronic long term conditions.
- ❑ Early intervention would greatly assist in Māori being assessed and treated before the illness reaches a more severe stage.
- ❑ Processes for assessment, treatment and follow-up can be more successful if there has been active Māori participation in the design, development and delivery of services.
- ❑ Service design and delivery must include Māori models of health which acknowledge the holistic multiple dimensions of health and wellbeing. This may require negotiation around funding, service expectations and staffing if it is to be more resource-intensive than mainstream services.
- ❑ Working closely with Māori community providers would improve detection and management of mental disorders in Māori.
- ❑ Recognition of Te Reo is important if your service has Māori service users. This can be as simple as bilingual signage and acknowledging Te Reo in your interactions as appropriate.

- ❑ The development and use of appropriate indicators for clinical and service success is important. Some of these may be the same as for non-Maōri, but in terms of service provision there may be additional elements.
- ❑ Be ready to work alongside or even within new Whānau Ora approaches that will be being rolled out.

Kaupapa māori mental health services

This vignette is linked to the issues guides. [Click here to go to 'Primary Mental Health Care for Māori'](#).

Mark is a 57 year old Community Mental Health Support Worker in a Māori Primary Health Organisation (PHO). He is of Ngāti Porou descent. He has been working in mental health services in various non-clinical roles since the mid 1980's. Over the years, Mark has done a lot of training in mental health through the different organisations he has worked for. He has also completed a Bachelor of Social Science degree. Mark's current role is community based. He and his colleagues travel throughout their region visiting individuals and whānau in the homes to deliver recovery programmes, provide support and education. Mark often sees that the Māori service users he visits have a number of chronic long term conditions. He tries to link up with other mental health workers, such as social workers and psychiatrists from the regional DHB mental health unit. Mark strongly believes in using a Kaupapa Māori approach when working with whānau. He works hard to incorporate Māori models of recovery into programmes he and his team deliver. Mark sees his goal as helping Māori mental health service users to meet their individual and collective needs in their recovery, and making sure the support programmes help facilitate links back into their community.

Questions to consider

How does Mark ensure that:

1. Māori service users in his region have sufficient access to mental health services;
2. There is sufficient funding available for delivering support and recovery programmes;
3. His unit builds effective linkages with other providers of mental health so that there is care of better co-ordinated of Māori with chronic and/or long term mental health issues?

Primary mental health care for Pacific Peoples

This issues guide is related to the vignette “Primary mental health care for Pacific peoples” (click link)

Pacific perspectives on mental health and wellbeing

Although Pacific peoples are a very diverse group with backgrounds in many nations, the approach of many Pacific peoples to mental illness is mostly markedly different from Western approaches. Mental health is viewed holistically, where spiritual, physical, emotional and family aspects act in harmony. An understanding of Pacific mental health perspectives and models will help health support workers, clinicians and managers better understand the needs of their population and respond appropriately. Many organisations now offer courses on achieving cultural competence – you may need to investigate ways you and your team could benefit from attending such courses.

Options for ongoing cultural support also need to be looked into; see if there are people in your organisation you can help support you. There may be some instances where you may need to work closely with the *matua* (elder, senior cultural advisor) to ensure that you and your team are able to provide the best level of care. Other issues to think about include the need for ethnic-specific services – the term ‘Pacific peoples’ was coined to encompass people from 22 different ethnic groups. Different models of care may exist for different ethnic groups. Care needs to be taken not to assume ‘one size fits all’ approach.

Prevalence

Te Rau Hinengaro revealed that the burden of mental health disorders in Pacific peoples is high, with 25% Pacific peoples experiencing mental health disorders compared to 20.7% of the general population.³³ Nearly half of Pacific peoples

³³ Foliaki S, Kokaua J, Schaaf D & Tukuitonga C. 2006. Pacific People. In Oakley-Browne, M.A., Wells, J.E. & K.E. Scott (Eds.), *Te Rau Hinengaro: The New Zealand Mental Health Survey* (pp. 178-208). Wellington: Ministry of Health.

(46.5%) had had some experience of mental illness in their lifetime. Further, only 25% of Pacific peoples who had been diagnosed with a serious mental illness accessed mental health services.

Protective mental health factors

Several protective factors have been identified for Pacific mental health. These include having access to appropriate family and community support networks, the ability to express oneself safely in one's culture, having access to adequate housing, education and satisfactory employment. To help your Pacific population achieve better mental health, consider linking with other support agencies such as housing. It may also pay to engage and support participation from Pacific consumers and their families in healthcare planning and ways of managing mental health in the home or community. To help with this, consider encouraging and supporting Pacific families to be involved in the care and recovery of their family where appropriate.

Funding for Pacific mental health services

Securing sufficient funding is an issue for most health services. Building strong networks with the DHB, particularly Funding & Planning, plus maintaining strong links with other providers in the community are crucial. If you are a Pacific mental health services manager, you need to consider the impact of existing and upcoming funding streams to ensure adequate resources are available for Pacific mental health services. Care must be taken, however, to have short, mid and long term goals to ensure that the funding available is sustainable and all the energy is not consumed by chopping and changing from one pool of funding, and one set of contracts to another. Small services providing for small populations can be especially at risk of this.

Building and maintaining links with PHOs, AOD and secondary care services

Pacific peoples interact with a wide range of services depending on factors such as service availability, access and cost. Consider using your networking skills to get to

know other community agencies. Start close to home – linking with church and community groups; consider getting a mentor who can help with networking and working to keep existing relationships active.

Challenges for PMHC for Pacific peoples

In one study, we observed that provision for Pacific peoples was a challenging area. Where there were specific services, utilisation was sometimes poor, and often there were no specific services, especially if one population was small. PMHC provision for this group is often located more precariously with some services dependent on NGOs and community groups, with concomitant additional burden for an identified high needs community. The Pacific mental health and primary care workforce is small but there are promising developments, such as the Counties-Manakau DHB programme to train health professional from its own community.

Meeting the needs of Pacific peoples

This vignette is linked to the issues guides. [Click here to go to 'Primary Mental health care for Pacific Peoples'](#).

Rachael is a 35 year old Pacific Mental Health Services Manager in a DHB. She was born in Samoa but raised in New Zealand. She has been working in mental health services for the past 10 years in various roles. Rachel has a degree in Psychology and a Diploma in Business Management. In her current role, Rachael is responsible for staff recruitment; service planning; managing budgets; monitoring staff performance development, implementation of service policies and overall quality management. She is strongly committed to her cultural roots and outside work is heavily engaged in her local Pacific community. Her experience has helped her gain sound knowledge of the Pacific mental health population in her DHB. She knows that many Pacific families in her community come from low socioeconomic backgrounds and that her DHB region has a relatively young Pacific population, a high proportion of which are New Zealand born. She also knows that in her community, young Pacific people aged 15 -19 access Alcohol and Other Drug (AOD) services more than any other age group. Rachael was brought up by Pacific-born parents who taught her to view Pacific mental health as holistic, incorporating social, cultural and spiritual wellbeing. Consequently, Rachael appreciates the value of Pacific models of illness and wellness when dealing with Pacific people.

Questions to consider

How does Rachael ensure that:

1. She gets enough funding for Pacific mental health services;
2. All staff who deal with Pacific peoples are culturally competent and understand Pacific models of care;
3. Her unit builds and maintains links with PHOs, AOD and secondary care services?

Asian peoples' mental health

This issues guide is related to the vignette "Asian peoples mental health" ([click link](#))

Asian perspectives on mental health

Beliefs about mental health and wellbeing vary across the wide range of cultures classed as Asian. There are however, a number of common elements across Asian cultures. These include: poor mental health is often believed to be a result of imbalances in the body which consequently result in negative behavioural states. Religious and spiritual beliefs also play a significant part in how health is viewed. Traditional therapies seek to counteract this via use of herbal remedies, body manipulation, massage or through interactions with the spiritual/ancestral world.

Health professionals working with Asian people need to be aware that there are a wide range of beliefs and perspectives on mental health.

Stigma and mental health

In Asian cultures, mental illness often carries a lot of stigma and discrimination. Stigma and discrimination can manifest in a multitude of ways: it may be self-directed, directed from others, viewed as bringing shame on other members of the family or not fulfilling family obligations. For many Asian people, shame, stigma and discrimination are key aspects of their experience of mental illness.

Clinicians treating Asian people need to be aware of these issues. In some cases, having staff that are the same ethnicity as the Asian service users may help improve the effectiveness and acceptability of the treatments. This may be particularly useful if a person identifies strongly with traditional Asian values and is able to develop rapport with the service user. Staff can be either clinicians or support workers. Cultural advisors or cultural competency trainers are highly recommended to help staff deliver effective service to Asian people. Staff working with Asian people must ensure that any treatments that they undertake fit with their preference and needs, to improve compliance. Particular attention needs to be paid to communication

styles as these vary across Asian cultures, as does competency in English. Interpreters should be used if English is perceived to be a barrier in communication.

Role of family

For many Asian people, family plays a key role their mental well-being and helping facilitate help-seeking behaviours. In many Asian cultures, families are central to a person's concept of self and can be highly influential in decision-making and life choices. Given this, health professionals need to develop positive working relationships with the family. However, care must be taken; while some Asian people may expect family members to be involved in their interactions with health providers, others may prefer that their family weren't aware of the mental health issues and treatments. It is imperative that staff check with Asian service users before involving family. Getting buy-in from the family will ensure that the treatment plans are adhered to and followed through. Care must be taken to demonstrate respect for family members and working sensitively with the family dynamics, particularly if extended family is involved.

Community support

An important protective factor in mental well-being across cultures is social support. Asian people may have access to many different levels of social support depending on a number of factors such as ethnicity, location, employment, education, transport and language resources. For some, social networks may be limited when most of the family members are based overseas, or if they have limited English language skills. An absence of social support may be a particular issue for Asian people living by themselves or those who have limited social contact through education and employment activities. There are a range of support services available specifically for Asian communities. Some options include:

Chinese Lifeline, which supports the Chinese community through telephone and face-to-face counselling services. Chinese Lifeline works under the umbrella of Lifeline Auckland.

BoAiShe is a mental health peer support organisation for Chinese people, which supports mental well-being through sharing stories and increasing mental health knowledge. Weekly meetings and regular recreational activities are held for members. To join the organisation, referrals can be made by mental health professionals, social workers. Family or Asian people who use mental health services can self-refer.

Affinity services is setup for South-Asian communities. They provide cultural support, and community out-reach and support services, such as group programmes and mental health promotion.

Asian peoples' mental health

This vignette is linked to the issues guides. [Click here to go to "Asian people's mental health"](#).

Jinjing came from China to Hamilton three years ago with her husband and two young children aged 2 and 4 years. Although her husband had a high-paying job as a local council accountant in China, in Hamilton he has found it impossible to get a job in his profession. For the last two years, he has been driving a taxi for a living. He works long hours as they are trying to save money for a house. Jinjing spends most of the day looking after the two children. In China, she had her mum and aunts to help with childcare. Since she now has no family close by, Jinjing struggles to look after the two children. She speaks very little English and finds it difficult to make friends easily. Jinjing finds it difficult to go shopping on her own and rarely leaves the house. She likes to call her family back in China but the costs of a growing family and saving for a house make it difficult for her to call them frequently. Jinjing finds herself alone and isolated most of the time. Jinjing had to take her children to their local PHO to get immunised. The practice nurse noticed the difficulties Jinjing had in communicating in English. At the end of the session, the practice nurse gave Jinjing some information on a local community group setup for migrants. The group met once a week and helped migrants improve their verbal English skills. The group also ran a Parent's Club which assisted in providing child care support.

Questions to consider

What would be the best ways to talk with Jinjing about her mental health?

What Asian focussed mental health services are there that Jinjing could access?

What other alternative support services could Jinjing access?

Toolkit for Primary Mental Health Care Development:

Part 4: Workshop Plans

Introduction

In this part of the Toolkit we present some general information about workshops and then outline two options for supporting your use of the Toolkit. This is followed by a generic workshop planning guide that you may use for both options. Within this generic guide we cover pre-planning your workshop, who does what, and a checklist for beginning and ending the workshop. Finally, we give you more detail on the two options for using the Toolkit.

What is a workshop?

People who work in teams (that is probably everyone who works in the health service) often need to meet together formally or semi-formally to make decisions about future activities, or to make choices. Managers and leaders use such gatherings for several purposes: to gather information to aid their decision-making; to create plans and make group decisions; to gauge stakeholder interest; to allow champions to emerge and networks to form; and to ensure 'buy in' for future plans. These gatherings can take a number of forms but are usually organised either with one person leading or directing, or some other structured activity.

How does a workshop differ from a meeting?

A **meeting** is a gathering of people for a common purpose- the sharing of information, the planning of joint activities, making decisions, or carrying out actions already agreed upon. Almost every group activity or project requires a meeting, or meetings, of some sort. A **workshop** is one, or a series of, educational or work sessions. Small groups of people meet together over a short period of time to concentrate on a defined area of concern. The purpose may be to inform, problem solve or train and the emphasis is on interaction, free discussion and the exchange of ideas. A workshop implies that there is an explicit expectation for active participation by all members to resolve issues about the defined area of concern.

Anyone who has ever planned a workshop will tell you it's a big job. However with the right organisation, planning, focus and a little creativity, you can prepare a

workshop that will not only be relevant and productive but also memorable. If done poorly, workshops can be a huge waste of time and money. However, if they are planned well they can be valuable for everyone involved.

Two suggested options for using the Toolkit

We have provided two options for supporting your use of the Toolkit for Primary Mental Health Care (PMHC) Development. The Toolkit provides examples of the way that PMHC is being developed in New Zealand and offers questions and suggestions about the decisions that are important for your own organisation, service or team.

These [workshop plans](#) are to guide you in your brainstorming, interactive learning, building relationships and problem solving. *Advance planning of your workshop is critical.* Allocating sufficient time for quality planning is as important as the workshop itself. By the end of your workshop(s) you should have a clear set of plans for your development work over the next year or two years, and hopefully a strategic direction beyond that. Whichever option is right for your organisation/team there is something in these plans for you.

Option 1: Business as usual

You and/or your team choose to continue with 'business as usual' and will use some of the material in the Toolkit, probably mainly from the Knowledge Bank. You may also like to hold your own workshops and plan your own use of some of the Toolkit materials. The [generic workshop plan](#) will assist you with this. Later on you may come back with the need for further structured work, and move to [Option 2](#).

Option 2: Toolkit workshop plan

You and/or your team choose to work through the Toolkit using all the elements of the Toolkit in a [planned sequence](#).

A Generic workshop plan

This section covers generic workshop planning that you can use for both Toolkit use options 1 and 2. It covers the steps you should take in planning your workshop, who should do what, a check list for beginning your workshop and tips for ending the workshop.

Before the workshop

By following the following steps you will ensure that your workshop is a relevant and valuable experience for everyone.

Step 1: Define the goals

Many workshops end up being a waste of time because there's no clear goal kept at the centre of the discussion. Without a clear goal there is really no point in getting people together.



Every workshop must have a goal, or a question to be answered. For example:

1. How can we make our PMHC development more focussed on the needs of child and youth?

Step 2: Decide who and how many should attend



Who attends should relate directly to your objective. For example if your workshop goal is to focus on the needs of child and youth then you probably want relevant health care and other professionals in that field such as a GP with a special interest , child and adolescent psychiatric team members - in this instance you might include professionals from education,

CYFS, justice and the police. If in your area there is already a service with an overlapping role, in this case, perhaps a 'Youth One-Stop-Shop', they should probably also be represented.

Do you want a larger group which can divide into smaller groups for discussion, or do you want a focussed detailed solution to a problem in which case you probably want ten or fewer people. Make a list of who needs to be at the workshop. It is a good idea to leave a few places open for last minute additions.

Step 3: Where to hold the workshop



The number of participants will give you an indication of whether you need a small conference room down the hallway or whether you need to find an outside location that's large enough. It is a good idea to think about the logistics and practical details of your workshop and then choose your location. What visual aids do you need? Do you need teleconferencing equipment? Will everyone be able to reach the location? What catering facilities do you need? Is there a usage fee for the space? What is the seating arrangement and how formal or informal do you want it to be? Go and see the space before deciding if it will meet your needs. For example, horseshoe seating arrangements give a focus and are inclusive, but imply that there will be something happening in the open area such as a PowerPoint presentation, and that the 'leader' will direct proceedings close to that area. Make sure that the lighting is adequate and that there are clear sight lines, especially if the workshop will be using audio/visual equipment.

Step 4: Determine the dates



The next task is to select the date(s) and times for the workshop. When selecting a date be careful not to conflict with holidays, or pre-existing events. Check with key people, especially if you plan to draw participants from a wide area.

Step 5: Create your agenda



Once you have decided on your main objective and you know who will attend, you can develop an outline of how you will achieve the workshop's goal. Create a list of the three or four main points to discuss and resolve and then break each point down into further details. Your biggest problem will not be finding enough to talk about, but limiting what you will cover. Breaking your main points down will give you an idea of the scope that is possible. The more detailed your plan the more it will ensure that your workshop runs to schedule and be successful.

Step 6: Publicise the workshop

Make sure the workshop information is easily accessible and understandable. You could develop a flyer for notice boards or email circulation: include this in an organisation newsletter or bulletin board. The type of advertising will vary depending on the workshop and the participants that you want to attend. The flyer should include date, time, title and description of workshop, facilitator's name (if applicable), location including room number or address, and contact information if someone has questions.

Step 7: Feedback



It is important to have a plan to communicate decisions that were reached during the workshop. This may be a mass email to everyone with the details, or something posted to the intranet. People need to know that their hard work actually resulted in a decision or action, so

keep them informed about what is happening after the workshop has ended.

Without this step it is easy for busy people to become cynical about the point of workshops.

Roles: who does what?

There are different roles that are critical in the planning and leading of all workshops. These should be clearly decided in the workshop planning stage.

Someone may even have to do parts or all of each role sometimes taking off one hat to reveal another.

Workshop leader / Facilitator

- Contributes to collection of resources prior to and following the workshop
- Prepares in advance for workshop discussions via readings, writing or discussion.
- Participates fully in the entire workshop
- Leads activities during, and action or implementation following the workshop.

Workshop convenor / Administrator

- Assists with the development of the workshop plan and the list of participants
- Books facilities, arranges any audiovisual equipment, arranges catering
- Promotes the workshops
- Answers questions about the upcoming workshop

- Collaborates with the workshop leader on dissemination of any preparation material for the workshop and of the results, decisions and actions resulting from the workshop

Participants

Nothing is deadlier or less effective than a workshop where participants do not participate. Everyone attending the workshop needs to be given opportunity to participate actively whether it is through small or large group discussion, short problem-solving tasks or scheduled thinking and writing time. Participants also bring valuable experiences and expertise which must be an integral part of the workshop. That is part of the point of bringing people together. Allowing time to interact and share experience and knowledge can support the development of networks that will last beyond the workshop. Participants can/should:

- Contribute to any collection of resources prior to the workshop
- Prepare in advance if there is any readings or material disseminated to attendees before the workshop
- Participate fully in the entire workshop.

Appropriate deadlines and timetable need to be set for participant input into the programme.

Workshop presenter/facilitator

The workshop leader may also be the facilitator or may decide to bring in a workshop facilitator from an external institution or discipline. The facilitator does not need to come from outside the organisation or team, but they must be able to take a neutral stance and be objective. The facilitator is able to step back from the detailed content and from his or her own personal views and focus purely on the process of managing the discussion. The facilitator's role is to ensure productive group processes, whether this is brainstorming a new idea to improve the availability of interpreters, discussing the development of a process to better liaise with secondary mental health service, or deciding how to limit demand for an over-subscribed psychological treatments service. The facilitator's role is to lead,

question, define, challenge and navigate the group to solutions that are better than the sum of what the individuals would arrive at alone. The workshop experience and product is enriched by the contribution of multiple viewpoints and approaches, and the facilitator ensures these are heard. The facilitator should be a good time manager.

Checklist for beginning the workshop

The following checklist provides you with a list of pointers for beginning any workshop.³⁴ The opening of any meeting or workshop sets the tone for the entire gathering.

- Housekeeping:** Tell people the location of toilets, emergency exits and other relevant safety and comfort information.
- Make introductions:** Introductions are a good way for people to begin to get their voices in the room. Spending time on introductions can pay off. It can help set group norms for people speaking up or sharing responsibility for the success of the session; and for taking at least a small risk in revealing something of themselves such as their name, job/role, and any concerns or aspirations for this workshop. For fun you can ask people to reveal something important about themselves that others may not know.
- Check and clarify expectations:** This is the time to check and clarify expectations with everyone present. This not only allows the session content to be adapted if necessary but also allows participants to make an informed choice about whether and how to align their goals for the session with those of others.
- Agree on the agenda for the workshop and the time allocation including breaks and any absences:** Find out if anyone needs to leave early or have taxis booked. Arrange this at the start as there is nothing more disruptive to a workshop than people needing a taxi booked at the crucial 45 minute point before the end when the important decisions should be made.
- Agree on the process, including ground rules and/or guidelines:**

³⁴ Schwarz, R., et al., *The Skilled Facilitator Fieldbook*. 2005, San Francisco: Jossey-Bass.

Example of a ground rule: confidentiality

If you want to encourage people to share their experiences and wisdom through specific examples and stories from which others can learn, then the appropriate level of confidentiality needs to be agreed upon. When people have been allowed or sent to attend a planning or policy workshop, it is usually reasonable to expect that they may be asked to report back. Where this is the case, one way of ensuring a safe environment for honest discussion is to use the Chatham House Rule. This rule states that participants may not reveal the identity or affiliation of other participants. People may use the information that is shared but cannot reveal the identity and affiliation of who contributed it.

Example of a ground rule: being respectful

Participants will have differing social and professional status, either actual or perceived. Since everyone has been invited so they may contribute it is important that this can actually occur. Power and status can inhibit this, especially if people are inadvertently disrespectful. Not interrupting other speakers, not hogging the floor, and critiquing ideas rather than people are all ways of being respectful, and it can be useful to write these rules, and others participants may suggest, on the board somewhere so they can be seen throughout the workshop.

Examples of guidelines:

Listen to understand and avoid interrupting.

Remain curious and open to the perspective of others.

Share the reasons behind your own questions and statements. The reason for this last guideline is because one of the things that people do naturally is try to understand what motivates a person to say certain things. Therefore, in order to reduce the likelihood of someone making up a story in their own minds, it is helpful to share the reasons behind your own statements, questions and comments.

- ❑ **Define roles including leadership:** Effective groups clarify the roles of their members including leadership. This also means defining the relationship between the leaders and other group members regarding how the group handles its processes, structures and functions. This should be clarified by the leader or facilitator.

Ending the workshop

At the end of the workshop you should:

- ❑ Repeat your initial goals for the workshop.
- ❑ Review the decisions that have been made and the plans for action.
- ❑ Do a self-critique of what went well in the workshop and what didn't go so well.
- ❑ Schedule the next meeting and agenda.
- ❑ Thank the participants for attending, recognising the opportunity costs in people's busy schedules.

Two suggested options for using the Toolkit

Option 1: Business as usual

The first option is for teams who choose to continue with 'business as usual' and will use some of the material in the Toolkit. You may for example choose to read material from the [Knowledge Bank](#) such as the essays or the guides to specific issues. We recommend referring to the [Navigation Guide](#) which is designed to support the use of the Toolkit. The [Navigation Guide](#) outlines principles that will help you use the Toolkit and also lists all the Toolkit components.

You may also like to hold your own workshops in combination with using some of the Toolkit materials. The generic workshop planning guide earlier in this document will assist you with this. Later on you may come back with the need for further structured work, and move to option 2.

If you choose to follow option 1 then think about this:

Which problem(s) have you identified to work on in your 'business as usual' way?

Option 2: Toolkit workshop plan

The second option is for those teams/organisations who want the option of using all the elements of the Toolkit in a planned sequence. It initiates a process whereby aspects of the provision of PMHC are systematically examined, and a process for specific problem-solving is established. These processes utilise the [Navigation Guide](#) to anchor your discussions and provide a pathway to work through in your problem solving; the [Knowledge Bank](#) which includes perspective essays and guides to tackling specific issues to provide you with information; and concludes by using information you have collected about your local primary mental health care issues using the [Systems Planning Guide](#) and the [Dynamic Systems model](#) to inform the choices you make.

This workshop option 2 will need you to set up a series of planned workshops beginning with problem identification and prioritising, moving through developing potential solutions, or 'what if' scenarios for the key problems, and then using the [Systems Planning Guide](#) and the [Dynamic Systems model](#) as a way of testing these possible solutions as a prompt for further discussion and finally decision making.

In order to get the most benefit from this, you will need a designated leader or facilitator who takes responsibility for becoming familiar with the Toolkit contents prior to any workshops.

This workshop plan is guided by the contents of the Toolkit.

1. The [Navigation guide](#) includes principles to get maximum use from Toolkit e.g. using a consumer journey focus, making explicit the trade-offs between a population focus and an individual focus. The [Navigation Guide](#) includes a process outline for using the Toolkit components to develop solutions for your service issues,

and some core principles you can use as anchors if your workshop seems to get 'stuck'. The [Navigation Guide](#) can also be used to help you choose your entry point if you want to bypass a workshop process for problem identification and prioritising, for example, if you are a service manager and you know you must find a way to provide PMHC for children and young people. After the introductory phase of your first workshop, we suggest referring to the [Navigation Guide](#) to 'ground' your workshop discussions on the basic principles you have prioritised for this particular decision-making/planning process.

2. The [Knowledge bank](#) contains perspective papers on the following topics:

- The ever present dilemma in Primary Mental Health Care
- Quality in Primary Mental health Care
- Specific issues in Primary Mental Health Care
- Optimal Model II

3. The [Guides for tackling specific issues](#) are accompanied by vignettes of real-life decision-making from the partners and include issues such as primary/secondary care interface, service eligibility criteria, clinical leadership, and integrating with chronic care management [click here to link to the guides for tackling specific issues](#).

5a and 5b. The [Systems Planning Guide](#) and the [Dynamic Systems model](#) is designed to help facilitate conversations about PMHC in your region, so that you can design solutions that best fit your particular circumstances. To facilitate the conversations we have designed a system model of the key elements within PMHC and how those elements link together. The model is derived from our conversations with planners and providers within the partner DHBs, and our combined knowledge of the literature, health system design and planning, and clinical practice, and focuses on common key themes.

By working through the following six steps you will be able to define your problem and work through a solution using the components of the Toolkit.

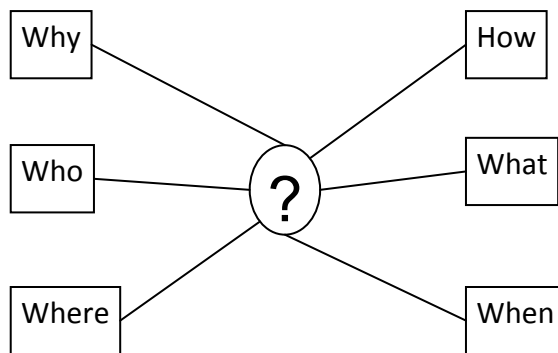
Step 1: Introduction

The first step involves using the [Navigation Guide](#) to set up your discussions. It outlines [Principles](#) that will help you get maximum benefit from the Toolkit. The guide includes a [process outline for using the Toolkit](#) components to develop solutions for your planning or service issues. We suggest making yourselves familiar with the guide at the start of the workshop and then after the introductory phase of your first workshop, referring back to the Navigation Guide to 'ground' your workshop discussions on the basic principles you have prioritised for this particular decision-making/planning process. Included in Appendix 1 to these workshop plans is Figure 1 from the [Navigation Guide](#) of the Pathway to Mental Health Care Development. This represents the kind of process you will probably use to apply the Toolkit.

Step 2: Define the problem

The first part of this step is to assess existing information and identify the problem that you want to address. This is often where people struggle. They react to what they think the problem is. Instead, seek to understand more about why you think there's a problem. The Five Ws and one H states that in order for a solution to be considered complete it must answer a checklist of six interrogative words which are: who, when, where, what, why and how. Each question should elicit factual answer-facts which are necessary to find a solution to the problem. Importantly, none of these questions can be answered with a simple "yes" or "no". Ask yourselves the following questions:

- What can you see that causes you to think there is a problem?
- Where is it happening?
- How is it happening?
- With whom is it happening?
- Why is it happening?



Write down a five-sentence description of the problem in terms of "The following should be happening, but isn't ..." or "The following is happening and should be: ..."
As much as possible, be specific in your description, including what is happening, where, how, with whom and why.

Defining complex problems:

If the problem still seems overwhelming, break it down by repeating the 5 steps until you have descriptions of several related problems.

Verifying your understanding of the problems:

It helps a great deal to verify your understanding of the problem with each other within the group.

Prioritize the problems:

If you discover that you are looking at several related problems, then prioritize which ones you should address first. Note the difference between "important" and "urgent" problems. Often, what we consider to be important problems to consider are really just urgent problems. Important problems deserve more attention. For example, if you're continually answering "urgent" phone calls, then you've probably got a more "important" problem and that's to design a system that screens and prioritizes your phone calls.

Understand your role in the problem:

Your role in the problem can greatly influence how you perceive the role of others. For example, if you're very stressed out, it'll probably look like others are, too, or,

you may resort too quickly to blaming and reprimanding others. Or, if you feel guilty about your role in the problem, you may ignore the accountabilities of others.

Examples of defining the problem:

Example 1

Problem statement: Our PMHC programme is not reaching Pacific people even though many are in our target group.

1. Who in our target group is not being reached by our programme?
2. What are the reasons for this?
3. Where are the gaps between our target group and the programme and where are they occurring?
4. When?
5. Why are our Pacific People not getting access to the programme?
6. How can we ensure Pacific people are reached by our programme?

Example 2

Problem statement: Our links between primary and secondary mental health care are generally poor.

1. What evidence supports this claim?
2. What underlies each point of evidence?
3. Where are the specific deficits? E.g. do they relate to particular consultants or community teams, particular general practices, or particular groups of consumers?
4. How would we know if this problem was fixed? What would be different about the service? (You could use the consumer lens here)
5. What can we do in the short, medium and long term to resolve this problem?

Step 3: Look at potential causes of the problem

Once the problem is defined you then need to start looking at potential causes of the problem. Write down a description of the cause of the problem and in terms of what is happening, where, when, how, with whom and why.

Step 4: Identify alternatives for approaches to resolve the problem

Brainstorm for solutions to the problem. Very simply put, brainstorming is collecting as many ideas as possible, and then screening them to find the best idea. It's critical when collecting the ideas to not pass any judgment on the ideas -- just write them down as you hear them.

Step 5: Select an approach to resolve the problem

When selecting the best approach, consider:

- Which approach is the most likely to solve the problem for the long term?
- Which approach is the most realistic to accomplish for now?
- Do you have the resources?
- Are they affordable?
- Do you have enough time to implement the approach?
- What is the nature and extent of risk associated with each alternative?

The nature of this step, in particular, in the problem solving process is why problem solving and decision making are highly integrated.

Step 6: Plan the implementation of the best alternative (this is your action plan)

Carefully consider:

"What will the situation look like when the problem is solved?"

- What steps should be taken to implement the best alternative to solving the problem? What systems or processes should be changed in your organization, for example, a new policy or procedure? Don't resort to solutions where someone is "just going to try harder".
- How will you know if the steps are being followed or not? (these are your indicators of the success of your plan)
- What resources will you need in terms of people, money and facilities?
- How much time will you need to implement the solution? Write a schedule that includes the start and stop times, and when you expect to see certain indicators of success.
- Who will primarily be responsible for ensuring implementation of the plan?

Write down the answers to the above questions and consider this as your action plan. Communicate the plan to those who will be involved in implementing it and, at least, to your immediate supervisor. An important aspect of this step in the problem-solving process is continual observation and feedback. After the plan has been implemented it needs to be monitored and whether the problems have been resolved or not needs to be verified.

One of the best ways to verify whether a problem has been solved or not, is to resume normal operations in the organisation. Still, you should consider:

- ❑ What changes should be made to avoid this type of problem in the future? Consider changes to policies and procedures, training, etc.
- ❑ Lastly, consider "What did you learn from this problem solving?" Consider new knowledge, understanding and/or skills.
- ❑ Consider writing a brief memo that highlights the success of the problem solving effort, and what you learned as a result. Share it with your supervisor, peers and subordinates

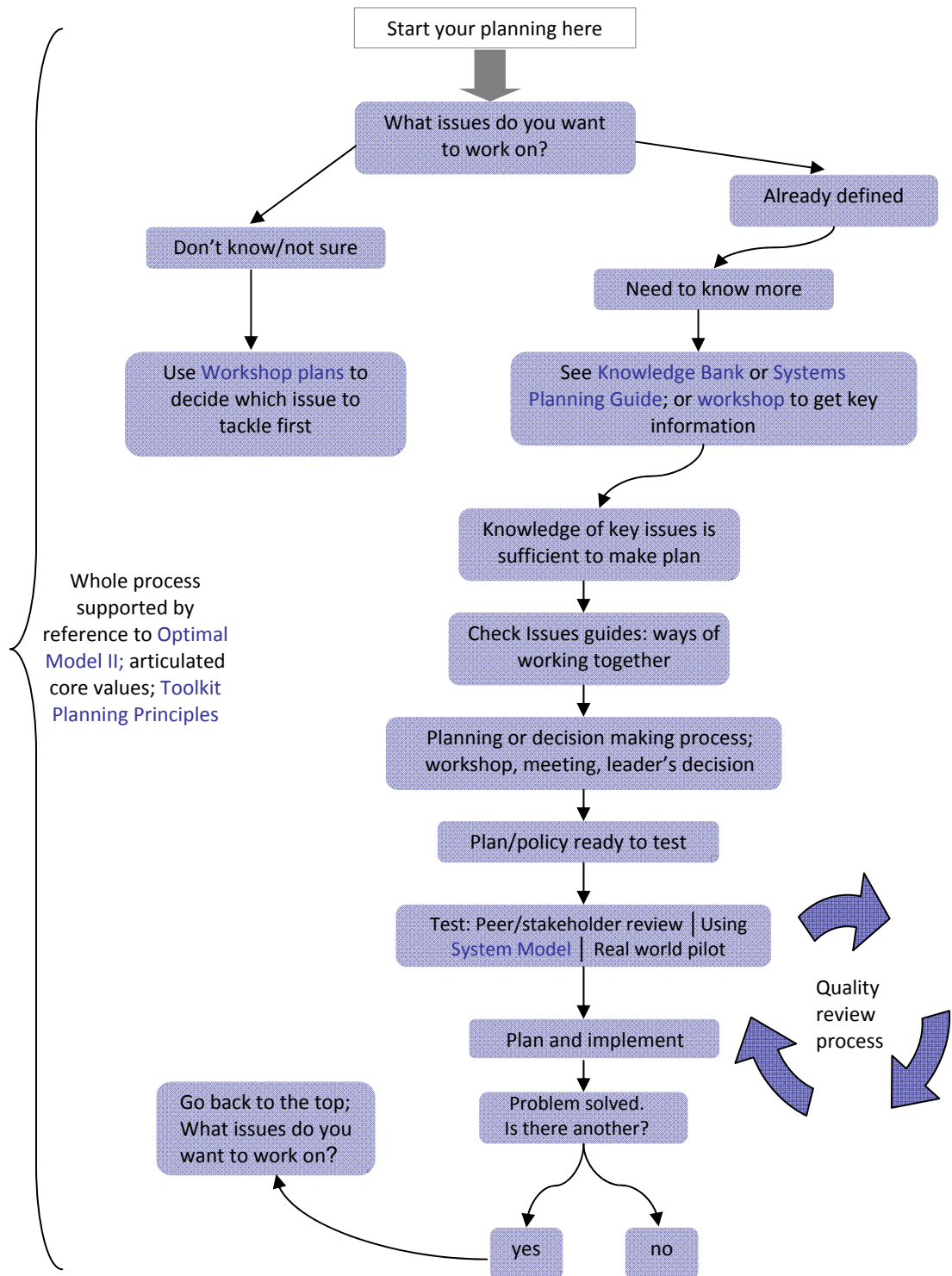
Workshop tips

1. The more people who attend, the less likely it is that you'll reach a decision. If your workshop's ultimate goal is to make a decision about something, have fewer than 10 people.
2. Not everyone has to stay for the entire workshop. For example if, the Clinical Director is too busy to attend the whole session, identify which sections he or she needs to be at and suggest in advance when they might want to arrive and leave. Make it clear that work will be done in their absence however. They may decide to prioritise it!
3. Where possible avoid holding your workshop after lunch when people are at their slowest and least productive time of day.
4. Figure out how to bring some excitement to your workshop. You know the areas that you want to cover, but how will you make the time rewarding and fun for your participants? Try to go for no more than 20 minutes without an activity that involves the participants such as "Share with your neighbour two ways..." Or "Jot down one way you might use ...". The idea is to get minds out of neutral and into gear to simulated discussion.
5. The key to successful workshops is to get everyone involved. If you create group exercises then make sure you keep the size of the groups small, mix up the different types of people in each group, determined how you will record and feedback ideas from each group, allow enough time for the entire group to evaluate the ideas from the smaller groups
6. Give people a break somewhere after about an hour and fifteen minutes,
7. Great workshops are the ones that feel more like a conversation than a lecture. If you as the leader of the workshop don't learn something from the participants about the topic, then you have not been successful.
8. End on time or even a little early.

Useful Resources

- ❑ Benedict Bunker, B. and B.T. Alban, Large Group Interventions. 1997, San Francisco: Jossey-Bass.
- ❑ Hayes, J. The Theory and Practice of Change Management. 2nd ed. 2007, New York: Palgrave Macmillan.
- ❑ Holman, P.T. The Change Handbook. 2007, San Francisco: Berrett-Koehler.
- ❑ Schwarz, R., et al. The Skilled Facilitator Fieldbook. 2005, San Francisco: Jossey-Bass.
- ❑ www.mindtools.com

Appendix 1: Figure 1: Pathway to Primary Mental Health Care development



Toolkit for Primary Mental Health Care Development:

Part 5: Systems Planning Guide

**A population-based approach to planning mental
health services in primary care**

Introduction

This [Systems Planning Guide \(Part 5a\)](#) accompanies the [Dynamic Systems Model \(Part 5b\)](#). The accompanying CD contains the software and the model. Instructions for installing the software and saving the model file are included at the end of this section.

This [Systems Planning Guide](#) is designed to help facilitate your conversations about Primary Mental Health Care (PMHC) in your district or area, so that you can design solutions that best fit your particular circumstances. The issues that any district or area faces in planning PMHC are varied and complex and there is no one solution that can be applied across the country. For this reason, it is important that planners in each region know their own population and its needs, and the characteristics of the people and resources who can respond to them. This [Systems Planning Guide](#) takes a systems approach because we know that any solution that does help improve mental health services will be required to address many issues. Isolating a single issue simply will not work.

To facilitate your conversations about PMHC in your area we have designed a model of the key elements within PMHC and how those elements link together. The model is based on our conversations with planners and providers within each DHB and focuses on key themes that are common across all. These themes are:

Demand (there's more to do that we could ever deliver)

- What are the appropriate service models to deliver those services?
- What are the resource implications and could we change who does what and when?
- What are the implications of and for different populations e.g. elderly, children and youth, Maori, Pacific etc?

Resources (there's only so much money, staff and time to go around)

- What can we do within the funding constraints we have?

- Are there untapped resources that we could utilise better?

Primary/Secondary Integration (working together for the patient)

- What is primary/secondary integration and what is the model of care it implies?
- What are the consequences of achieving it/not achieving it?
- What supports/hinders its development?

This [Systems Planning Guide](#) will not give you direct answers to these questions. Instead it provides a process which can support the appropriate discussion that will be needed to understand the issues in more depth and develop answers that are relevant for your own district or area.

Building a model of Primary Mental Health Care

This [Systems Planning Guide](#) is a tool to help you direct and structure your conversations about the PMHC services you wish to have in your region. This can be a difficult task for a number of reasons. One critical reason is that often, when people come together from different backgrounds, they each bring their different 'dialects' and perspectives into the conversation; doctors use a different language to patients, GP's have a different language to psychiatrists; and planners have a different language to clinicians. Having a visual model of the key elements within PMHC can help to address this issue by providing a common visual language that all can learn in order to facilitate conversations, planning and problem solving.

This [Systems Planning Guide](#) will work by building up the model, stage by stage, guiding you through a series of key questions that you can use to support your conversations. Throughout the guide we will highlight additional resources within the Toolkit that can assist you in this task.

The modelling approach used in this [Systems Planning Guide](#) is known as System Dynamics (SD). We have used this approach as the language for the model as it is

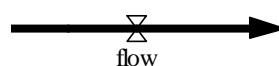
relatively easy to learn and provides a simple, yet powerful, tool for describing complex issues while avoiding complicating it further.

Learning the language of the model

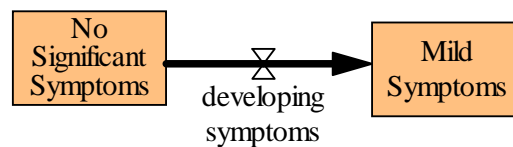
System Dynamics (SD) modelling uses a set of stylised visual icons, which are connected together to build up representations of the systems we are interested in. This section will describe these icons and provide you with the understanding you need to read and understand the PMHC model.

Most languages make a distinction between nouns and verbs. Nouns name things, people, places and abstract ideas. Examples include patients, doctors, beds, money, knowledge and morale. Verbs convey actions or activities such as treating, referring, planning or screening. These are the '*stocks*' and '*flows*' of the SD modelling language and are the fundamental elements upon which even the most complex systems can be described. The *stocks* are the nouns that describe things and the *flows* are the verbs that convey activity.

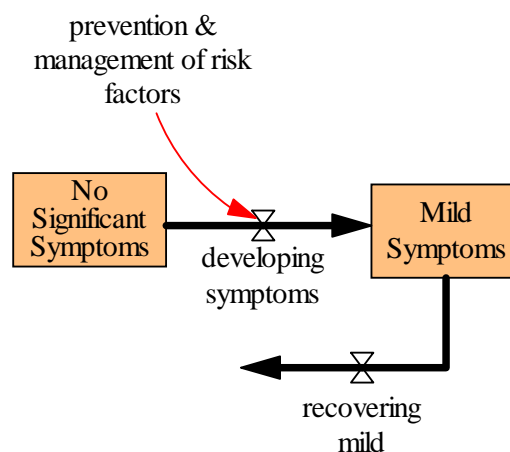
In SD we think of stocks as containers, like bathtubs. In a bathtub, at any stage in time there is some level of water in there, even if that level is zero. A bathtub also has a capacity; there is only so much water you can get in there and when that capacity is exceeded the water just overflows so nothing is added to the stock of water in the bathtub. Stocks are represented in the SD language as rectangles. To get water into and out of the bathtub a flow is needed. Flows are the verbs - the actions and activities in the system. The flow icon has three components that you need to understand. The first is the 'pipe' through which things flow. The second is the arrow which shows the direction of the flow. In this example the flow is from left to right. The third is the 'tap' which regulates the flow. 'Turning' the tap increases and decreases the rate of flow through the pipe.



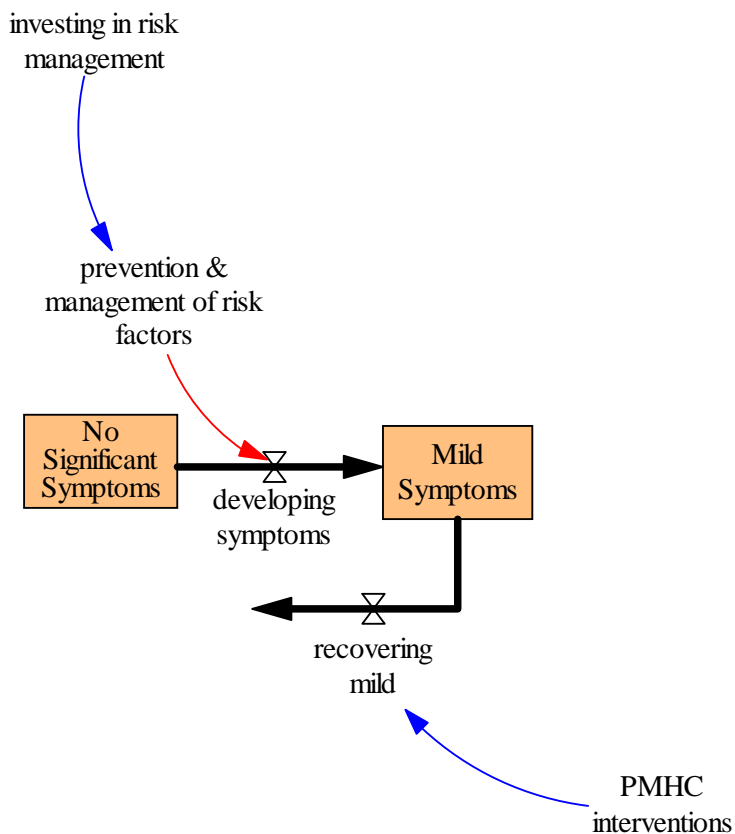
If we are to move things and information from one element in the model to another we need to connect them. This is done with the arrow. The example shows how a stock and a flow could be connected. The arrow shows the direction of the information; in this case from the stock of people with 'No Significant Symptoms' to the stock of people with 'Mild Symptoms'.



So far we have stocks and flows. However, if 'things' are to move between them we need to provide some inputs; information about the connections and how the rates of flow in the system are affected. We need something to turn the tap. In this example, the model highlights the link (shown with a red arrow) between efforts to improve the 'prevention and management of risk factors' and their impact upon the numbers of people 'developing symptoms'. What this link is saying is that if we **INCREASE** the promotion and management of risk factors we will **REDUCE** the number of people developing symptoms. Conversely, if we **REDUCE** prevention and management of risk factors we will **INCREASE** the number of people developing symptoms. This example also shows that it is possible for people to recover, thus reducing the numbers of people who currently have 'Mild Symptoms'.



In the following simple example, the model shows that the number of people with 'Mild Symptoms' at any point in time is affected by the numbers of people 'developing symptoms' and those who recover, 'recovering mild'. To reduce the numbers of people with 'Mild Symptoms' we therefore have at least two possible options to consider.



The first option is to increase 'investing in risk management'. This will improve the prevention and management of risk factors - as shown by the blue arrow - and therefore reduce the numbers of people 'developing symptoms'. The second option is to focus PMHC on those people with 'Mild Symptoms' thus increasing the recovery rate. Either, in theory, would reduce the numbers with 'Mild Symptoms'. Which, if any, would be a suitable option in your region is what this [Systems Planning Guide](#) is designed to help you explore.

The model extends these links to cover the full spectrum, from those people with no significant mental health symptoms to those with severe symptoms. It highlights those factors that affect the population of people with mental health conditions, the

impact that has upon need and demand for services and the potential strategies that you could use to manage that demand and to respond to need.

Model overview

The model shown on the following page describes the key elements, and the links between them, that impact upon the service user, their need for services and the ability of services to respond, over time, to those needs. The model aims to highlight some of the key questions you will need to ask in developing an effective and sustainable plan for PMHC in your region. It provides a 'checklist' of the things that you will need to consider and, because it is in the form of a system model, helps you consider the relationships that can help sustain, or undermine, your efforts.

Following the model overview this [Systems Planning Guide](#) takes you through each stage, highlighting the key issues and questions you will need to consider in planning PMHC services in your region. Do not be concerned if at first the model seems strange and complex. Work through the steps in the [Systems Planning Guide](#) and you will find that your understanding and ability to read the model will evolve along with the planning process itself.

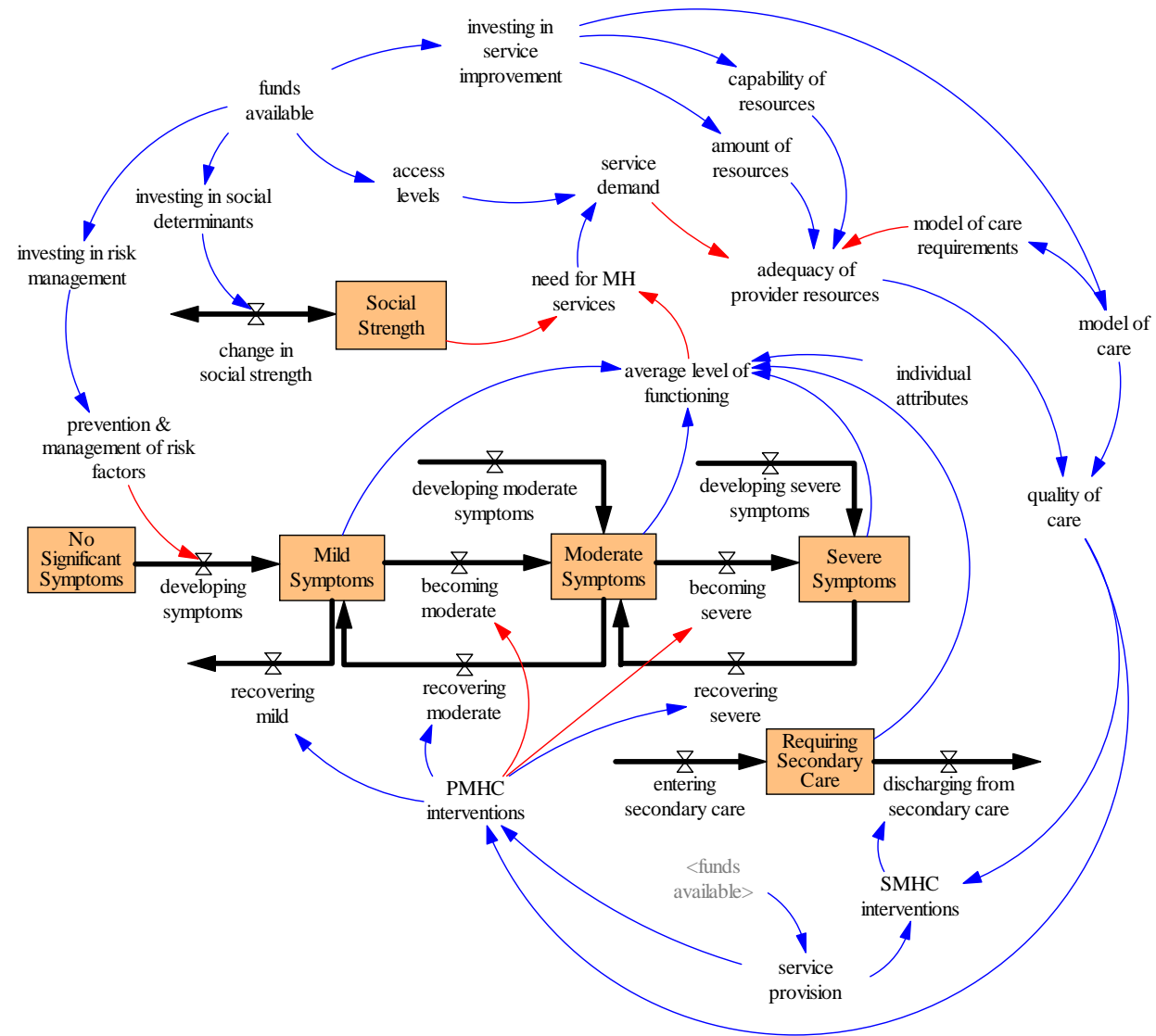
Model overview (the system of primary care)

Patient care and patient journeys are dependent upon the overall numbers of people with different levels of symptoms and the different interventions that are possible.

The model is a picture of the various factors that influence the outcome and the planning guide takes you through key steps in thinking about your population, their needs and the range of interventions you may want to consider within your region.

The [Systems Planning Guide](#) considers the following key areas of focus:

- Managing Symptoms
- Service Demand
- Service Provision
- Service Improvement
- Models of Care
- Access Levels
- Risk Factors
- Social Strength



What do the arrows mean?

The model shows the causal relationships between key factors that impact upon the sustainability of primary mental health initiatives. These relationships are shown by red and blue arrows. Thick **blue** arrows depict a 'positive' causal relationship.

Positive does not imply good, but simply that **more** of one leads to **more** of another, or conversely, **less** of one leads to **less** of another. For example, increased 'access levels' leads to, everything else being equal, increased 'service demand'. Thin **red** arrows depict a 'negative' causal relationship. This does not imply bad, but simply that **more** of one leads to **less** of another, or conversely, **less** of one leads to **more** of another. For example, increased 'average level of functioning' leads to less 'need for MH services'.

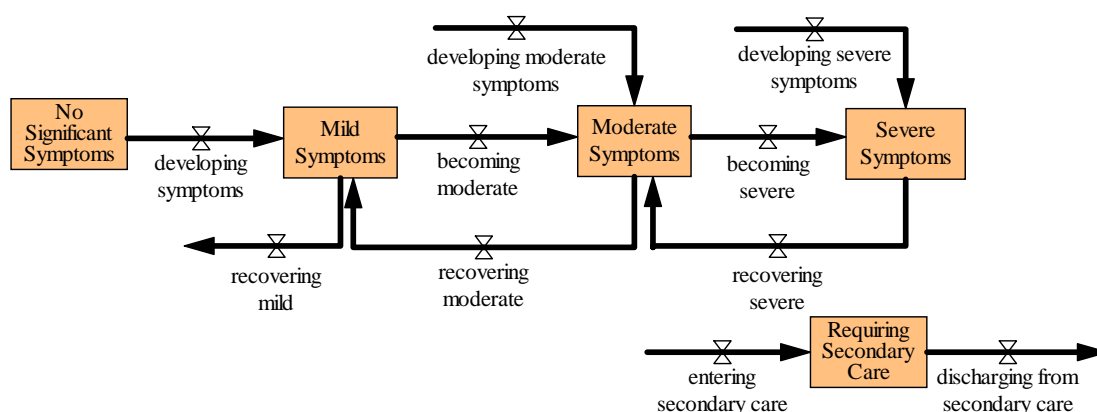
In addition, the model focuses on the development and progression of symptoms related to mental health rather than diagnostic categories. This is an important aspect of the model as it reflects the fact that i) in primary care the focus is on responding to symptoms and ii) regardless of diagnostic category an individual could have symptoms ranging right across the continuum and iii) it is these symptoms, along with the social context within which the individual lives, that drives the demand for MH services.

Understanding your population

The first important task is to understand your local population in relation to primary mental health needs. Are you able to determine the numbers of those with existing symptoms and diagnosis? Are you able to define populations who might be at risk and how that might be linked to age, gender, ethnicity and poverty?

The model we are using focuses on symptoms, as it is symptoms, and functioning, rather than diagnostic categories that are the main focus of primary care interventions. This is not to say that diagnostic categories are not important but it is the symptoms that providers in primary care have to respond to and help the person manage. Furthermore, symptoms levels can fluctuate during the course of an illness

or episode of mental ill-health. It is quite possible for some people with a diagnosis that might indicate the need for secondary specialist care, for example schizophrenia or bipolar disorder, to be managed in primary care at times when symptoms are minimal and the patient is stable. The diagnostic category is important but it does not automatically consign a person to one form of care over another. The symptoms that a person is coping with are an important determinant of the type and location of care needed.



KEY POINTS

- ❑ Primary care deals with symptoms and functioning rather more than diagnostic categories.
- ❑ Symptoms levels fluctuate regardless of underlying conditions.
- ❑ Population mental health status is measured by the distribution of people across the symptomatic states.
- ❑ Population mental health status is improved by i) slowing down the development of increasingly severe symptoms ii) speeding up the rate of symptom recovery and iii) management of the complications associated with any symptom state.

KEY QUESTIONS

- What is the 'symptom mix' of your population?
- How does it change with ethnicity, gender, age?
- What prompts you to action with any of the population groups in your region?
- What is the link between symptoms and disorders in your population?
- Who in the population really needs to be managed by secondary care?

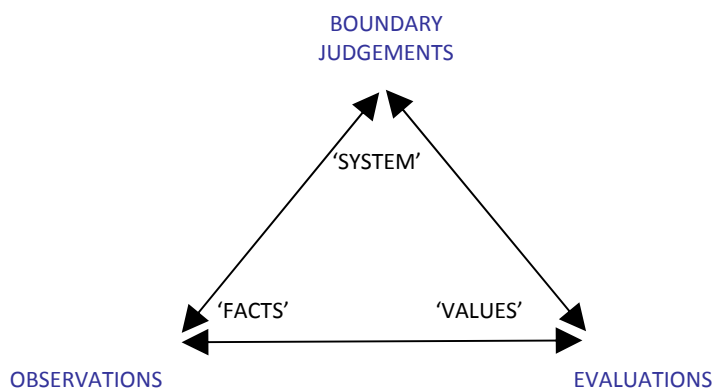
Making choice about priorities

In our reality of finite resources, the choices we make about service priorities mean that some people will get the services they need and others will not. Because of this it is important that we engage a number of people in the process of choice, using a process that is transparent, and one that allows people to consider both the evidence and the values that are important to us in making the choices we have to make.

In trying to plan within any complex system, in this case PMHC, we are always faced with the decision of what to include and what to leave out, who will benefit and who will lose out. What we choose to include within our plan for PMHC is influenced by what we know and see; the facts. We are influenced by the evidence in front of us, the information we consider important. It is also influenced by what we value; our norms. We are influenced by what we think is important and desirable – our values. For example we are influenced by our attitudes to issues such as equity, efficacy and need. Our judgments about the ‘facts’ we see and the ‘values’ we hold, determine what we consider to be a priority, and inside the boundaries of what we wish to do, and what we consider to be less important or outside these boundaries.

While you (and we) might wish to take a ‘whole system’ perspective we cannot avoid the fact that our observations and judgments will always be partial. Partial in that firstly, our knowledge of the facts, and our values, will always limit our understanding and secondly, any judgment we make will benefit some people more than others. It is important therefore to make this process of establishing priorities explicit so that there is a clear understanding of what the priorities are, and what needs to be done to address issues that may, as a result, affect those who are not considered high on the priority list.

The 'eternal triangle' developed by Werner Ulrich is a useful tool to guide these discussions³⁵. Any decision about the priorities of PMHC asserts the importance of some 'facts' (observations) or 'values' (evaluations) over others. So it is important to consider each corner of the triangle in the context of the other two. For example, what new 'facts' become important if you expand the boundaries of PMHC or change the predominant values. If you decide to emphasise issues of equity, do your current priorities do justice to the perspectives of different stakeholder groups? If new values, such as financial sustainability, become prominent how does that affect your priorities and what new facts do you now have to consider?

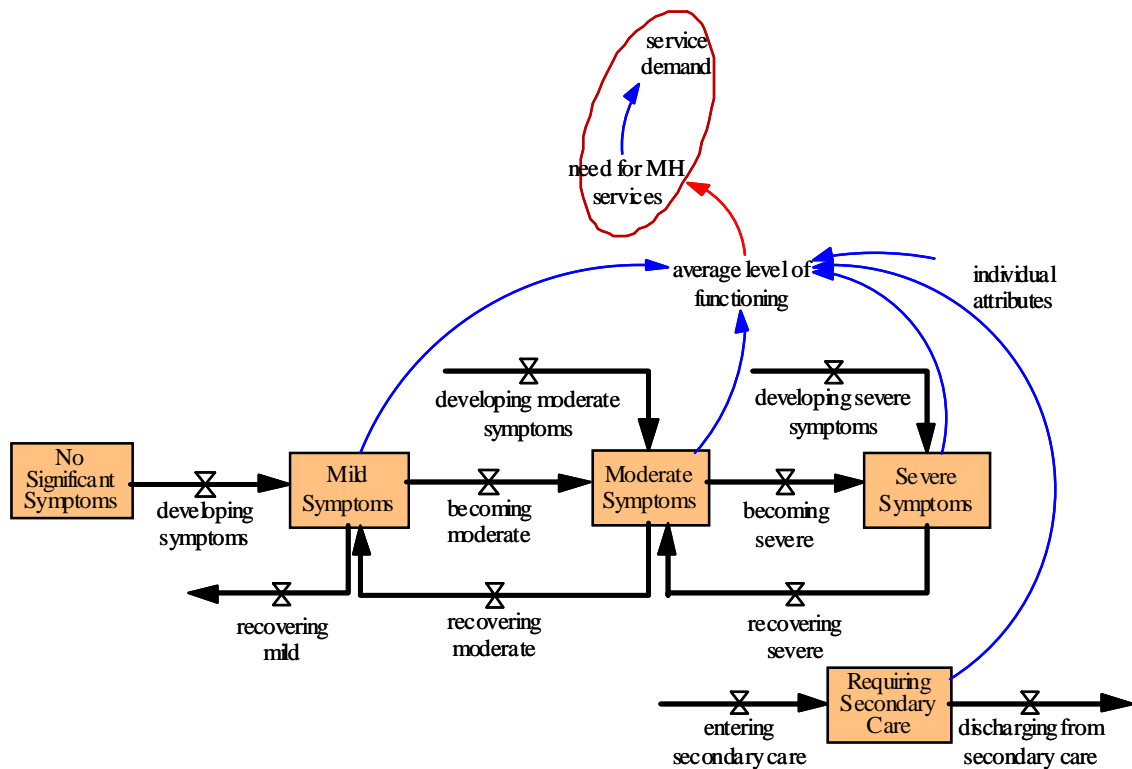


Using this framework to facilitate discussions about your priorities can be helpful in improving understanding of your population and the priorities you set. To support this, a simulation model is also included in this toolkit to help you assess the prevalence of mental health conditions in your region. In addition, the toolkit also has a prioritisation matrix to help you assess the relative importance of any priorities that emerge in your discussions.

³⁵ Ulrich, Werner, (200). Reflective practice in the civil society: the contribution of critically systemic thinking. *Reflective Practice*, 1, No. 2, 2000, pp. 247-268

Service demand

Demand for mental health services is driven by the nature of your population and the population you decide to prioritise, as well as by other external influences such as public media campaigns. The symptoms experienced by people affect how well they are able to function, which in turn drives need for mental health services. This need is a major, but not the only, determinant of service demand. A major challenge then in focusing on any population group is to understand how you will respond to demand.



KEY POINTS

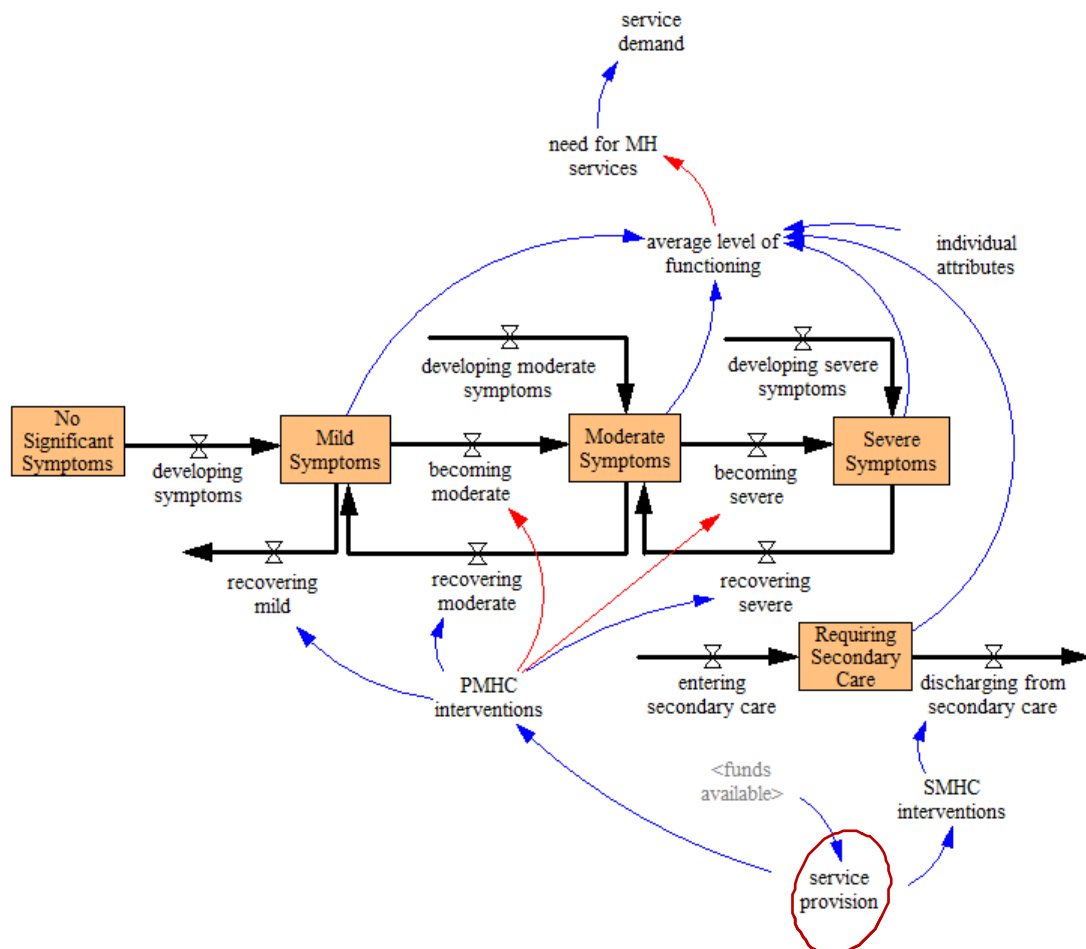
- ❑ The mix of symptom states is a major driver of need and therefore of demand.
- ❑ While there is significant individual difference, the more the population shifts to the right, other things being equal, the greater will be the need and the greater will be the demand for services.

KEY QUESTIONS

- ❑ What is the level of demand for PMHC services likely to be; what is the level of need and what is the gap between the two?
- ❑ How do your answers change for different ethnicities, genders and ages?

Service provision

While this [Systems Planning Guide](#) focuses on PMHC it is important to explore the relationships between the services and resources in primary care and those within secondary care. Who controls what resources and where are they located? Furthermore, those who require secondary care are likely to have severe and enduring symptoms, resulting in a low level of functioning and a high level of need. So, whilst the focus here is on PMHC, it is important to consider secondary mental health care (SMHC) and how each affects the other.



KEY POINTS

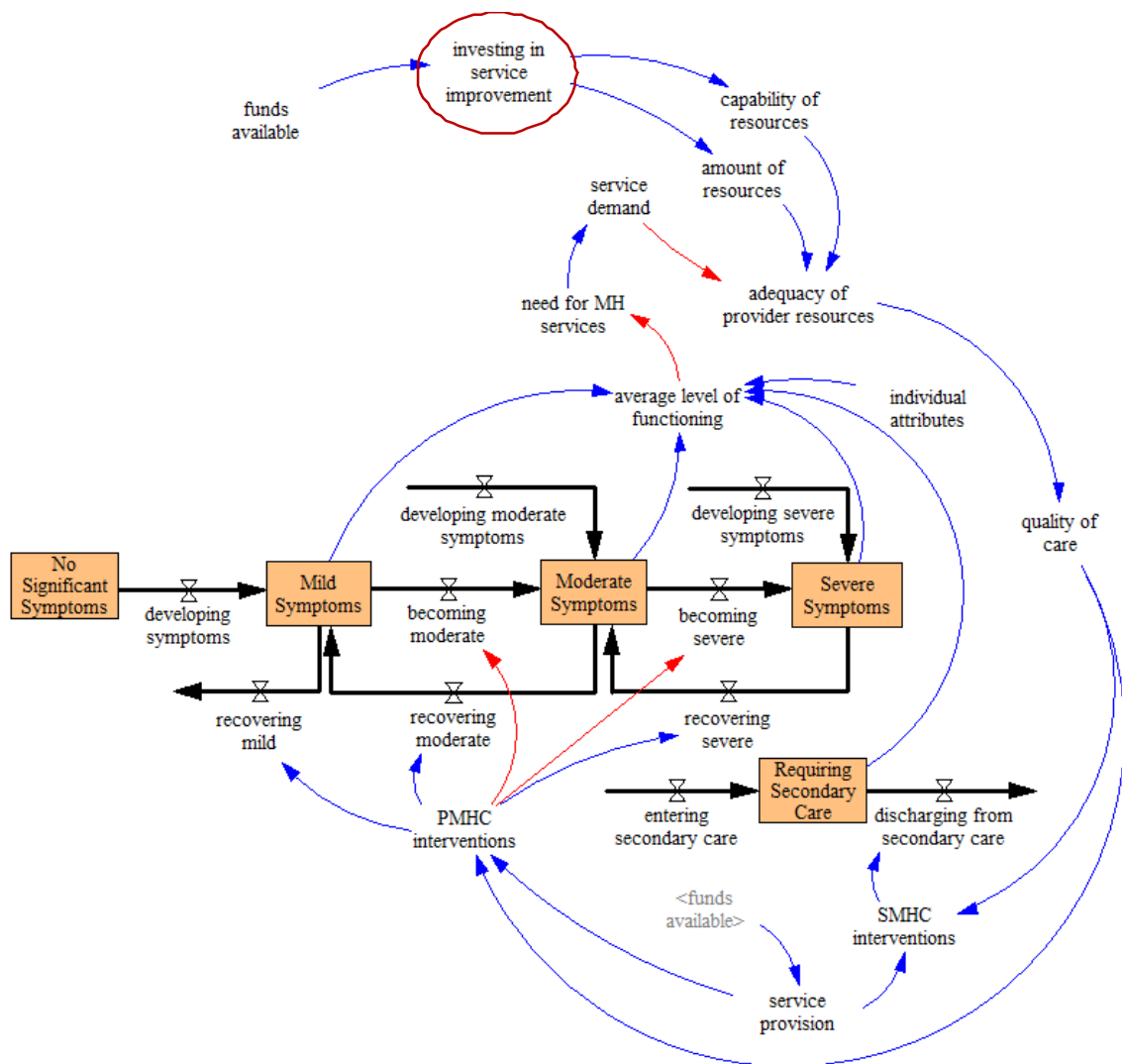
- One way of responding to demand is to provide more services.
- While the focus of PMHC is on managing those with mild and moderate symptoms and trying to slow down their progression and speed up their recovery, it is important not to assume that all severe cases should be handled in secondary care. Their focus is likely to be on patients whose symptoms are severe AND enduring.
- The focus of SMHC is on managing those with enduring severe symptoms.

KEY QUESTIONS

- What are the relationships and roles of PMHC and SMHC providers?
- Given symptoms change, regardless of diagnosis, who manages the patients' access to care?
- What roles are there for secondary specialists in primary care?

Service improvement

An alternative focus might be that of service improvement. Rather than developing additional services, could you gain more by improving the services that you already have in place? Service improvement focuses on improving the quality and/or quantity of resources that you have. This may involve training and development to improve capability it may involve recruitment to increase the resources available.



KEY POINTS

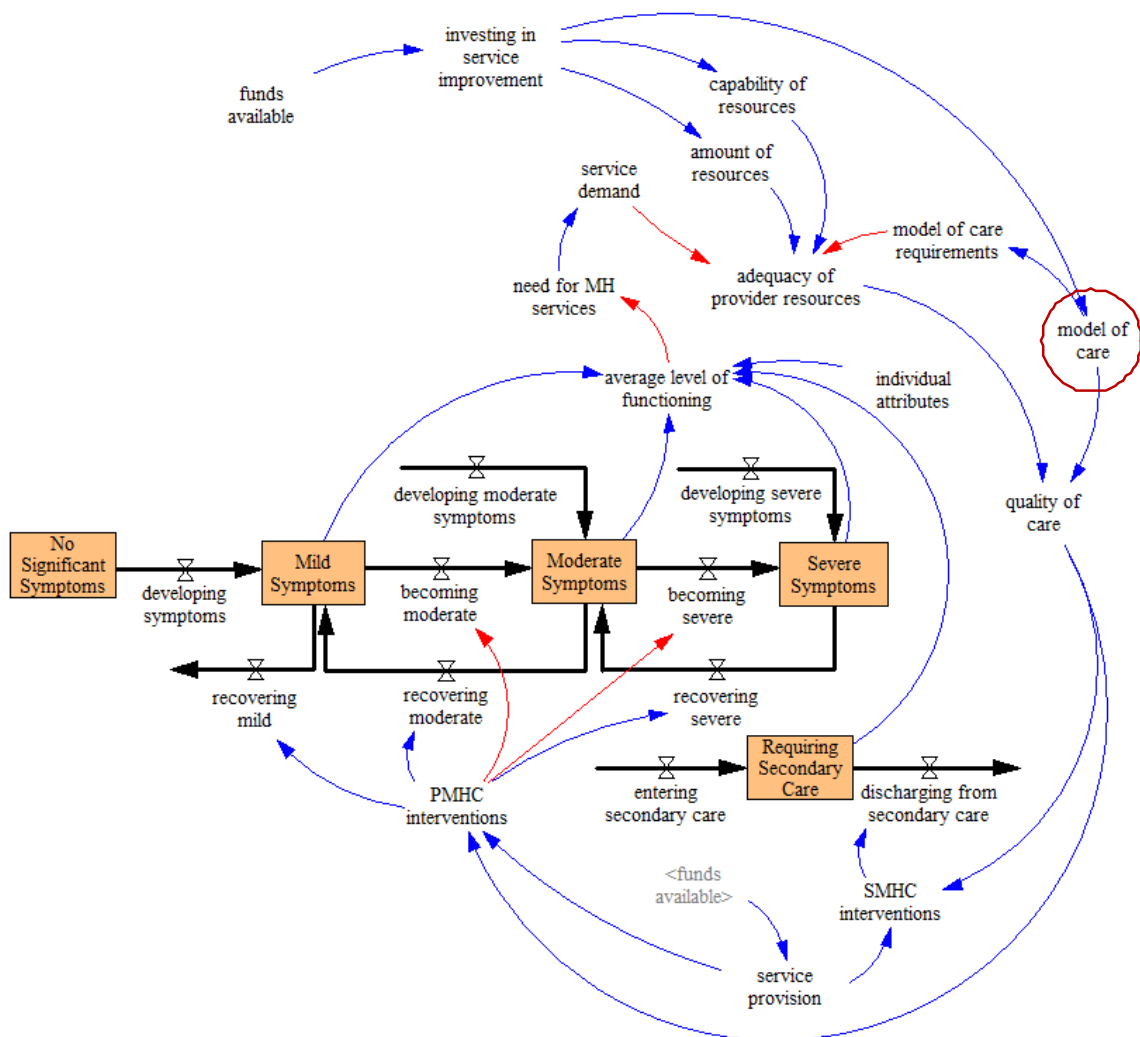
- One way of responding to the demand is to invest in improving the services you already have.
- This can be done by increasing the capability of resources and/or increasing the amount of resources available.
- Whether or not those resources are adequate depends on the level of demand on change when you consider service demand by ethnicity, gender and/or age?

KEY QUESTIONS

- How adequate are your current resources given current levels of demand?
- If they are not adequate, is it that there is not enough, they are not capable enough, are in the wrong place, or some mix of all three?
- Does this situation change when you consider service demand by ethnicity, gender and/or age?

Models of care

Existing service improvement may not be enough to deliver the service you need and an approach is required that is based new models of care. Changing who delivers what service, in what location is a major issue in an environment of increasing patient demands and decreasing resources. Maybe you need to consider different roles for doctors and nurse, for allied health professionals, for community works and for the mental health patient themselves. How would any new model affect care requirements, and therefore the adequacy of the resource you have available? Also how it would it impact quality of care?



KEY POINTS

- Models of care describe what you provide, how you provide it and who provides it. Changing any one of the factors changes the model of care.
- The model of care you use has an impact upon the quality of care provided and upon the resource requirements needed to deliver it.

KEY QUESTIONS

- What is your model of care?
- Is there any desire to change i) what is provided, ii) how it is provided and/or iii) who provides it?

KEY POINTS

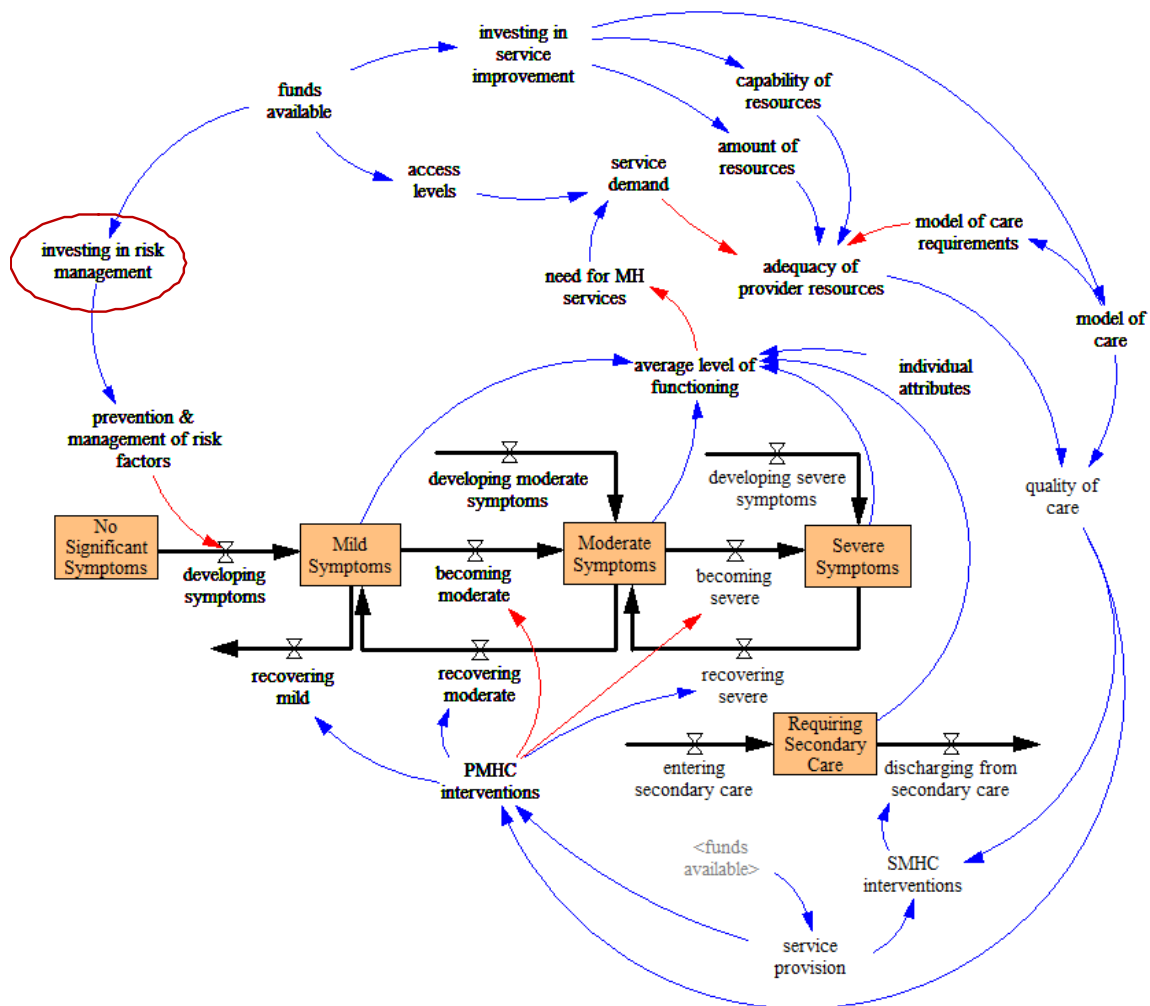
- An additional way of responding to this demand is to change your access criteria.
- Access criteria are one of the major mechanisms by which health services are rationed.

KEY QUESTIONS

- What are your current access criteria: formal and informal?
- Is access equitable? If not why not and who gains access and who does not?
- Who is on the margins of being included and excluded? What are the consequences of moving these margins?

Risk factors

The focus so far has been on those who have mental health conditions that need to be responded to. However, none of the options discussed does much to reduce the development of mental health conditions in the first place. Community or workplace strategies to promote positive mental health, or attempting to try and reduce factors that may lead to mental health problems might be considered. Is this an area that you consider important? How much do you do already? What is the balance you consider important between meeting and preventing demand.



KEY POINTS

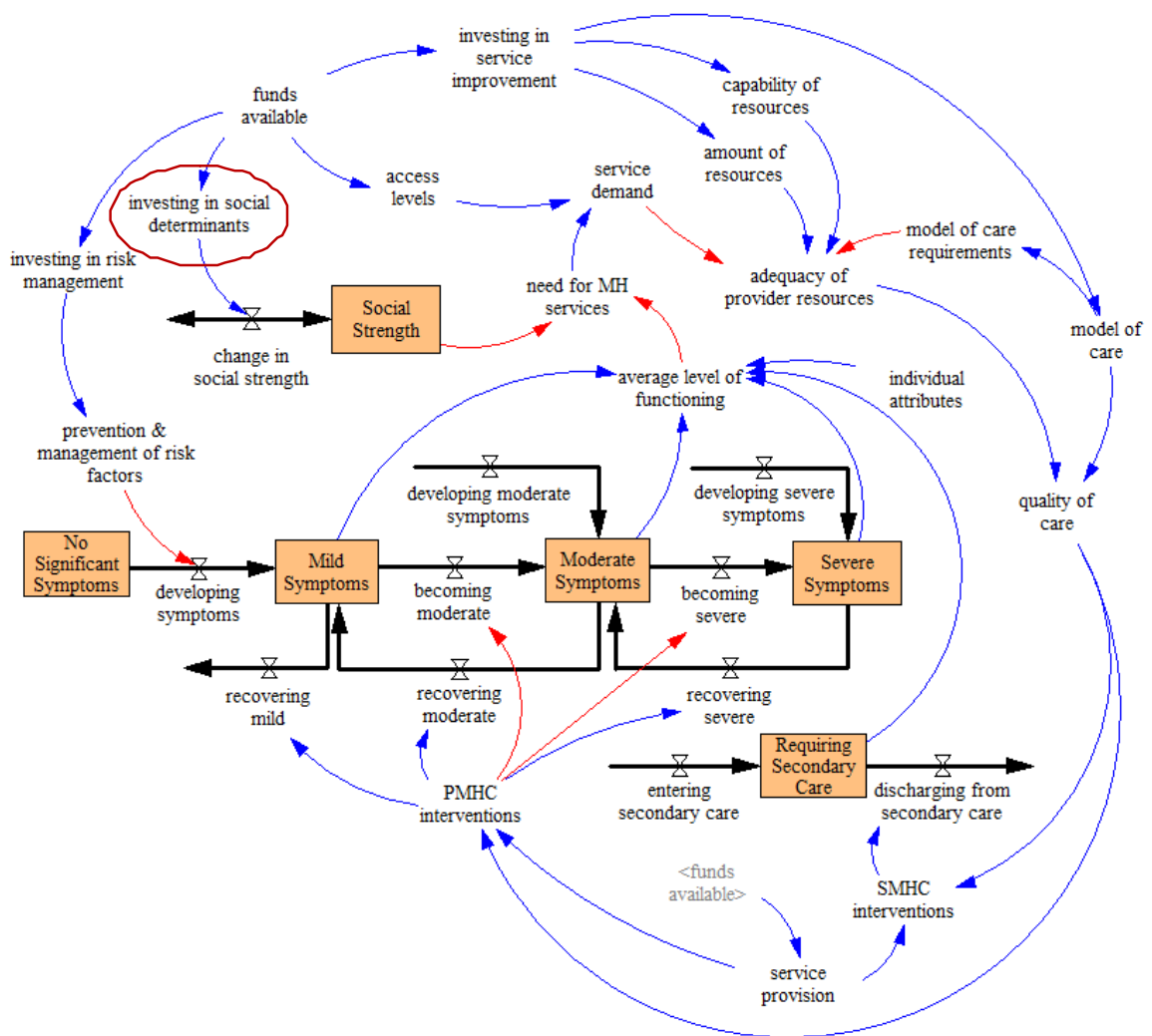
- ❑ Rather than simply responding to the demand that is there, is it possible for you to take the 'longer term' view and invest in the prevention and management of the risk factors that contribute to the development of mental illness, and thereby reduce the demand over time.
- ❑ But taking the 'longer term' view, while laudable, does nothing to address current demand.

KEY QUESTIONS

- ❑ What percentage of your resources, time, dollars and people, are invested 'upstream'? How does this compare with the resources invested 'downstream' in primary and secondary treatment?
- ❑ Does the balance of where the resources lie change when you consider ethnicity, gender and age?

Social strength

Social strength is the term we have given to the community, family and whānau support the service user has. Do they have people and facilities around them that can help them cope with their condition? Do the resources available to them enable them to manage their condition outside of the health system? Is there room to build the 'social strength' of people with mental health conditions, and if so how would it impact upon service demand?



KEY POINTS

- ❑ For any given level of symptom severity the need for care will be mediated by the 'social support' available to the patients. The greater the support available the less the need for health services.

KEY QUESTIONS

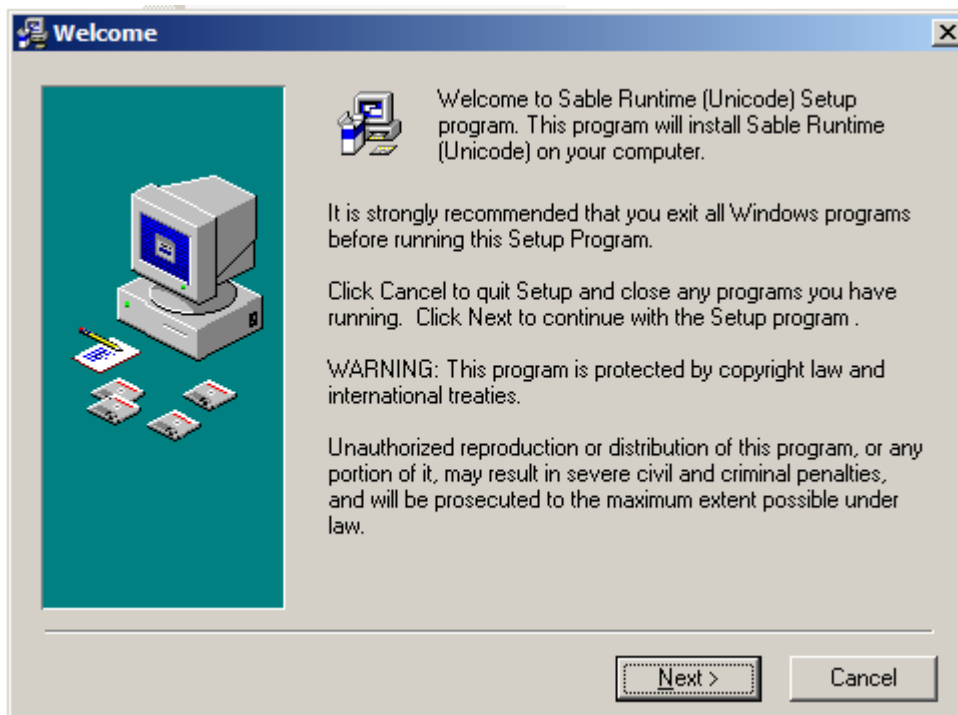
- ❑ What role do health services have in developing 'social strength'?
- ❑ How much does the social context of the patients you have to deal with impact upon their need and upon the services you provide?
- ❑ Is it the business of health planners and providers to address social issues?

Dynamic systems model: installation instructions

The following instructions explain how to install and operate the *Dynamic systems model* that accompanies the *Systems Planning Guide*. The software you will be installing is similar in function to Adobe Reader in that it allows you to read specific files, in this case the model simulation file. The CD with the *Dynamic systems model* contains 2 files. One file is the model file itself – ‘Mental Health Survey.spk’. The other is the programme file that will allow you to run the model.

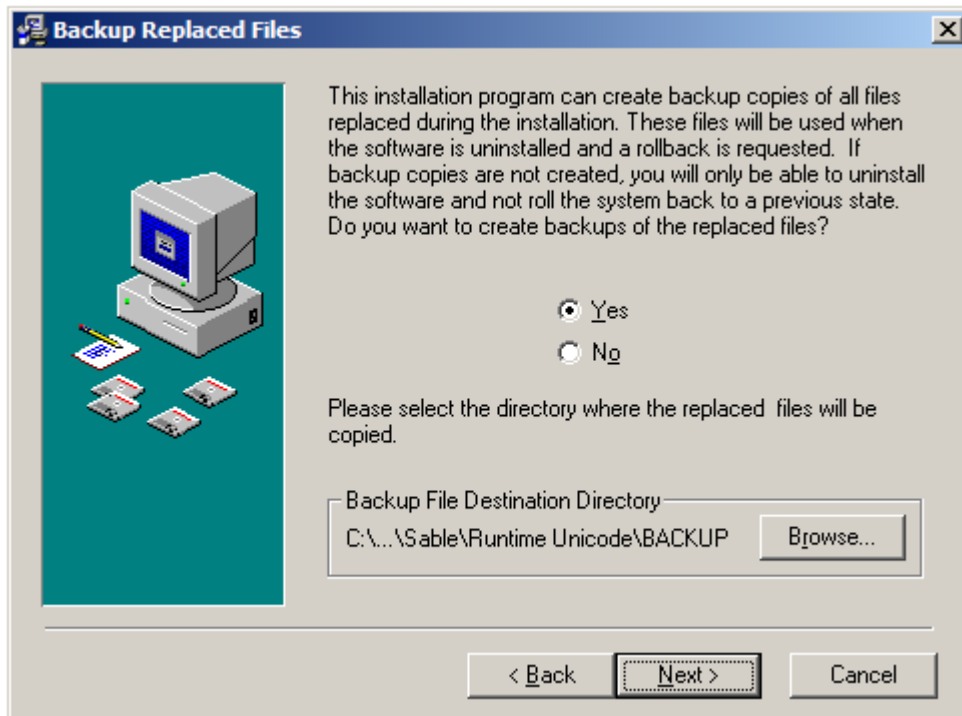
Name	Date modified	Type	Size
Mental Health Survey.spk	23/09/2010 11:57 a.m.	SPK File	162 KB
SableRuntimeSetupU.EXE	2/09/2010 9:45 p.m.	Application	10,477 KB

The software that runs the model is the file ‘SableRuntimeSetupU.EXE. Click on this file and the installation screen will appear.



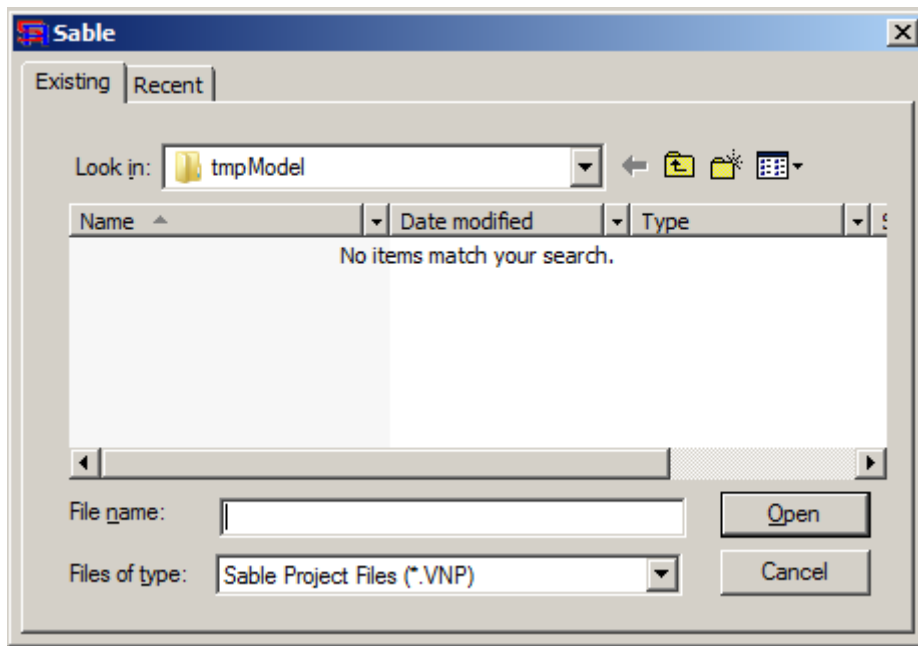
Follow all instructions during the installation procedure.

During the installation you will be asked if you wish the installation programme to create backup files. This is useful if you have any problems and need to make repairs. It is recommended that you click 'yes' at this point.

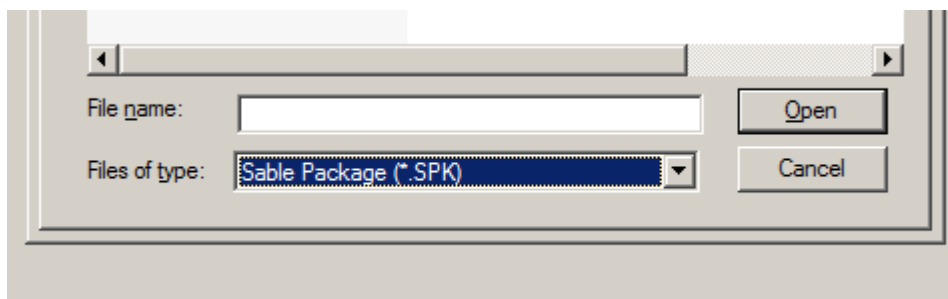


Unless you changed the file destination the software will be installed in the folder `c:\program files\Ventana Systems UK`. To make running the programme easier you may want to 'right click' on the file and either 'pin to start menu' or create a shortcut.

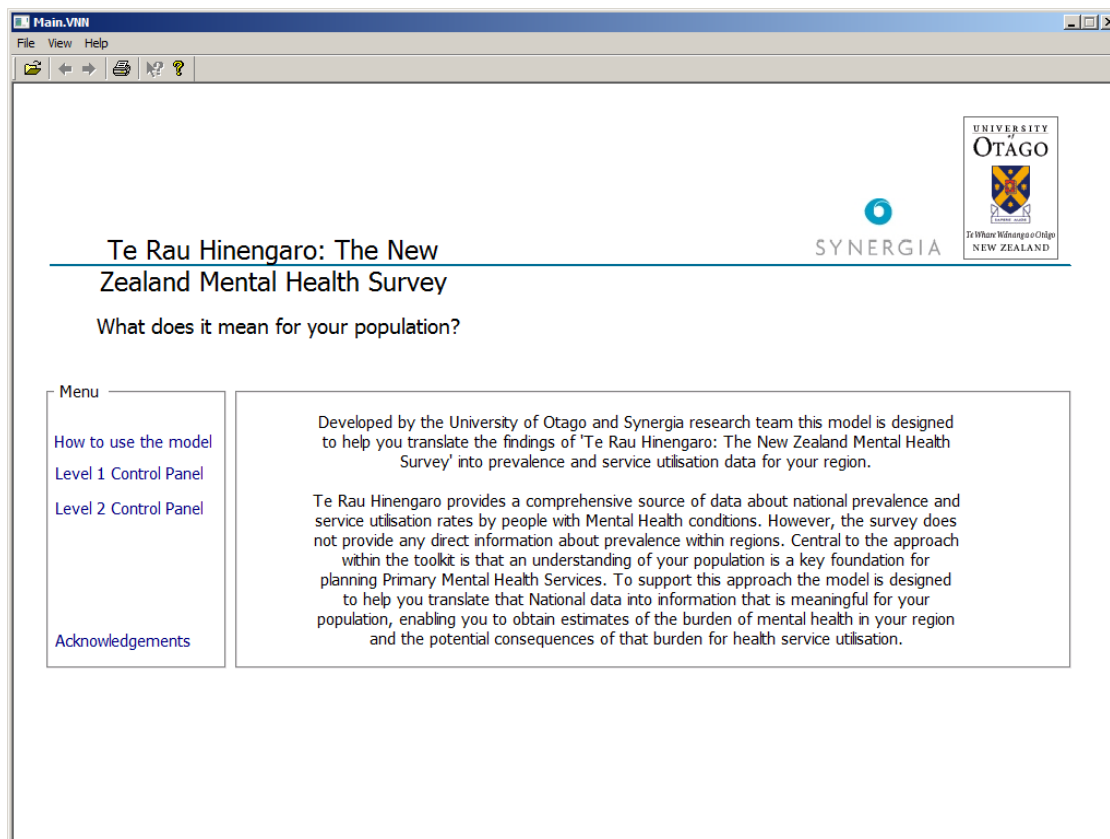
Once you have installed the programme file move the model file 'Mental Health Survey.spk' to an appropriate folder. When you open up the programme you will get the following dialogue box.



The first task is to change the file type to '.spk'. by clicking the down arrow in the 'files of type' section. When you have done that go to the appropriate folder and open up the model file.



When you have opened the file you will see the following front screen:



There are on-line instructions. However, as we hope to continue refining the model, making it more useful and easier to use please contact David Rees of Synergia Ltd., if you have any problems operating the model or you have ideas for improvement.

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