Primary Mental Health

A review of the opportunities

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Foreword

The Mental Health Directorate in the Ministry of Health is focused on the implementation of the National Mental Health Strategy. A considerable amount of work is in progress to expand the capacity and range of specialist mental health services for the 3 percent of the population with the most serious mental health problems.

In addition to this essential work, it is important to consider the mental health needs of the wider population. Of particular relevance to primary health care are the needs of the 17 percent of the population experiencing some form of diagnosable mental health disorder that requires intervention/treatment. It is well recognised internationally that the mental health needs of most people with mild to moderate mental health problems must be met in a primary health care setting.

In February 2001 the Hon Annette King, Minister of Health, released the Primary Health Care Strategy, setting a new vision for primary health. Key to the Strategy is the development of Primary Health Organisations – local structures that, when developed, will work to improve the health of the communities they serve to the greatest extent possible by organising services around defined populations.

Up until now there has been little policy emphasis on the development of mental health services in the primary sector. The Primary Health Care Strategy presents a significant opportunity to improve services to people experiencing mental illness, which the World Health Organization has identified as the leading cause of disability burden to society.

In primary mental health, such opportunity lies in prevention and early intervention activities, workforce development and building effective linkages. The costs of ignoring the burden of mental disorder in society are immense.

The Directorate commissioned this report to identify key issues and evidence in relation to primary mental health care. This information is intended to assist District Health Boards and Primary Health Organisations in planning for the delivery of future primary health care services.

This document produced by Jo Chiplin under contract to the Ministry of Health is part of a continuing process to identify new, innovative primary mental health models of service delivery that are both cost effective and beneficial to service users. I hope that it stimulates discussion about the potential for primary health care providers to meet the mental health needs of their populations more effectively.

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Executive Summary

The Mental Health Directorate of the Ministry of Health has commissioned this report. Its aim is to identify and summarise key issues in relation to primary mental health care that will need to be considered in planning for the implementation of the National Primary Health Care Strategy and for the ongoing implementation of the National Mental Health Strategy.

Estimates of the prevalence of mental health problems amongst adult New Zealanders suggest that:

- about 3 percent of the population have severe mental health problems or disorders
- another 5 percent of adult New Zealanders have moderate/severe mental health problems or disorders
- another 12 percent of adult New Zealanders have mild/moderate mental health problems or disorders.

The focus of the National Mental Health Strategy is the 3 percent of the population with the most severe mental health problems; specialist services are targeted at this group. Of particular relevance to primary health care services are the 17 percent of the population with mild to moderately severe mental health problems. It is well recognised internationally that the mental health needs of most people in this group must be met in a primary care setting.

Good national and international evidence shows a high prevalence of mental health problems amongst people presenting to primary health care services. A World Health Organization study identified that 24 percent of people presenting to primary care services have a major psychiatric disorder, while a further 9 percent have a subthreshold disorder. Furthermore, preliminary data from a local study suggest that as many as 35 percent of people presenting to general practitioner (GP) practices in New Zealand meet the criteria for mental disorder. However, mental health problems are frequently missed in primary care consultations; up to 50 percent are not detected explicitly.

Although many people with mental disorders present to primary care services, service provision in response to their needs depends on the interest and expertise of individual practitioners. Therefore models and standards of service delivery are haphazard and inconsistent. In the current primary health care system, barriers to the provision of effective primary mental health services include:

- cost to the GP
- cost to the service user
- GP confidence and competence.

In particular, the current fee-for-service funding system and service user part-charges create financial incentives for both the GP and service user to meet the user's needs through specialist mental health care.

The provision of primary mental health services in New Zealand is predominantly GP-based. Internationally, in contrast, other professional groups such as nurses, social workers, counsellors and psychologists have an increasing role in such provision. Despite very little formal evaluation of the effectiveness of these roles, recent work suggests interventions that consistently improved outcomes for people presenting to primary health care services with depression incorporated some form of case management approach. Typically the case management role is taken on by staff other than GPs at relatively low cost.

The literature shows clear support for primary health care practitioners taking the lead role in the provision of mental health services for people with mild to moderate mental health problems. With respect to mental health services for the 3 percent of the population with severe mental health problems, however, the role of primary health care practitioners is less well defined.

In New Zealand there is a somewhat ad hoc approach to the provision of primary health care services for this group. In recent years a few 'pilot initiatives' have aimed at transferring the lead role in clinical service provision for people with severe mental health problems from specialist mental health services to GPs. Because these initiatives are generally locally initiated, the way in which they are funded and delivered varies considerably.

A key issue in relation to the provision of primary health care services for people with severe mental health problems is the interface between primary and specialist services. Various models to improve this interface have been suggested, although the literature offers little evidence-based material on their effectiveness. Most models focus on various mechanisms for attaching mental health clinicians to primary health care services; their roles and responsibilities differ from model to model.

New Zealand has no national guidelines regarding the interface between specialist mental health and primary care services. Most often they operate as two 'hard-pressed' services that relate poorly to each other. A growing trend has been to improve this interface with the development of primary care liaison services. These services aim to encourage appropriate referrals to specialist services and enhance the skills of the GP so that they can deliver services to those people with mild to moderate mental health problems. Currently this type of initiative is locally driven and dependent on the interests and skills of individual providers.

In relation to improving the interface between specialist mental health and primary mental health services, the key issues may be summarised as follows.

- Improving this interface should not mean diverting scarce, highly trained specialist resources from services to those with the greatest need.
- Mental health workers who work at the interface should divide their time among face-to-face work with those most in need, shared care and consultation activities and providing support and education to the primary health care team.
- The interface works more efficiently and effectively with good communication between the services, agreed criteria for referral and discharge, agreed guidelines and mutual support.

Summary of recommendations

- Plans for the implementation of the Primary Health Care Strategy should state explicitly that primary health care providers will be expected to incorporate a substantial mental health component into their work in a systematic way. This could be initiated by the development of a detailed service specification for mental health to be included in the initial set of Establishment Service Specifications.
- Over the medium term, primary health care providers should take the lead role in delivering mental health services to people with mild to moderate mental health problems. Effective primary care interventions for this group will include a combination of:
  - pharmacology
  - therapeutic interventions of known efficacy
  - provision of information to support self-help
  - a case management approach.
- Once a service specification is developed, the capitated funding formula for primary health care will need to be adjusted to include primary mental health services. The costs to both GP and service user should be considered in this regard. Furthermore, if the capitated funding model includes additional targeted payments for specific service areas mental health should be considered as one such service, given that:
  - mental health is a national health gain priority
  - the prevalence of mental health problems in primary care is high
  - the costs associated with time-consuming assessment, interventions and case management are higher than average treatment costs.
- Effective primary mental health care services require the development of mechanisms for multidisciplinary input into their delivery. It is important that the expansion of the primary mental health workforce includes appropriate guidelines and mechanisms to ensure that service delivery is based on best practice and interventions of known efficacy.
- The government's Primary Health Care Strategy provides challenges and opportunities for nurses to develop more integrated and collaborative models of service delivery in community and primary health care settings. Mental health nurses working in community and primary health care settings will need to be involved in the development of new ways of working as Primary Health Organisations (PHO) are progressively implemented. It seems appropriate to consider developing the primary health care nursing role as the top priority in establishing a multidisciplinary approach to mental health service delivery. Part of actioning this priority would be to develop mechanisms that ensure:
  - registered nurses working in primary health care settings demonstrate core mental health competencies, to effectively screen and assess clients with mental health problems
  - mental health primary health care providers work with PHOs to develop innovative nursing initiatives based on evidence and best practice to provide

assessment, brief interventions of known efficacy and case management services for people with mild to moderate mental health problems in the community.

- In addressing primary health care workforce development needs, credentialing and quality improvement issues, an essential expectation is that primary health care providers are competent in managing mild to moderate mental disorders. Although the move to capitation may remove the financial disincentives against GP participation in specialist mental health training, a remaining need, once the work to develop service components is completed, is the need to identify and organise suitable training for GPs and primary health care nurses. Implementing this recommendation should include establishing mechanisms for ensuring that primary health care practitioners receive ongoing support and training in primary mental health care.
- Ongoing planning should be cognisant of new, innovative models of service delivery that are both cost effective and beneficial to service users. Implementing this recommendation would include considering further the use of cognitive behavioural therapy programmes that are CD-ROM–based.
- To inform future policy development, there should be a stocktake of local initiatives that aim to transfer clinical service provision for people with severe mental health problems from specialist mental health services to primary health care services. This stocktake should include a review of:
  - current and planned initiatives
  - funding and pricing models used in these initiatives
  - mechanisms for monitoring and evaluating initiatives
  - results of any evaluations.
- Further work on the national service framework for specialist mental health services should identify as a priority the improvement of the interface between specialist mental health services and primary health care services. The possibility of developing a more integrated model of service provision should be considered.
- Provision of mental health services to people with multi-agency high support needs (severe disability) should remain the role of specialist mental health services. However, the role of primary health care providers is likely to develop considerably over the next few years, with moves to a broader base of multidisciplinary service provision and the ongoing workforce constraints in the specialist mental health sector. Given this probable trend, there is a need for further clarity and consistency with respect to the role of primary health care providers in delivering mental health services to the remaining people with severe mental health problems. Information from the stocktake and review, as recommended above, should be used in decision-making regarding this issue.

1 Introduction

In February 2001 the Minister of Health released the Primary Health Care Strategy. It identified the following six key directions for primary health care in New Zealand.

1. Work with local communities and enrolled populations.
2. Identify and remove health inequalities.
3. Offer access to comprehensive services to improve, maintain and restore people's health.
4. Co-ordinate care across service areas.
5. Develop the primary care workforce.
6. Continuously improve quality using good information.

The Strategy is to be implemented in an evolutionary manner, with early priority given to:

- reducing barriers, especially financial barriers, to access
- supporting the development of PHOs
- encouraging multidisciplinary approaches to service delivery and decision-making
- supporting the development of Māori and Pacific providers
- facilitating enrolment through public education/information.

The Clinical Services Directorate in the Ministry of Health is leading a number of projects to develop implementation plans for the Primary Health Care Strategy. Its work includes the development of specific work streams to consider, in relation to primary health care services:

- implementation of the Primary Health Care Strategy in rural New Zealand
- review of the Community Services Card
- development of minimum requirements and guidelines for PHOs
- the role of nurses in primary health care
- workforce development issues in relation to implementation of the Primary Health Care Strategy
- issues in relation to the development of a capitated funding formula.

In this context the Mental Health Directorate is working closely with the Clinical Services Directorate. This joint approach is to ensure that plans developed in the primary health care sector are consistent with the National Mental Health Strategy and address the primary mental health needs of the population.

The Mental Health Directorate has therefore commissioned this report on issues in relation to primary mental health care in New Zealand. Although it refers to possible models for addressing some of these issues, this report is not intended as a detailed plan for implementation of primary mental health care. Rather, it provides a broad overview of the issues that need to be incorporated into future decision-making regarding:

- the implementation of the Primary Health Care Strategy with respect to primary mental health services
- the relationship between primary health care and specialist mental health services
- the implementation of the National Mental Health Strategy.

2 Background Information

The Mental Health Directorate in the Ministry of Health is focused on leading the implementation of the National Mental Health Strategy. The aim of this Strategy is to develop more and better specialist mental health services for the 3 percent of the population with the most serious mental health problems.

The level of funding for specialist mental health services in New Zealand allows for less than 1 percent of the population to access these services in any one month.[1] Consequently, a considerable amount of work is in progress to expand the capacity and range of specialist mental health services nationally. The Government has made available additional funding (Blueprint Funding) specifically for this work.

To build on the gains of recent years, it is essential that implementation of the National Mental Health Strategy continues. However, it is also important to consider the mental health needs of the wider population.

The Ministry of Health's (1997) *Moving Forward*: *The National Mental Health Plan for More and Better Services* details the prevalence of mental disorders (including drug and alcohol problems) as follows.

- About 3 percent of adult New Zealanders have severe mental health disorders. (Of these, an estimated 0.06 percent have complex problems with very high support needs and a further 0.38 percent have severe disability.)[2]
- Another 5 percent of adult New Zealanders have moderate/severe mental health disorders.
- Another 12 percent of adult New Zealanders have mild/moderate mental health problems or disorders.

Of particular relevance to primary health care are the needs of the 17 percent of the population experiencing some form of diagnosable mental health disorder that requires intervention/treatment but does not fall into the category of the '3 percent with the most severe problems'. The people in this 17 percent group range from those with mild mental health problems to those with moderately severe mental health problems. For the purposes of this report, these people are described collectively as having 'mild to moderate mental health problems'.

It is well recognised internationally (Jenkins and Strathdee 2000) that the mental health needs of most people with mild to moderate mental health problems must be met in a primary health care setting. Furthermore national and international epidemiological research has found a high prevalence of mental health problems amongst people presenting to primary health care services.

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1 Preliminary data from the New Zealand Health Information Service as captured by Mental Health Information National Collection.

2 Estimates of the prevalence of 'disability' are taken from the Mental Health Commission (1999).

The World Health Organization (WHO) study of prevalence of mental health problems in primary care identified that 24 percent of people presenting to primary health care services have a major psychiatric disorder, while a further 9 percent have a subthreshold disorder (using ICD-10 criteria). Preliminary findings from a local investigation (the MaGPle study) (J Bushnell, personal communication, 2001) confirm New Zealand also has a high prevalence of mental health disorders amongst people presenting to general practitioners (GPs). Although the findings from this study are still being analysed, the early indication is that as many as 35 percent of people presenting to GP practices meet the DSM-IV criteria for a mental disorder. However, these people often do not present with a mental health disorder as their primary problem (J Bushnell, personal communication, 2001). Evidence from international research suggests that mental health problems are frequently missed in primary care consultations; up to 50 percent are not detected explicitly by the GP.

No local work has yet quantified the cost of undiagnosed and untreated mental illness, although the MaGPle study will cast light on this issue. Findings from international research, however, indicate that it is likely to be high. Jenkins and Strathdee (2000) report that the 'immense' costs of ignoring the burden of mental disorder in society include the costs of:

- repeated GP consultations
- sickness/absence from employment
- labour turnover
- reduced productivity
- the impact on family and children.

Furthermore, a WHO report (Murthy and Bertolete 2001) identifies mental disorders as the leading cause of disability burden to society. Taking the disability component of burden alone, estimates show that mental health and neurological conditions account for 30.8 percent of all years lived with a disability (YLDs); depression causes the most of all disability (12 percent).

Hence emerging data and anecdotal feedback indicate a need to ensure that mental health service provision is a key facet of primary health care. However, in the absence of any national direction or consistency in service delivery, there is currently considerable variation in how much and how well mental health needs are addressed in primary health care settings. Indeed it is likely that a significant portion of the population have their mental health problems unrecognised or inadequately treated.

The key issues that impact on service delivery in this area are identified and discussed in Sections 3 and 4. For practical reasons this report has been structured so that issues in relation to people with 'mild to moderate mental health problems' and those in relation to people with 'serious mental health problems' are discussed separately. However, these are not entirely separate groups. Individuals move into, out of and between these two groups as their needs change over their lifetime.

3 Mental Health Services for People with Mild to Moderate Mental Health Problems (17 percent of the population)

3.1 Overview of the New Zealand situation

The delivery of primary mental health services requires a somewhat different approach to delivering other primary health care services. For example:

- generally more time is needed to assess the problem as it requires a detailed history-taking rather than a brief description of symptoms and physical test(s)
- interventions are often time consuming, requiring close face-to-face and telephone follow-up
- multidisciplinary input is usually required.

Most GP services are funded on a fee-for-service basis. Under this system, GPs claim government funding for each individual they see, and service users pay a part-charge towards their visit. GP appointments are typically scheduled at 15-minute intervals; neither government funding nor service user part-charges vary for the time taken. Funding for practice nurses is based on the 'practice nurse subsidy'. As a result, there is no incentive to develop the practice nurse role into that of autonomous case manager.

Although many people with mental disorders present to primary care services, the nature and level of primary mental health care provided are variable around New Zealand. As service provision depends on the interest and expertise of individual practitioners, models and standards of service delivery are haphazard and inconsistent. Not surprisingly, given the current funding approach, most primary mental health services are focused on GPs, with only minimal use of practice nurses or other health professional groups.

The barriers to the provision of effective primary mental health services in New Zealand are described in greater detail below, in relation to:

- cost to the GP
- cost to the service user
- GP confidence and competence.

Cost to the GP

In an Otago study, Bathgate, Bermingham, Curtis and Romans (2001) identified that although GPs are keen to be involved in the provision of primary mental health services, time and cost represent major obstacles to their ability to do so. The current funding system, which is based on a fee-for-service arrangement and 15-minute appointments, provides neither the incentive nor the opportunity for primary health care providers to deliver the range and type of services that will meet the needs of people with mental health problems.

Among the difficulties with the current GP remuneration system are that it does not provide for:

- the longer appointments required for mental health consultations (particularly assessments)
- the telephone follow-up with the client and other agencies that is necessary for effective mental health services
- the development of multidisciplinary teams in the primary health care setting.

Cost to the service user

The New Zealand primary health care system is funded by a combination of public and, through the service user part-charge, private funding. The part-charge has particular significance to mental health service provision because service users are likely to require more than a one-off consultation to address their mental health needs; often they have regular follow-up appointments, such as weekly sessions for six weeks. Repeated use of the service creates a cost burden for these people.

The situation is further complicated by an apparent inequity. Namely, people with access to specialist mental health services do not incur a service user part-charge, while those accessing GPs do.

All of these factors create a financial incentive for both GP and service user to meet the user's needs through specialist mental health service care.

GP confidence and competence

GP confidence, skill and expertise form another barrier to the provision of primary mental health care. This issue requires further consideration.

The Otago study (Bathgate et al 2001) indicated that GPs were confident in diagnosing common conditions such as depression and anxiety but were less confident about conditions such as alcohol and drug problems, somatisation, personality disorders and eating disorders. GPs who had received some specialised psychiatry training were no more confident than others in their diagnostic and management skills. Supporting these findings, other researchers (Rutz, Von Knorring and Walinder 1992) showed that the benefits of an intense education programme did not last longer than three years.

Providers of postgraduate medical education also report that the funding system provides no incentive for GPs to access postgraduate training in mental health. The University of Auckland has developed a Diploma in Mental Health programme for GPs. However, it has not yet delivered the programme because GPs consider they would receive little or no return for the financial and time costs of completing it.

Several changes identified as part of the Primary Health Care Strategy have the potential to address the disincentives operating against the provision of primary mental health services. In particular, the move to a capitated funding system, workforce development initiatives such as the development of a more comprehensive primary health nursing role could contribute to more comprehensive primary mental health services for people with mild to moderate mental health problems. Because the details of these plans are not yet developed, it is not possible to identify which models will be most appropriate or the exact impact of these changes.

3.2 Overview of international trends

The literature clearly supports the view that primary health care services have a key role in the provision of mental health services, particularly for those people with mild to moderate mental health problems. The most common types of problems that will require intervention at a primary health care level are depression, anxiety and alcohol and drug problems. The prevailing view is best summarised in the WHO Report 2001 (Murthy and Bertolote 2001). It states as its first recommendation:

> *'The management and treatment of mental disorders in primary care is a fundamental step which enables the largest number of people to get easier and faster access to services – it needs to be recognized that many are already seeking help at this level. This not only gives better care; it cuts wastage resulting from unnecessary investigations and inappropriate and non-specific treatments.'*

In regard to models of primary mental health service delivery, the literature identifies the role of professional groups – such as nurses, social workers, counsellors and psychologists – as a key issue. Generally, models are reported through a case study type of approach after being trialled in various services. Often the outcomes of such models have not been evaluated formally, hence there is no conclusive evidence on which of the various models is most effective. One United Kingdom study of mental health professionals working in general practices (Corney 1999) suggests that, overall, GPs considered that they and 'their patients' received the most benefit from employing nurses in a mental health role in their practices.

In the United Kingdom new funding for 1000 new primary care mental health workers will be available from 2003/04 (United Kingdom Department of Health 2001). The specific roles and responsibilities of these workers are yet to be developed. However, it is intended that they will have three broad areas of responsibility:

1. client work – information provision, assessment, screening and onward referral where appropriate, as well as the provision of brief evidence-based therapeutic services such as anxiety management and cognitive behavioural therapy (CBT)
2. practice team work – support for audit, routine measurement of outcomes, implementation of referral protocols and liaison with specialist mental health services
3. wider network – liaison with other statutory and non-statutory sector services such as housing, welfare and social services.

To support these extended responsibilities, it is intended to establish a national programme of locally focused, modular accredited training so that primary mental health care staff can strengthen their knowledge, competence and teamwork.

A recent article in the *British Medical Journal* (Von Korff and Goldberg 2001) provides support for the development of this type of primary care mental health worker. After reviewing 12 different trials of enhanced care for major depression in primary health care settings, the authors concluded that 'both effective and ineffective interventions used treatment guidelines, patient education and screening for depression'. They found the interventions that consistently improved patient outcomes incorporated some form of 'case management with specialist support'.

In general, non-medical staff carried out the case management functions. In many trials, much of the follow-up was conducted over the phone at low cost per 'case treated'. Case management typically encompassed the responsibilities of:

- taking responsibility for patient follow-up
- determining whether patients were continuing the prescribed treatment as intended
- assessing whether depressive symptoms were improving
- taking action when patients were not adhering to guideline-based treatment or were not showing expected improvement.

The Von Korff and Goldberg study (2001) also examined the effects of providing mental health specialist support to primary care practitioners (see Section 4.2 for a description of various models). Its results indicated that such support is likely to benefit people with mild to moderate mental health problems who are receiving services from a primary health care practitioner.

In Australia a National Primary Mental Health Care initiative to promote systemic change in the delivery of primary mental health care was launched in 1999. This ongoing initiative has (Catchpole 2001):

- appointed a national primary mental health co-ordinator to provide leadership and support in the advancement of primary mental health care nationally
- established the Primary Mental Health Care Australian Resource Centre to foster the development of best practice models in education, training and shared care
- developed a primary care psychiatry scholarship fund, which offers two-year scholarships to GPs studying for postgraduate qualifications in mental health.

In addition, subject to final budget approval, the following changes to GP funding for mental health are planned (L Latham, Mental Health Development and Liaison Officer, Queensland Divisions of General Practice, personal communication, 2001).

- A $56 million package of care funding will encourage better assessment, more focused planning between the GP and client, and a structured review to support follow-up. This approach will be modelled on the idea of a 'package of care' involving three encounters between GP and client. The GP can claim funding at two levels – one level is for consultations of at least 20 minutes' duration and the other is for those of at least 40-minute duration.

- $15.7 million will be made available over three years to fund a specific MBS counselling item available only to GPs with appropriate training in psychological medicine. It will be available for a maximum of 12 counselling sessions per patient per year. It is estimated that this fund can purchase about one million sessions for about 180,000 people receiving on average six sessions each.
- A committee is to be convened to develop guidelines and models for contracting allied health services to support GPs.

Most of the literature reviewed concentrates on traditional models of service delivery. However, some emerging evidence indicates that more innovative, accessible and cost-effective methods of service delivery, particularly self-help approaches, may be possible. Among these methods are the use of assisted bibliotherapy for moderate anxiety problems and a range of technologies based around CD-ROMs. The National Institute for Clinical Excellence in the United Kingdom is appraising CD-ROM–based CBT, while a pilot study for self-management of depression is under way in Canada.

3.3 Recommendations and issues for further consideration

A number of issues identified above need to be considered in planning for the implementation of the Primary Health Care Strategy. In view of this need, the following recommendations are made.

- Plans for the implementation of the Primary Health Care Strategy should state explicitly that primary health care providers will be expected to incorporate a substantial mental health component into their work in a systematic way. This could be initiated by the development of a detailed service specification for mental health to be included in the initial set of Establishment Service Specifications.
- Over the medium term, primary health care providers should take the lead role in delivering mental health services to people with mild to moderate mental health problems. Effective primary care interventions for this group will include a combination of:
  - pharmacology
  - therapeutic interventions of known efficacy
  - provision of information to support self-help
  - a case management approach.
- Once a service specification is developed, the capitated funding formula for primary health care will need to be adjusted to include primary mental health services. The costs to both GP and service user should be considered in this regard. Furthermore, if the capitated funding model includes additional targeted payments for specific service areas mental health should be considered as one such service, given that:
  - mental health is a national health gain priority
  - the prevalence of mental health problems in primary care is high
  - the costs associated with time-consuming assessment, interventions and case management are higher than average treatment costs.

- Effective primary mental health care services require the development of mechanisms for multidisciplinary input into their delivery. It is important that the expansion of the primary mental health workforce includes appropriate guidelines and mechanisms to ensure that service delivery is based on best practice and interventions of known efficacy.
- The government's Primary Health Care Strategy provides challenges and opportunities for nurses to develop more integrated and collaborative models of service delivery in community and primary health care settings. Mental health nurses working in community and primary health care settings will need to be involved in the development of new ways of working as PHOs are progressively implemented. It seems appropriate to consider developing the primary health care nursing role as the top priority in establishing a multidisciplinary approach to mental health service delivery. Part of actioning this priority would be to develop mechanisms that ensure:
  - registered nurses working in primary health care settings demonstrate core mental health competencies, to effectively screen and assess clients with mental health problems
  - mental health primary health care providers work with PHOs to develop innovative nursing initiatives based on evidence and best practice to provide assessment, brief interventions of known efficacy and case management services for people with mild to moderate mental health problems in the community.
- In addressing primary health care workforce development needs, credentialing and quality improvement issues, an essential expectation is that primary health care providers are competent in managing mild to moderate mental disorders. Although the move to capitation may remove the financial disincentives against GP participation in specialist mental health training, a remaining need, once the work to develop service components is completed, is the need to identify and organise suitable training for GPs and primary health care nurses. Implementing this recommendation should include establishing mechanisms for ensuring that primary health care practitioners receive ongoing support and training in primary mental health care.
- Ongoing planning should be cognisant of new, innovative models of service delivery that are both cost effective and beneficial to service users. Implementing this recommendation would include considering further the use of CBT programmes that are CD-ROM based.

4 Primary Health Care for People with the Most Severe Mental Health Problems (3 percent of the population)

4.1 Overview of the New Zealand situation

As noted in Section 2, the aim of the National Mental Health Strategy is to develop more and better services for the 3 percent of the population who have the most serious mental health problems. Specialist mental health services are targeted at this group.

The needs of people in this 3 percent group, and how those needs are met, vary considerably. The group can be split into three broad subgroups.

1. 0.44 percent of the population have severe disability. Anecdotal evidence suggests that almost everyone in this subgroup receives specialist mental health services, which generally include a range of community- and inpatient-based services. These people are likely to be frequent and high users of inpatient services.
2. An additional 0.6 percent[3] of the population are accessing specialist mental health services. People in this subgroup are likely to be receiving a range of multidisciplinary community-based specialist mental health services, as well as possibly using inpatient services from time to time.
3. The remaining 2 percent of people are targeted for specialist mental health services but are not receiving them. There are no clear data to identify how the mental health needs of this subgroup are met. However, it is likely that some receive mental health services in some form from primary health care providers.

The primary health care services delivered to a range of people in the 3 percent group relate to both their physical and mental health needs. There is no national data on how many people in this group access primary health care providers for mental health services nor, for those who do access them, on what type of mental health services the primary health care providers deliver.

In recent years a number of ‘pilot initiatives’ have been undertaken to transfer the lead role in clinical service provision for people with severe and ongoing mental health problems (including those with multi-agency high support needs) from specialist mental health services to GPs. These initiatives have generally been developed in response to a local need or interest, without national or regional co-ordination.

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[3] Data on the percentage of the population accessing specialist mental health services are preliminary only. Therefore, the percentages quoted in this report should be considered as indicative only.

Because of the ad hoc nature of their development it is difficult to get comprehensive information regarding the nature and extent of these initiatives nationally. For the purposes of this report, meetings were held with representatives of the Capital and Coast/Wellington Independent Practice Association initiative and the Newtown Union Health Centre initiative. Information regarding the Hawke's Bay Shared Care Pilot Project was also reviewed. From this brief review, the following key issues in relation to this type of initiative were identified.

- Providers are eager for a more co-ordinated approach to such initiatives. They would welcome the opportunity to share information with people involved in similar programmes.
- The national mental health purchase framework does not provide for this type of initiative.
- Funding and pricing mechanisms for the initiatives vary considerably with funding sources. Variations include:
  - District Health Board (DHB) provider arm funding for specialist mental health services, which are subcontracted to PHOs
  - DHB funder arm mental health contracts (formerly Health Funding Authority mental health contracts)
  - funding via primary care contracts
  - use of the disability allowance (Work and Income New Zealand funding).
- Some initiatives and contracts are not actively monitored or lack any formal evaluation processes.

Anecdotal feedback suggests that a number of new initiatives of this type are being planned in various places nationally. However, it was not within the scope of this review to complete a stocktake of all initiatives, current and planned.

No national guideline or policy covers the interface between specialist mental health services and primary health care services. In general, the two operate as distinct 'hard-pressed services' that relate poorly to each other. Models and standards of practice vary considerably, with few opportunities for information sharing.

However, some specialist mental health service providers have attempted to improve the interface between their services and primary health care services. Such initiatives are generally based on a consultation/liaison type of model. Once again, because these initiatives have been developed at a local level, there is little information available on the extent to which the practice has been developed nationally or on their outcomes.

4.2 Overview of international trends

It is generally accepted that people with multi-agency high support needs (severe disability) require specialist mental health services with a recovery-oriented, case management and partnership approach. Ideally these services should be provided by a well-integrated multiple service mental health sector that addresses clinical and non-clinical needs, including those related to housing, employment and education. Consequently the complex multi-agency needs of this group are generally not best suited to the primary health care setting.

One of the major primary health care issues for people in this group is the importance of having a clearly identified GP who is able to address their physical health needs. The other is the necessity of a good relationship between the GP and mental health services, along with effective communication channels.

The remainder of those with severe mental health disorders are also likely to require a range of community-based multidisciplinary services. In some circumstances they may need access to short-stay, acute inpatient services. The degree to which primary health care providers should be involved in providing mental health services to this group is not clearly identified nationally or internationally.

What is clear is that the key issue for this group is the quality of the interface between specialist mental health services and primary health care services. Various models to improve this interface have been suggested in the literature. Most models focus on various mechanisms for attaching mental health clinicians to primary health care services. The roles and responsibilities of these clinicians differ depending on the model used; the most common models of service provision fall into one of the following four categories.

1. **Shifted outpatient clinics** – visiting mental health clinicians operate in primary health care settings to provide services to both new and follow-up clients. Services may be relatively independent of GPs. Clinicians do not have fixed meetings with the primary health care teams and may have little or irregular contact.
2. **Consultation liaison** – mental health clinicians meet regularly with primary health care practitioners to advise on providing services to specific individuals whom the GPs are treating for a mental health problem. Joint sessions may be held with the client for assessment or review by the specialist mental health clinician. The aims of this model are to encourage appropriate referrals to specialist services (decreasing referrals for people with mild to moderate problems and increasing referrals for people with serious mental health problems) and to enhance the GP's skills in detecting and treating mental health problems.
3. **Location of a named mental health worker in primary care settings** – mental health professionals employed by specialist mental health services are attached to a primary health care team as a named link person. Their roles and responsibilities vary but may include direct service delivery, consultation and liaison, and education and training.

4 **Co-location of mental health and primary care teams** – this model, being trialled in parts of the United Kingdom (Briscoe 2001), involves co-locating specialist mental health and primary health care services at the same site. In addition, there are moves to blur the boundaries between the two teams in order to develop an integrated, streamlined service. Anecdotal feedback from services such as Small Heath Birmingham is that co-location of these teams has proved an effective mechanism for countering the stigma associated with people with mental health problems.

Most of the literature on these models describes specific projects or initiatives in a case study type of approach. To date, because relatively little formal evaluation of these models has been undertaken, data regarding their outcomes are minimal. Furthermore, there is a dearth of literature regarding their funding mechanisms.

In the literature on the interface between specialist mental health and primary health care services, the key points may be summarised as follows.

- Improving this interface should not mean diverting scarce, highly trained specialist resources from services to those with the greatest need.
- Mental health workers who work at the interface should divide their time among face-to-face work with those most in need, shared care and consultation activities and providing support and education to the primary health care team.
- The interface works more efficiently and effectively with good communication between the services, agreed criteria for referral and discharge, agreed guidelines and mutual support.

4.3 Recommendations and issues for further consideration

A number of issues identified above need to be considered in planning for the implementation of the Primary Health Care Strategy and ongoing implementation of the National Mental Health Strategy. In view of this need, the following recommendations are made.

- To inform future policy development, there should be a stocktake of local initiatives that aim to transfer clinical service provision for people with severe mental health problems from specialist mental health services to primary health care services. This stocktake should include a review of:
  - current and planned initiatives
  - funding and pricing models used in these initiatives
  - mechanisms for monitoring and evaluating initiatives
  - results of any evaluations.
- Further work on the national service framework for specialist mental health services should identify as a priority the improvement of the interface between specialist mental health services and primary health care services. The possibility of developing a more integrated model of service provision should be considered.

- Provision of mental health services to people with multi-agency high support needs (severe disability) should remain the role of specialist mental health services. However, the role of primary health care providers is likely to develop considerably over the next few years, with moves to a broader base of multidisciplinary service provision and the ongoing workforce constraints in the specialist mental health sector. Given this probable trend, there is a need for further clarity and consistency with respect to the role of primary health care providers in delivering mental health services to the remaining people with severe mental health problems. Information from the stocktake and review, as recommended above, should be used in decision-making regarding this issue.

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