

Primary Mental Health Care in New Zealand

March 2008

Ministry of Health Update

This update provides information on developments in primary mental health care, particularly those led by the Ministry of Health. Much of this March issue is dedicated to discussing the potential policy direction of primary mental health care and some of the principles underlying the policy development.

Dr Geraldine Strathdee's Reflections on Primary Mental Health Care

Dr Geraldine Strathdee is a consultant psychiatrist for the Oxleas NHS Foundation Trust in the UK and an international expert in primary mental health care. In October and November 2007, she attended the primary mental health regional network meetings held in Auckland, which consisted of five local hui.

Geraldine's reflections on the Auckland workshops include the following themes.

- There is high value in setting up a primary mental health website or network to share information and learning across different regions.
- There are a large percentage of people with medically unexplained symptoms that are actually due to psychological problems. Addressing the mental health issues frees up resources being used to treat the physical health symptoms or being wasted in days off sick from work.
- The link between economic evidence and service models should be highlighted in the argument for further primary mental health development.
- There is recognition of the importance of addressing mental health issues for children and young people, for example, through teaching life skills, how to manage mood and anxiety, addressing bullying and learning problems through schools.
- There are workforce implications if specialist mental health staff shift to work in primary health care.
- Private psychologists and counsellors are a potential untapped workforce.
- Key performance indicators need to be identified, for example, availability of a directory of all the community services in the area.
- Addressing mental health problems requires understanding the determinants of mental health problems and a joined up approach where targets are shared across different sectors, for example, for getting people back to work, health utilisation, economic data.
- Need to take a holistic approach, especially for Māori for whom whānau, physical and spiritual health are inextricably linked to psychological health and life.
- Technology can be used in innovative ways to support primary mental health care.
- The interface between primary and specialist mental health care is very important and can help to determine how a stepped care approach could work.

A Stepped Care Approach to Primary Mental Health Care?

The evaluation of the primary mental health initiatives, conducted by the Wellington School of Medicine, shows that the initiatives have good access rates by Māori and that nearly 80 percent of service users improved. Such findings help to justify the continued development of primary mental health care. The lack of differentiation in clinical effectiveness across different primary mental health care models provides no obvious basis for primary mental health policy to favour one service delivery model over another. However, one thing that all of the models have in common is that they introduce another level of care that people with mild to moderate mental health problems previously did not have as an option.

Extended GP consultations, assessments by primary mental health co-ordinators, and packages of care all represent an additional service 'step' between traditional primary health care (standard GP consultations) and secondary or specialist care. In other words, all of the models have moved towards a 'stepped care' approach to primary mental health service provision.

A stepped care model is one in which:

- there are interventions of different levels of intensity available to the service user
- the service user's needs are matched with the level of intensity of the intervention
- patients usually move through less intensive interventions before receiving more intensive interventions (if necessary)
- there is careful monitoring of patient outcomes, allowing treatments to be 'stepped up' if required
- there are clear referral pathways between the different levels of intervention
- the importance of supporting self care is recognised as an important aspect of managing demand (Chapple and Rogers 1999).

Figure 1 attached to this update provides a visual representation of a stepped care model.

In this figure, the pyramid is used to represent the proportion of the population who have mental health problems of increasing severity (Oakley Browne et al 2006). The black box around the centre of the pyramid represents the target group for primary mental health care. The box depicts that the majority of primary mental health patients have mild to moderate mental health and/or addiction problems. Ideally, primary health care also promotes and supports health while people are well and has a role in supporting people with severe mental health problems, either through facilitating clear referral pathways or managing the care of people with stable conditions.

The figure also shows how patients' needs may be matched with services of different levels of intensity. For example, the needs of service users with mild mental health problems may adequately be addressed through extended GP consultations, active monitoring, lifestyle advice and/or green prescriptions, electronic or web tools, or referral to libraries to access self-help resources. Patients with moderate mental health problems may require a more thorough assessment by a primary mental health co-ordinator, possibly followed by a package of care or drug prescription (eg, SSRIs). Several screening tools are available that may be used to help clinicians in their assessment of the level of patient need.

Finally, the model also shows the importance of a supportive environment and health promotion, relevant to the whole population. Initiatives such as the National Depression Initiative (NDI) and Like Minds help to provide an environment in which primary mental health care is strongly supported.

There is now evidence for both the clinical and cost-effectiveness of stepped care models (Needham 2007; Walters and Tylee 2005). Potential benefits of a stepped care approach include:

- increased recognition rates (Walters and Tylee, 2005)
- greater numbers of people receiving treatment for mental health and addiction problems
- increased recovery rates (Walters and Tylee, 2005)
- reduced disability and impairment related to work, family, and social participation
- reduced socioeconomic and ethnic inequalities in mental health and addiction
- economic and social benefits associated with fewer patients developing more severe mental health and addiction problems
- a more cost-effective way of delivering services
- shorter waiting times (Needham 2007)
- reduced demand for specialist mental health and addiction services
- reduced stigma for patients

- a more relaxed environment for the patient
- increased patient satisfaction
- a more holistic and integrated approach to treating health problems
- greater opportunities for promotion, prevention, and early intervention in mental health and addictions
- enhanced communication between GPs and specialists.

Regardless of the overall service delivery model adopted, District Health Boards (DHBs) and Primary Health Organisations (PHOs) will need to tailor service configuration to the needs of the local population. Many decisions remain concerning workforce development, the unique needs of different population groups, and the resources required.

The principles that could underpin future primary mental health policy development are summarised below.

1. Adopt a stepped care model of service provision.
2. Have the flexibility to tailor service configuration to the characteristics of the population and providers in different regions.
3. Identify and address the underlying determinants of mental health problems.
4. Be clinically and cost effective by matching service users' needs with the least intensive yet effective level of intervention.
5. Support people with mild to moderate mental health problems through active monitoring, provision of lifestyle advice, and connecting people with self-help resources such as books and e-therapies.
6. Better support self care.
7. Provide evidence-based psychosocial interventions as a treatment option for people with mental health or addiction problems.
8. Have some flexibility to provide complementary and alternative treatments and traditional healing options when the efficacy of such interventions can be demonstrated.
9. Have clear referral pathways and good integration with specialist mental health services.
10. Listen to service users and identify and build upon each individual's assets, strengths, and areas of health and competence.

Meeting the Unique Needs of Māori

Māori as a population have a higher prevalence and severity of mental disorder than others (Oakley Browne 2006). Although the majority of Māori experiencing mental health problems do not receive any form of care, GPs are the leading point of contact for those who do (Oakley Browne 2006). To address inequalities, it will be important to identify the unique primary health service requirements for improving Māori access, detection and appropriate management of mental health problems.

Findings from the New Zealand Health Survey, showing that Māori have lower access rates to GP services than NZ European/Pākehā (Ministry of Health 2004), suggest that initiatives aiming to enhance Māori pathways to primary health care for mental health needs will need to enhance access to primary health care generally.

Appropriate management of Māori mental health problems is likely to include consideration of cultural identity, whānau ora, Māori models of health, and offering a choice of kaupapa Māori or mainstream services.

The policy paper will also identify some of the unique service requirements for Pacific peoples and other population groups.

Current Activities of Primary Mental Health Team

In addition to developing the policy advice on primary mental health care, the team is involved in several other activities. Nemu Lallu has been renegotiating contracts with DHBs and PHOs for the one-year extension of funding, based on what was learnt from the evaluation.

Kristan Johnston has been involved in securing extra one-off funding targeted at PHOs with established initiatives that have the lowest levels of funding relative to their enrolled population. This funding should enable several PHOs to provide more primary mental health services in the immediate financial year.

Alana Ruakere is overseeing a contract with Te Pou to set up a website or clearinghouse dedicated to primary mental health care. This site will contain useful details about the tools and interventions being used in different initiatives and enable easier sharing of information. We will let you know when this site 'goes live'. Te Pou will also develop an 'early implementation plan' for primary mental health workforce development.

Planning is also under way for an action research project to develop and evaluate demonstration sites for the better management of depression and reduction of suicide attempts. This work follows the positive findings from the Nuremberg Alliance against Depression (Hegerl et al 2006), which established and assessed the effectiveness of a four-level intervention program including training for GPs, a public relations campaign about depression, cooperation with community facilitators (eg, teachers, church leaders, local media), and self help activities for at risk groups.

In the next few months, we will be releasing a Request for Proposals (RFP) that aim to develop and trial computer administered cognitive behaviour therapy (CBT) for adults within the primary health care environment. This will mirror some of the work, already funded through the Ministry, on the development of e-therapies for young people.

Finally, the New Zealand Guidelines Group (NZGG) has recently released the draft *Guidelines for the Identification of Common Mental Disorders and Management of Depression in Primary Care*, along with an implementation plan for the Guidelines. The Ministry of Health is currently finalising the implementation plan to help ensure the Guidelines have wide uptake within the sector. The final Guidelines should be available soon.

Other Related Activities: Working New Zealand Programme

New health and disability services, provided through Work and Income's 'Working New Zealand: Work Focused Support' programme, are being introduced to support people with ill health and disabilities move toward suitable work.

Research shows that increased access to evidence-based services such as cognitive behavioural therapy, counselling and extended GP consultations, has a significant impact on their wellbeing and ability to engage in paid work.

Dr David Bratt, Principal Health Advisor, says, 'The Ministry of Social Development is initially purchasing services for people with mild to moderate mental illness and is looking to engage with providers of contracted primary mental health services.'

The mild to moderate mental health services offered by the Ministry of Social Development are being developed in collaboration with DHBs and PHOs. Services will become progressively available nationally through 2008.

Invitation to Contribute to Policy Paper

If you have any comments on the principles being considered in policy development (outlined above) or have ideas that you would like to see reflected in the first draft of the policy paper on primary mental health care, please feel free to email Dr Sarah Dwyer: sarah_dwyer@moh.govt.nz.

References

Chapple A, Rogers A. 1999. Self-care and its relevance to developing demand management strategies: A review of qualitative research. *Health and Social Care in the Community* 7: 445–54.

Hegerl U, Althaus D, Schmidtke A, Niklewski G. 2006. The alliance against depression: 2-year evaluation of a community-based intervention to reduce suicidality. *Psychological Medicine*, 35, 1225–1233.

Oakley Browne MA, Wells JE, Scott KM (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.

Ministry of Health. 2004. *A portrait of health: Key results of the 2002/03 New Zealand Health Survey*. Wellington: Ministry of Health.

Needham M. 2007. *Treating common mental health problems through stepped care: Informing commissioning, provider management and practice based commissioning in primary care*. Cheshire, England: Care Services Improvement Partnership (CSIP), North West Development Centre.

School of Medicine & Health Sciences, University of Otago. 2007. Primary mental health initiatives: Interim report. Report prepared for the Ministry of Health. Wellington: Department of Primary Healthcare & General Practice, School of Medicine & Health Sciences, University of Otago.

Walters P, Tylee A. 2005. In: M Maj, J Lopez-Ibor, N Sartorius, M Sato, A Okasha (eds). *Early detection and management of mental disorders*. World Psychiatric Association. Chichester: John Wiley.