# The challenge of improving access to mental health services within a primary care setting

*Sue Garrett, Tony Dowell, Valerie Bos, Sunny Collings, Lynn McBain and Eileen McKinlay*

*Correspondence to: susan.garrett@otago.ac.nz*

***Sue Garrett** is a Research Fellow from the Department of Primary Health Care and General Practice, Wellington School of Medicine and Health Sciences. She has a Masters in Public Health.*

***Tony Dowell** is a general practitioner in Wellington and Professor of Primary Health Care and General Practice, Wellington School of Medicine and Health Sciences.*

***Valerie Bos** is an Assistant Research Fellow from the Department of Primary Health Care and General Practice, Wellington School of Medicine and Health Sciences. She has a Master of Arts (Applied) – Social Science Research.*

***Sunny Collings** is a Senior Lecturer in Social Psychiatry and Population Mental Health, working in the Departments of Public Health and Psychological Medicine, Wellington School of Medicine and Health Sciences. She is also a Consultant Psychiatrist in the Regional Personality Disorder Service, Capital and Coast DHB.*

***Lynn McBain** is a general practitioner in Wellington and a Senior Lecturer from the Department of Primary Health Care and General Practice, Wellington School of Medicine and Health Sciences.*

***Eileen McKinlay** is a Senior Lecturer from the Department of Primary Health Care and General Practice, Wellington School of Medicine and Health Sciences. She is a registered nurse and quality auditor.*

## ABSTRACT

This paper describes the introduction of Primary Health Organisation (PHO) developed Primary Mental Health Initiatives throughout New Zealand. These initiatives, funded by the Ministry of Health, represent a significant opportunity to improve both access to mental health care, and mental health outcomes. The PHOs have developed a diverse range of locally appropriate services and models of care. The initiatives have led to new roles and ways of working for primary care practitioners, and promoted a multi-disciplinary approach to managing mental health problems in the primary sector.

## Introduction

The increasing recognition of mental disorders as a major public health problem[1,2,3] has emphasised the need to focus on quality and performance in mental health care.

Mental health resources and public funding in most countries have, until recently, concentrated on addressing the needs of those people with severe and enduring mental disorders. In New Zealand, discussion about improving mental health service performance has been largely focused on the '3%', i.e. those with psychotic or mood disorders including bipolar disorder and severe depression. Care of these people is predominantly provided by secondary care services. Recent recognition of patterns in the prevalence and distribution of mental health problems, and the burdens of disorder and disability within the community have generated discussion and debate about how quality mental health care can be delivered in primary care settings including the '17%', being those considered to have mild to moderate mental health disorders.

Historically, the engagement of the primary care sector in helping service users address their mental health problems has been hampered by a lack of funding for comprehensive primary mental health provision, limited availability of, and access to, evidence-based psychological and other therapies, and the limited capacity of the wider health care system to implement and sustain new initiatives in primary mental health. In addition, in many health systems it is challenging to ensure that the extra time required to address psychological issues in primary care settings, is available. One outcome of this is that care has commonly been limited to provision of medication for DSM IV diagnoses.

In New Zealand this has been compounded by the financial barriers of the fee for service system, limiting provision of care to the general practitioner. The consequence of all these factors is that in many instances ei-

ther mental health problems are not presented, elicited or addressed, or the practitioner effectively subsidises the cost of care.

Despite these barriers, up to three quarters of all mental health care in New Zealand is delivered from a primary care context.[4] Recent surveys including *Te Rau Hinengaro: The New Zealand Mental Health Survey*[5] and the MaGPIe study[6] confirm the high prevalence of common disorders in the community. Up to 46.6% of the population are predicted to meet criteria for a disorder at some time in their lives,[5] and 36% of those attending general practice have one or more of the three most commonly presenting disorders: anxiety, depression or substance use disorder.[6]

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While standard measures of quality, performance and good professional practice also apply to mental health care, there are no particular New Zealand standards for mental health care provision in the primary care sector. Until now, the lack of dedicated population-based funding for comprehensive care in this field and the lack of multidisciplinary involvement has inhibited the development of a standard. In the absence of a New Zealand standard, the following parameters seem particularly important:

- Detection and recognition of 'cases' for treatment
- Access to care: barriers and facilitators
- Liaison and integration of care
- Use of 'specialist services'
- Responsiveness to the different needs of individuals and population groups.

In New Zealand the first innovations in primary mental health care were either individual project initiatives from Independent Practitioners Associations (IPAs) to improve access to psychological services, or integrated liaison schemes from Health Care Aotearoa. With the advent of PHOs there were expectations from the Ministry of Health to develop and implement mental health plans, however neither the overall role of the PHO nor the source of funding was explicit for mental health care provision.

A number of PHOs developed and incorporated mental health work streams. Types of programme included access to PHO funded counselling for low-income groups, the introduction of a GP liaison role between primary care and secondary mental health services, outreach clinics involving practice-based consultations with visiting psychiatrists and package-of-care funding assessed for and administered by GPs.

With this in mind, and in an effort to support the implementation of *The Primary Health Care Strategy*[7] the Ministry of Health developed a Request for Proposals (RFP) for Mental Health Initiatives and Innovations, which was sent to PHOs in April 2004 for the purposes of developing a package of initiatives to support PHOs with developing primary mental health care.

The RFP was scheduled to coincide with the release of a Ministry of Health *Service Development Toolkit for Mental Health in Primary Care*.[8] The toolkit aimed to provide relevant evidence and information to assist with PHOs' capacity and capability to deliver primary mental health services.

PHOs were given three months to respond to the RFP, potentially enabling linkages with other agencies in developing proposals. The intention of the Ministry of Health was to provide funding, in addition to 'Blueprint'[9,10] funding for specialist mental health services for severe mental illness, and for PHOs to engage with District Health Boards (DHBs) to ensure proposals were consistent with the DHB's health objectives for their region.

The initiatives and innovations were intended to be demonstration projects from which a range of best practice and evidence-based initiatives could be disseminated throughout the primary care sector.

### Aims

The aims of the Ministry of Health funding for the Initiatives were to reduce the prevalence and impact of mental health problems on enrolled populations, develop the skill mix of primary health care practitioners and build effective linkages with other providers of mental health care.[11] There was an expectation that PHOs would include the following principles in their proposals but beyond this, PHOs were able to develop their own initiatives.

Mental Health Initiatives were to:

- Support a population approach – services could involve mental health education, prevention, promotion; early intervention strategies, screening and assessment services for enrolled populations
- Address the mental health inequalities for high needs groups
- Ensure that mental health is effectively integrated within the primary health care services delivered by a PHO, and integrated with other mental health providers
- Develop and provide culturally responsive services for Maori and for Pacific Peoples
- Promote a multi-disciplinary approach to managing mental illness in the primary sector. This approach could mean more clearly defined roles for groups such as nurses, pharmacists, community mental health workers, psychologists, and the opportunity for participation in traditional healing (for example rongoa).

In a separate process during March/April 2005, the Ministry requested proposals for the evaluation of these primary mental health initiatives.[9] A research group from the Department of Primary Health Care and General Practice from the Wellington School of Medicine and Health Sciences began work on the evaluation in June 2005.

## Methods

### *PHO implementation of new services*

PHOs have used a variety of methods to implement primary mental health care services. These include the establishment of a reference or advisory group to inform decision-making on various aspects of the initiative including its structure. Decisions on structure were also informed by information gathered during community consultation processes and experience using pre-existing PHO mental health or other disease management work streams. In some cases, implementation and design have been driven or motivated by one or more mental health champion(s) already part of the PHO team.

In many cases funding was directed to new positions with minimal time increases for the existing PHO workforce. Many of these new positions have involved a 'mental health coordinator', a generic term for a clinician involved in assessing and referring service users on to various services.

Some initiatives have put the majority of funding into increased time for existing staff (usually GPs and practice nurses) with only a small allowance for a coordinator who usually functions more in a project management role without a caseload.

Many initiatives have included free counselling as part of their new service undertaken by psychologists or counsellors and, in some cases, by the mental health coordinators in addition to the coordination role.

### *Evaluation*

A range of methods are being employed to capture information[12] for the evaluation. This mixed method approach is in line with accepted methodology for health service evaluations. The methods include:

1. Group/individual interviews undertaken with strategic, operational and clinician groups within initiatives.
2. Face-to-face, semi-structured service user interviews undertaken with selected initiatives.
3. Collection and assimilation of quantitative, individual service user data for each initiative.
4. Informal visits to initiatives for the purposes of information sharing.

*Table 1*

| Service | Description |
|---|---|
| **Packages of care** | A specific dollar amount allocated per service user to cover one or more of the following: counselling (variety of modalities), transport, childcare, home help, alternative therapies. |
| **Mental health nurse** | Usually based in one or a small number of practices, service users are referred to the nurse for assessment, coordination of services, sometimes counselling, and referral on to other agencies. |
| **Counsellors/psychologists** | Can be either employees of the PHO or on fee for service contracts. Employed to provide therapeutic intervention to service users. |
| **Mental health coordinator** | Similar role to Mental health nurse but not discipline specific, usually nurses, but also some social workers. Some focus only on coordination role. Caseloads and intensity of work per service user varies across initiatives. |
| **Relapse prevention nurse** | Works with secondary mental health service users who are being referred back to primary care. Develops a wellness plan and sees service user at least four times a year. |
| **Medication review** | Review by pharmacist of current medications. |
| **Chronic care management programme** | Based on pre-existing chronic care management programmes for other diseases, has been modified and is being used for depression. Involves decision support software incorporating a prescribed care pathway. |
| **Kaiawhina/community support worker** | Involves more intensive one-on-one work with service users and can include group work. |
| **Non-clinical coordinator/project manager** | Involves coordinating programmes without the clinical component. Can include managing referrals, providing support to referrers and planning and implementing CPD. |

## Results

The evaluation is in the early stages of data collection and analysis. The following results highlight some of the themes that will form the subject of more data collection and analysis.

### *New services*

A total of 51 projects were submitted during the RFP process, which were assessed by an interdisciplinary panel on two occasions and, following this, 41 PHOs were funded. Some PHOs have combined, resulting in approximately 23 distinct projects, three in the South Island, and the remainder in the North Island. Service provision started for some PHOs in June 2005 with the final two due to start early 2007.

There are many different types of models of care that have been funded and Table 1 details these. Many initiatives involve a combination of one or more interventions listed in Table 1. Each initiative has its own unique combination of services and roles. Table 1 does not reflect the diversity inherent in these programmes but merely acts as a mechanism for summarising what is involved.

### *Reaction to new services*

Overall, patient outcomes have yet to be fully evaluated. The impression, however, is that although many initiatives have had challenges to overcome, these projects are enthusiastically welcomed not only by primary health care staff, but also by the wider community. There has been considerable commitment by most DHBs and PHOs in assisting with the start-up of initiatives and providing ongoing support via reference groups or similar and for some initiatives providing additional funding.

The evaluation team are collecting quantitative data, which will provide 'before' and 'after' mental health status results. Qualitatively, a significant theme is developing of positive responses to these initiatives, in many instances from those who had previously been unable to access a full range of services.

*'...because I have been on antidepressants for about ten years or so. It just didn't seem like I was going anywhere and finally the doctor suggested [funded newly available counselling service] and it was great' – Service user*

A wide variety of agencies are providing support, often using collaborative models of service delivery where the care of service users is individually planned and tailored to specific circumstances. The initiatives have given primary health care staff and their service users a range of low cost, accessible options to deal with these problems.

**It is evident from the variety of staff employed and interventions that local need, capacity, capability and prior PHO health management programmes have shaped what has emerged**

A new workforce of primary mental health care clinicians is developing; these professionals are mainly from nursing backgrounds, often working independently within coordination roles. Success in coordination roles has been largely dependant on individual personalities and the passion given to implementing the new initiatives.

*'This is an expert counselling service and you have more confidence than if you were sending someone to secondary services' – GP*

*'...surprised how many of them seem to have their problems fixed in one session, they [counselling team] are amazing' – GP*

## Discussion

These initiatives and innovations have provided an opportunity for PHOs to design and implement their own primary mental health programmes. It is evident from the variety of staff employed and interventions that local need, capacity, capability and prior PHO health management programmes have shaped what has emerged.

Historical barriers to providing quality services to this group of primary health care service users such as time constraints, lack of funding, limited access to multidisciplinary team input and poor interface with secondary mental health care services are beginning to be overcome.

Some PHOs who had existing mental health work streams, funded from other sources have now been able to increase the services provided or increase the number of service users seen. For PHOs who have never been able to access these types of services before, knowing that a service is available has meant that clinicians now feel able to offer a wider range of treatment options for mental health problems.

Primary care staff report improved interface between primary care and secondary mental health services as a result of these services. This appears to have transpired in several ways. Many of the new roles that have been introduced into primary care have been filled by those working in secondary mental health services who bring previously established good networks within secondary mental health care. In addition they bring knowledge about appropriate referral pathways to services and community agencies.

Continuing evaluation will provide information about a number of other issues including the overall impact of these initiatives on mental health status, and also the level of additional services that can be provided using limited sources of funding.

## Conclusion

These initiatives represent an exciting opportunity to reduce barriers to access and extend delivery of comprehensive evidence-based primary mental health services by multidisciplinary teams, all-important to the maintenance of quality care. It is premature to comment on service user outcomes resulting from these changes, however the external evaluation will reveal these. It will be important to identify and develop those elements within initiatives that are effective and promote the evolution of a variety of different and successful models of care.

## Authorship

Sue Garrett and Tony Dowell wrote the first draft of this paper on behalf of the Primary Mental Health Initiatives Evaluation Team. Other team members were involved in aspects of data collection and provided comments on subsequent drafts of this paper.

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**Competing interests**

Lynn McBain is contracted on a casual basis by WIPA in a role of clinical facilitator. The organisation runs three of the Mental Health Projects being evaluated by the research team.

Valerie Bos has previously worked as a Project (Evaluation) Administrator for WIPA from 1999–2003.

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## Incident reports

*'Incident reports by themselves, however, tell you comparatively little about causes and prevention, a fact which has long been understood in aviation. Reports are often brief and fragmented; they are not easily classified or pigeon holed. Making sense of them requires clinical expertise and a good understanding of the task, the context, and the many factors that may contribute to an adverse outcome. At a local level, review of records and, above all, discussions with those involved can lead to a deeper understanding of the causes of an incident. Surprisingly little attention, however – and even less funding – has been given to the key issue of incident analysis.'*

*Vincent CA. Analysis of clinical incidents: a window on the system not a search for root causes. Qual Saf Health Care 2004; 13:242–243.*

## Manslaughter due to medical error

*'We identified 85 doctors over the past two centuries who were charged with manslaughter due to medical errors…Several cases involved drunkenness or brutal lack of skill, but many were classified as mistakes (errors in planning) or slips (errors in executing an action). Slips are inherent to human cognition and are more likely to occur when an individual is tired, distracted, or interrupted. They can only be prevented or minimized when the systems and processes in which doctors work are made safer. This is most likely to happen when practitioners are candid about their errors.'*

*Ferner RE, McDowell SE. Doctors charged with manslaughter in the course of medical practice, 1795-2005: a literature review. J R Soc Med 2006; 99:309–314.*

## Adverse drug events (ADEs) in Australia

*'Each year in Australia, about 17.5 million people make 95 million visits to their general practitioner. Based on Miller et al.'s estimate – that 10.4% of patients attending general practice experience an ADE – almost 2 million people have an ADE annually. Moreover, their findings show that these ADEs are not trivial, with about one million being moderate or severe and 138 000 requiring hospitalisation, a finding consistent with previous estimates. Many of these ADEs are preventable, although the exact proportion of preventable events can be debated.'*

*Roughead EE, LexchinJ. Adverse drug events: counting is not enough, action is needed. MJA 2006; 184 (7): 315–316.*