PRIMARY CARE MENTAL HEALTH PLAN

2008 - 2015

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EXECUTIVE SUMMARY

Nelson Bays Primary Health and Kimi Hauora PHO have produced this Primary Care Mental Health Plan, with the view to improving and supporting the ability of primary health providers to better assess and treat patients who experience mild to moderate mental health symptoms.

The Mental Health National Epidemiology Study (Te Rau Hinengaro) estimates that 17% of the population has experienced a mild to moderate disorder in the last 12 months. Translated to a Nelson Marlborough Tasman district, that is an estimated 20,811 people who may experience mild to moderate mental health symptoms.

This plan considers the challenges facing the primary care sector and offers a list of recommendations aligned to the Primary Health Strategy and Te Tahuhu - The Second NZ Mental Health and Addiction Plan. Recommendations are offered in terms of how best to support the sectors maintain the populations wellness, support those with a mild to moderate mental illness, and finally increase the interface supports between primary and specialist mental health services.

There are a number of challenges to overcome which require changes to the way we currently think and deliver primary mental health services, and an increased investment in the sector. Throughout the production of this report, a clear commitment and passion has been shared from the sector to improve current and support future primary mental health service delivery.

The question must be asked: What is the 'real' cost of this unmet need, and what is the direct cost to society by *not* meeting demand?

There is a large percentage of people with medically unexplained symptoms that are actually due to psychological problems. Addressing the mental health issues frees up resources to treat physical health symptoms. In terms of the impact of mental unwellness, three percent of the population report days completely out of role due to mental health problems in the past month, with at least 7.8% to 8.2% reporting partial role impairment due to mental health problems. This directly impacts on service users education, housing, employment and relationships.

While we contemplate the cost of providing better support to those suffering mental illness, we can't dismiss the evidence**.** Just under 50% of people in Aotearoa/New Zealand during

their lifetime will experience a mental health episode/issue. The people experiencing mental health issues are members of our families/whanau, our children, our parents, our partners, colleagues/workmates, families, neighbours, friends, Iwi and communities. Therefore at some time in our lives, we are all affected. If we feel unwell, we need help and support with the focus being on wellness and recovery.

It is unknown whether the Primary Health sector has the capacity to cope with the existing and future volumes. Hence the need to plan now.

Further work is required on the details for implementation and funding for the Primary Mental Health Plan and for each proposed initiative. These may be subject to prioritisation, and a 'staged' approach for implementation adopted, in line with financial and other considerations.

It is clear that we have started the journey to empower those in society with a mild to moderate mental illness. Lets continue to enhance that journey so that we can protect, promote and improve the wellbeing of our communities

RECOMMENDATIONS

R	Challenge: Respect	Key Tasks	
1	There is accessible and appropriate mental health promotion and information in the community	(i) (ii)	Work with the Ministry of Health and NMDHB to explore the development of primary care-based Mental Health Promotion teams, operating in the community. Develop a campaign that promotes General Practice as the place to go for mild to moderate mental health issues.
2	There is better support in the education sector to develop awareness of mental health.	(i) (ii)	Work with the Education sector to identify best practice pathways for students. Link in with Healthy Promoting Schools to provide advice and guidance around the mental health component of the health curriculum
E	**Challenge: Effectiveness and Response**		
1	Demand for mental health support throughout the region is identified.	(i) (ii)	Ensure mental health is screened for during enrolment health checks. This will enable over time the collection of actual incidence data. From the above exercise ensure that general practice has information in terms of referral agencies, self help sites, brochures/leaflets on specific conditions including best practice literature.
2	Demand for mental health support throughout the region is enhanced for general practice teams.	(i) (ii) (iii) (iv) (v)	Establish and operate three Mental Health Clinical Teams (Brief Intervention Coordination), in Marlborough, Tasman and Nelson (1.0 FTE per TLA). Work closely within the chronic conditions framework, to enhance the physical health of service users/tangata whaiora. Enhance/develop the NMDHB Mental Health website to include self help/self management tools. Showcase Mental Health NGO/Specialist Mental Health Services, Voluntary/Community Groups at General Practice Team information sharing workshops. Work with NMDHB to explore opportunities for enhancing the

			number of General Practitioners operating in the Marlborough and Tasman districts.
3	GP's, Practice Nurses and other health professionals in the community are supported to meet the demand.	(i) (ii)	Up-to-date, regular free training and information is available to health professionals across the region. In the first three years this will focus on depression, anxiety disorders, addictions, opportunities to improve access for Maori, Pacific and Children and Youth. Develop a Memorandum of Understanding with Specialist Mental Health Services that covers the Mental Health Primary Care Liaison roles, BIC interface, and information sharing processes and protocols. This will include the enhancement of a Stepped Care model.
4	Robust communication and IT systems are in place to support health professionals to work together across primary and secondary sectors.	(i)	Investigation into appropriate IT systems that will improve the continuity of care (*and responsiveness)* across primary and secondary care.
A	**Challenge: Access**		
1	Better support is available for women who are experiencing post-natal depression	(i)	Implement the findings of the Post Natal Depression Report as resources become available.
2	Rural and other isolated communities including migrant and deaf communities have appropriate access to psychotherapy and counseling services.	(i) (ii)	Explore the extension of video-conferencing facilities (*or other IT)* in rural areas. This that would link with medical professionals and other community agencies to assist support tangata whaiora assessment, diagnosis and treatment. Promote access to the NMDHB mental health website.
3	Maori communities in the region have access to culturally appropriate and effective primary care services.	(i) (ii)	Explore the development of mobile general practice service targeted at the Maori community, designed to improve early access and intervention. Explore the extension of whanau ora services to encompass mild to moderate mental health services.
4	Improve access to primary mental health services for key target groups.	(i) (ii) (iii)	Establish stronger linkages with migrant centres and widen interpreter support services. Work with Pacific communities to enhance support and advice for the sector. Work with the Child Youth Expert Advocacy Reference Group to

			consider ways to improve access to services for children and youth.
5	Schools have better access to psychotherapy and counseling services.	(i)	Explore a collaborative intersectoral approach with Ministry of Social Development (MSD), NMDHB, Primary Health Organisations, Child Youth and Family, Ministry of Education in terms of supporting the education sector with students who have mild to moderate mental health problems.
C	**Challenge: Choice**		
1	There is a range of options available to support tangata whaiora and their family/whanau.	(i) (ii)	PHO and NMDHB websites lists the number of 0800 self help numbers and mental health websites available. PHO and NMDHB websites lists the full range of services currently available both specialist and primary health care, community/voluntary organizations. Continue the practice of identifying general practice charges.
2	There are a range of interventions that are appropriate and accessible	(i) (ii)	NMDHB and PHO's continue to develop the primary mental health initiative in conjunction with the Ministry of Health. NMDHB, PHO and MSD work together collectively to develop PATHS and Mild to Moderate packages of care.
T	**Challenge: Time**		
1	Appropriate services are made available when required and for as long as needed.	(i)	Develop an agreed Tangata Whaiora pathway that is widely accepted.
2	Tangata whaiora have access to extended consultations with practitioners.	(ii) (iii) (iv)	Ensure tangata whaiora who are eligible have access to extended GP consultations either through PATHS, Primary mental health initiative, chronic conditions packages, MSD mild to moderate, or other packages. Work with the Pharmacy sector to enhance the provision of one to one medication advice. Upon evaluation of the Primary Mental Health Initiative, work with NMDHB and the Ministry of Health to extend and increase the initiatives volumes.

The above recommendations are further detailed in the main body of the plan. Pages 36 to 47.

METHODOLOGY

NMDHB, Nelson Bays PHO and Kimi Hauora Wairau PHO saw the benefits in producing a Primary Mental Health Plan that assists and support:

(a) General Practice teams better recognise mental health symptoms, provide best practice effective assessment and treatments for their population.
(b) People will be better able to access primary mental health services and the primary care sector has the capacity and capability to deliver.
(c) Recognition that there is a wide range of primary care services that support primary mental health.
(d) Concatenation between services that improve co-operation and collaboration within the sector.
(e) Improves the interface between primary and secondary based mental health services.

The process and methodology undertaken to complete this plan included:

- The establishment of a Primary Mental Health Advisory Group. This group met twice and provided valuable input and advice at face to face meetings (*and by email)* to the Project Manager throughout the life of the project. (See Appendix 2)
- Extensive face-to-face consultation with stakeholders throughout Nelson/Marlborough/Tasman asking key questions around how primary mental health can be improved. (See Appendix 7).
- Review of international and national literature on best practice and models of care.
- Review of local and national mental health strategies.

A Project Board oversaw the project from its initiation.

BACKGROUND

OUR COMMUNITY

DEMOGRAPHICS

At the 2006 census, Nelson Marlborough region had a population of 130,086. The population is spread, reasonably evenly between Nelson, Tasman and Marlborough. The region has a smaller percentage of Maori (8%) than the New Zealand average (15%). However, in the 2006 Census 15% of children were identified as Maori.

Nelson/Marlborough has a larger proportion of its population aged over 65 (14% compared to the NZ average of 12%). This proportion is forecast to reach 22% by 2021.

Income is lower, and employment is higher than the national average and educational achievement is variable, particularly between rural and urban schools.

While relatively few live in the highest and lowest deciles, there are pockets of need and relative deprivation. Some areas within the region are relatively isolated (e.g. Marlborough Sounds, Murchison, Nelson Lakes, and western Golden Bay).

Populations are subject to seasonal variations, with large numbers of tourists visiting over the summer months (e.g. in Golden Bay the population swells from 5000 to 20,000), and people coming from overseas and throughout NZ to work in horticulture (grapes in Marlborough and apples in Nelson/Tasman).

NELSON MARLBOROUGH PRIMARY MENTAL HEALTH ENVIRONMENT

Nelson Bays PHO and Kimi Hauora Wairau PHO are currently developing a Primary Health Strategy. This will detail the future direction of primary health care for the districts. Mental health plays a pivotal component of any future planning and this document is intended to inform its content, as well as the NMDHB Mental Health Action Plan.

The total number of people enrolled with Nelson and Marlborough PHO's is 126,259 (as the 1st April 2007). At the present time there is minimal specific data as to the population of need for those people within our community who experience mild to moderate mental health problems.

In terms of general practice, there are 100 General Practitioners (GP's) across Nelson Marlborough and Tasman delivering services from 39 practices. Nelson has the highest number of GP's at 45, followed by Marlborough at 29 and Tasman at 26. The number of pharmacies (25) is relatively evenly spread across the district.

In terms of health promotion, there are 7.23 FTE (Full time equivalent staff i.e. working 40 hours per week) who are predominantly based from the Nelson district (4.8) and Marlborough (2.23). There are no health promoters based in Tasman as the Nelson district serves this population.

There are eight Maori health providers across the districts who provide a range of Whanau Ora (family health and wellbeing), Disability, Specialist Mental Health and gambling services.

Currently there are no Pacific health services operating. However the PHOs (Primary Health Organisations) and NMDHB are working closely on assessing how best Pacific health needs could be met.

The Community/Voluntary sectors also provide a range of complementary services and supports to those with a mild to moderate mental illness. This includes groups such as Lifeline, Bipolar Support, Youth Groups and Church Groups etc.

WHAT IS PRIMARY MENTAL HEALTH

Mental Health can be defined as 'a *state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'*, [1] and *'the provision of basic preventative and curative mental health care at the first point of contact into the health care system'.* [2]

Mental health care is normally delivered within a primary or secondary care health environment. Primary Health care plays a fundamental role in caring for people with mental illness and ensuring that patients return to their full level of functioning by identifying and subsequently managing the health issue. The Ministry of Health provide further endorsement "*The role of a primary healthcare provider is to recognize that there is a mental health issue, provide self-help information, support appropriate treatment/therapy to assist a person to rapidly resolve the issue and to support them to maintain and build their links with their community resources.*" [3]

National and international evidence shows a high prevalence of mental health problems amongst people presenting to primary care services. However, mental health problems are often missed in primary care consultations. A study in the UK says that up to 50% are not detected explicitly.[4] The World Health Organisation (WHO) states that one in four patients visiting a health service has at least one mental, neurological or behavioral disorder but most of these disorders are neither diagnosed nor treated

Current national mental health strategy sets a direction for the development of community-based services and a move away from hospital-based care whose intent is to build the capacity of the community sector. This is important as WHO predicts that by 2020 depression will be the highest-ranking cause of the burden of disease in developed regions of the world. Accordingly, greater connectedness between primary health care providers and mental health services is needed.

Primary mental health care services are predominantly delivered from a general practice base. For many people the primary health care sector will be their first point of contact with the health system. The term primary care can include a wide range of community-based health services including general practice, community nursing, community-based therapies and sometimes emergency services [5]. Research from NZ [6] and internationally suggests

that about a third of people who consult their GP's have a mental health problem or illness at time of consultation, or have experienced one in the past year.

The Mental Health Commission acknowledges that General Practices are the first point of call for most people with mental illness and that there are real opportunities and benefits for early intervention and treatment. Therefore access to appropriate primary care services is pivotal to ensure early assessment, diagnosis and treatment.

However, not all individuals will seek help from general practice. Te Rau Hinengaro is New Zealand's first national epidemiology study and identifies that in terms of seeking help from a health professional, visits to the health sector are low. Of all people who met criteria for a mental disorder in the last 12 months, 16.4% had a mental health visit to a mental health specialist, and 28.3% had a mental health visit within the general medical sector (the general medical sector includes nurses and other healthcare professionals as well as doctors). Of all 12 month cases, 38.9% had at least one mental health visit to a care provider within either the health sector or non-health sector (Non health sector includes complementary or alternative medicines, human services and any non healthcare provider). Te Rau Hinengaro also illustrates findings that 75% Maori with mild to moderate mental health issues have no contact with health services.

There are a number of reasons for delaying seeking help, the three most frequently endorsed reasons identified in Te Rau Hinegaro were *' I wanted to handle the problem on my own'*, *'I thought the problem would get better by itself'* and *'The problem didn't bother me very much at first'.*

In some instances the situation may resolve itself without any intervention. In addition, support may be sought from family/whanau, friends and partners, community and voluntary agencies, family/whanau, friends/partners, general practice teams, Maori health providers or specialist mental health providers.

The three most common conditions that mild to moderate mental health consumers present are depression, anxiety and substance abuse disorders. A recent evaluation of Primary Mental Health initiatives for tangata whaiora with mild to moderate illness in NZ has found that 63.6% had depression, 19% anxiety, and 4% substance overuse issues. [(7)]

In addition, the linkages with chronic conditions cannot be understated. There is increasing evidence that people with mental illness have significant physical health problems (*and vice versa)* that are often neglected.

WHAT IS THE DEFINITION OF MILD TO MODERATE MENTAL ILLNESS

Te Rau Hinengaro definition for severity is that the disorders had to have occurred in the previous 12 months. Impairment in the Sheehan Disability Scales was for the worst month in the past 12 months. The mild, moderate and serious disorders were determined as follows:

- ***Serious Disorder:*** Twelve-month bipolar I disorder, 12 month substance dependence with substantial impairment, a suicide attempt in the past 12 months and a DSM-IV, CIDI 3.0 12-month disorder; at least two areas of severe role impairment due to a 12 month psychiatric disorder in the disorder-specific Sheehan Disability scales, or a combination of other criteria found in the NCS-R to predict a global assessment functioning of 50 or less in conjunction with a DSM-IV CIDI 3.0 disorder (*12 month disorder and 51 or more days out of role in the past 12 months, and no more than one Sheehan domain with a maximum score less than 7 for work or social domains less than 8 for home and personal relationship domains).*

- ***Moderate disorder:*** Cases not classified as severe were classified as moderate if they reported at least moderate interference in any Sheehan Disability Scales domain or if they had substance dependence without substantial impairment.

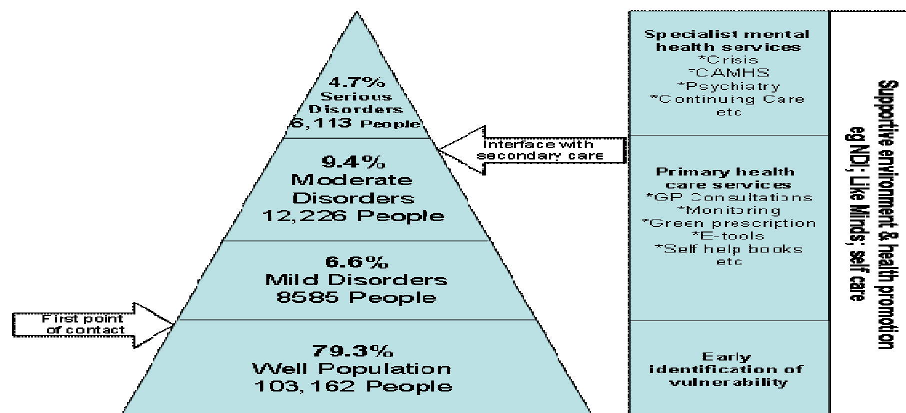
- ***Mild disorder**:* Everyone else with any 12-month diagnosis, not classified as serious or moderate, was classified as mild.

Please note that General Practice will also support tangata whaiora/service users who have serious mental health disorders. This is normally a shared care arrangement with specialist mental health services.

TE RAU HINENGARO – ESTIMATED PREVALENCE

As identified in the recently completed Mental Health Populations of Health Report [(8)], there are just under an estimated 27,000 people over a twelve month period who may need support for their mental wellbeing. The support may be received either through community and voluntary agencies, family/whanau, friends/partners, general practice teams, Maori health providers or specialist mental health providers.

The following diagram depicts the Nelson Marlborough Tasman populations and the role/interface between severity/services.



The next table outlines the estimated number of people with mild to severe mental health issues across the three districts (*all ethnicities, all ages)*.

Districts Total Pop 130,086	Well Population	Mild 6.6%	Moderate 9.4%	Severe 4.7%	Total
Tasman	33752	2809	4000	2000	42561
Nelson	34021	2831	4032	2016	42900
Marlborough	35389	2945	4194	2097	44625
Total	**103,162**	**8585**	**12,226**	**6113**	**130,086**

Of the estimated 20,811 mild to moderate population, this equates to around 208 patients for each of the 100 General Practitioners operating within Nelson Marlborough and Tasman (*if these individuals were presenting to the general practice teams*).

GOVERNMENT STRATEGY

Mental health is a priority health area for the Government. This is reflected in a wide range of policy documents, including the *New Zealand Health Strategy* (2000), the *NZ Disability Strategy* (2001), Te *Puawaitanga: Maori Mental Health Strategic Framework* (2002), the *NZ Suicidal Prevention Strategy* (2006), *NZ, Primary Health Care Strategy* (2001) and as set out in *Te Tahuhu – Improving Mental Health 2005-2015: The Second NZ Mental Health and Addiction Plan* and *Te Kokiri: The Mental Health and Addiction Action Plan* (2006).

NEW ZEALAND HEALTH STRATEGY (2000)

Three of the *NZ Health Strategy's* population health objectives apply directly to the development of mental health services. They are:

- Reduce the rates of suicides and suicide attempts.
- Minimise harm caused by alcohol and illicit and other drug use to both individuals and the community.
- Improve the health status of people with severe mental illness.

NEW ZEALAND DISABILITY STRATEGY (2001)

The NZ Disability Strategy identifies that one-in-five New Zealanders have a long-term impairment. The aim of the Strategy is to become a more inclusive society, eliminating the barriers to people with disabilities participating in and contributing to society.

The Strategy has the vision of a society that highly values the lives and continually enhances full participation of disabled people. It provides an enduring framework to ensure that government departments and agencies consider disabled people before making decisions.

NEW ZEALAND PRIMARY HEALTH STRATEGY (2001)

A strong primary health care sector is essential to improve the health of New Zealanders. The launch of the Primary Health Care Strategy in 2001 signalled a significant change to, and investment in, primary health care.

The Primary Health Care Strategy directed DHBs to work with local communities and health care providers to establish Primary Health Organisations (PHOs) as the local structures for delivering and coordinating primary health care services. PHOs are responsible for implementing the Primary Health Care Strategy.[9]

The NZ Primary Health Care Strategy provides a clear direction for addressing inequalities in health and reducing barriers to accessing care.

The change in structure and funding of the primary health care sector brought about by the implementation of the Primary Care Strategy [10] provides an opportunity to improve responsiveness to mental health and addiction needs as an integral part of PHO's. They, like other primary health care providers have an opportunity to emphasize the importance of good mental health and wellbeing in every aspect of health care.

The change in structure and funding of the primary health care sector brought about by the implementation of the Primary Care Strategy [10] provides an opportunity to improve responsiveness to mental health and addiction needs as an integral part of PHO's. They, like other primary health care providers have an opportunity to emphasize the importance of good mental health and wellbeing in every aspect of health care.

TE PUAWAITANGA; MAORI MENTAL HEALTH STRATEGIC FRAMEWORK (2002)

Is currently under review and due to be launched by the Minister of Health in June 2008.

The five goals for Te Puawaitanga (2002) were to:

- Provide comprehensive clinical, cultural and support services to at least 3% of Maori with the greatest mental health needs, and to their whanau within any 6 month period.
- Ensure active participation in the planning and delivery of mental health services so that these reflect Maori models and Maori measures of mental health outcome realities.
- Ensure that 50% of Maori adults accessing services will have a choice of a mainstream or a Kaupapa Maori community mental health service.

- Increase the number of Maori mental health workers (including clinicians) by 50%.
- Maximise opportunities for intra and inter-sectoral co-operation.

The consultation framework for Te Puawaitanga Tuarua (2008) takes a wider population of need approach (*stronger focus on health prevention/promotion and primary care).* It strongly suggests that given the evidence and disparities Maori mental health should be prioritised.

TE TAHUHU

Te Tahuhu is the Government's most recent policy statement on mental health and addiction and joins Looking Forward (1994) and Moving Forward (1997) as part of the National Mental Health Strategy.

Te Tahuhu broadens the Government's interest in mental health from people who are affected by mental illness and addiction. It describes the outcomes the Government wants to achieve and sets priorities for action to 2015 which includes a wider focus on health promotion/prevention, primary health care. It identifies ten leading challenges for action that must be addressed to achieve government outcomes. The 10 leading challenges for action several of which require a lead role for the primary health care sector.

Further Te Tahuhu states that that …..'Over the next ten years we can expect major shifts…

Where

- People with experience of mental illness and addiction, and their families and whanau are having their needs addressed earlier through access to a broad range and choice of services that are responsive to their communities, and take into account all aspects of their health and wellbeing

Through a

- More comprehensive and integrated mental health and addiction system that coordinates early access to effective primary health care, and with an improved range and quality of specialist mental health and addiction services that are community based and built on collaborative partnerships

That is built on

- A culture of recovery and wellness: that fosters leadership and participation by people affected by mental illness; is supported by a workforce that delivers effectively at the interface between cultural and clinical practice and is firmly grounded in a robust evidence base, quality information, innovation and flexible funding mechanisms that support recovery'

The action plan identifies specific actions that require working together across agencies to realize key outcomes for people, whanau and families affected by mental illness and addiction.

Te Tahuhu – Improving Mental Health and Te Kokiri Action Plan, provide a framework for DHB's, the Ministry of Health and key stakeholders to take leadership in mental health and addiction in New Zealand.

The specific primary health care leading challenge is to build and strengthen the capacity of the primary health care sector to promote mental health and wellbeing and to respond to the needs of people with mental illness and addiction, with immediate emphasis on:

1. Build and strengthen the capability of the primary health care sector to promote mental health wellbeing and to respond to the needs of people with mental illness and addiction.

- Provide advice to the Government on the future direction of primary mental health care, including funding and possible models using information from PHO, demonstrations, review of international models, the Mental Health Epidemiology study, Primary Health Care Strategy evaluation, targeted primary health care services to improve access (SIA), the review of Care Plus, integration of mental illness with the care-co-ordination programme development work.

- Develop clinical and key performance indicators at the primary health care level for mental health.

2. Building the capacity of primary health care practitioners to assess the mental health and addiction needs of people and to meet these when they can best be met within primary health care settings. The specific actions are to:

- DHBs and primary health care providers will address the physical health needs of people most severely affected by mental illness and those suffering the severe ongoing physical consequences of alcohol and/or drug use, in the context of a holistic health approach.

- Engage mental health and addiction service user participation in the planning and development of primary mental health and addiction services.

3. Building linkages between Primary Health Organisations (PHO's) and other providers of mental health and addiction services to ensure integration occurs to meet the needs of all people with mental illness and addiction. The specific action is to:

- Strengthening linkages between primary health care and specialist mental health and addiction services and other community agencies to ensure continuity and quality of care and appropriate integration.

- Strengthening the role of PHOs in communities to promote mental health and wellbeing. The specific action is to:
- PHOs will make mental health and wellbeing and mental illness and addiction an integral part of the PHO/primary health care health promotion.

BEST PRACTICE

Following is a summary of "Best Practice" interventions that have been identified in national and international literature. This information was largely taken from New Zealand Health Technology Assessment Best Practice Annotated Information Packages (2007)[11]

MOOD DISORDERS

- For mild depression anti-depressants are not recommended, the risk-benefit ratio is poor
- Screening should be undertaken in primary care for depression in 'high risk' groups
- For mild depression healthcare professionals should consider a guided self-help programme based on cognitive behavioural therapy(CBT)
- In mild to moderate depression, psychological treatment specifically focused on depression(such as problem-solving therapy, brief CBT and counseling) of 6-8 sessions over 10-12 weeks should be considered [12]
- Cognitive therapy and interpersonal psychotherapy reduce symptoms of mild to moderate depression
- Combining psychological treatment with anti-depressant drugs may be more effective than either treatment alone
- Non-directive counseling and Care pathways may improve effectiveness of treatment for depression [13]
- Anti-depressant medication should not be used to treat young people with mild to moderate depression
- First-line treatment should be a specific psychological therapy(CBT), interpersonal therapy or shorter-term family therapy (of at least 3 months) [14]
- Women with mild to moderate Post Natal Depression should be supported by : self-help strategies(guided self-help, computerized CBT or exercise); non- directive

counseling at home(listening visits); and brief cognitive behavioural therapy or interpersonal psychotherapy

- Women requiring psychological treatment should be seen within one month of initial assessment [15]
- In the treatment of bi-polar disorder prevention of suicide must be a central goal
- Integration of a range of health professionals, as well as family and friends is required [16]

ANXIETY DISORDERS

Major recommendations:

- Multi-model treatment planning that considers the severity and impairment of the anxiety disorder, education of the parents and the child, and consultation with school personnel and primary care physicians
- Psychotherapy(e.g. CBT, psychodynamic psychotherapy and family therapy)
- Pharmacotherapy with selective serotonin-reuptake inhibitors or other indicators
- Classroom-based accommodations
- Treatment of co-morbid conditions [17]
- In the treatment of Post-Traumatic stress there should be a focus on vocational, family and social rehabilitation interventions from the beginning of treatment [18]
- Psychosocial rehabilitation may be used as an adjunctive therapy in combination with psychotherapy or pharmacotherapy
- Regular aerobic exercise and self-care practices may be helpful in managing symptoms
- Trauma-focused CBT is recommended
- Medication treatment can be effective in treating PTSD, acting to reduce its core symptoms as well as associated depression and disability [19]
- Psychological therapy based on CBT principles is effective in reducing anxiety symptoms for the short-term treatment of Generalized Anxiety Disorder [20]
- The interventions that have evidence for the longest duration of effect in descending order are: Psychological therapy(CBT), Pharmacological therapy(an SSRI), and self-help(bibliography based on CBT principles) [21]

ADJUSTMENT DISORDERS

- The elements of intervention should include education about stress, stress responses and adjustment disorders; provision of a rationale, positive re-labelling, and a schedule of non-demanding activities – these interventions can help the patient regain control at a cognitive and emotional level
- No anti-depressant was found to be more effective in treating adjustment disorder [22]
- Therapy should use encouragement, support for the patient's strengths, and minimize or play down past problems
- Education and information play an important role. Cognitive-behavioural intervention, based on cognitive restructuring has proved effective in both preventative and curative programmes
- Early efforts to help the patient regain function appear to be effective
- Providing patients with adjustment disorders with a rationale for the problems they experience is a powerful form of intervention
- The aim of interventions is to enable patients to complete the recovery tasks and to increase their problem-solving capacity
- It is important that patients do not receive a prescription defining how they should solve their problems, because such a prescription encourages dependence rather than independence and discourage an active approach by the patient [23]

PSYCHOTIC DISORDERS

- Care across all phases should involve optimism, getting help early, assessment, working in partnership with service users and carers, consent, providing good information and support, appropriate language and culture, advance directives [24]
- Specific treatment modalities include; consumer and family engagement with services, consumer and family psycho education, the use of atypical antipsychotics, interventions targeting alcohol and drug use, stress management, relapse prevention and trauma-related issues.
- Vocational training can benefit those with competitive work as a personal goal [25]
- Community education is key to ensuring early identification of onset of psychotic disorders
- Consumer and family engagement is key to developing effective treatments
- Development of community-wide initiatives to address stigma
- Early intervention is the best strategy for effective treatment
- Provision of user-friendly and timely mental health services within outpatient services or the home environment [26]

- Individual placement and support model is shown to be successful in assisting people with psychosis to achieve their educational and vocational goals. [27]

SUBSTANCE ABUSE

- Patients with alcohol problems and anxiety or depression should be treated for the alcohol problem first
- Good access is needed to relapse prevention treatments
- Advising families – the primary care team should help family members use behavioral methods which will reinforce reduction of drinking and increase the likelihood that the drinker will seek help
- Early substance and alcohol misuse screening for at-risk populations [28]
- Treatment for drug misuse should always involve a psychosocial component
- Psychosocial interventions can be delivered alongside pharmacological interventions, or alone

Key working is a basic delivery mechanism for a range of key components including the review of care treatment plans and goals, provision of drug-related advice and information, harm reduction interventions, and interventions to increase motivation and relapse. Help to address social problems, for example housing and employment, is also important. [29]

STEPPED CARE

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

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

- increased recognition rates (Walters & Tylee, 2005)
- greater numbers of people receiving treatment for mental health and addiction problems
- increased recovery rates (Walters & 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

SUPPORTS THAT ENHANCE RECOVERY

- There is evidence (studies in Canada, USA and one other country) that interventions offering 'buddying', self-help network or group-based emotional, educational, social, or practical support to at-risk (widowed) older people can help to improve self-reported measures of health perceptions adjusting to widowhood, stress, self-esteem and social functioning. [30]

- There is evidence that family interventions in families of people with schizophrenia and related disorders can have 'limited' positive effects on variables relating to the

family unit such as a reduction in family distress and quality of interpersonal relationships. [31]

- Family interventions have been found to have a modest positive effect on variables relating to the relative's burden of care and can also improve general understanding (by family) of Tangata Whaiora needs.

- Research supports the theory that the levels of trust, tolerance and participation in a community are a crucial factor in determining health [32]

WHAT IS HAPPENING LOCALLY FOR PRIMARY MENTAL HEALTH

The Ministry of Health has supported a number of Primary Mental Health projects to support the development of PHO's implement the Primary Health Care Strategy.

These initiatives have been piloted and are currently being assessed by the Ministry of Health (see Appendix: 5 Review of Key Primary Mental Health Initiatives)

Major themes emerging from preliminary findings are:

- That the initiatives are all developing on 'an evolutionary timeframe'
- Broad definitions of mental health, including 'life's complexities, are being adopted
- The enthusiasm to target those Tangata Whaiora with high needs
- Specialist staff including counselors and therapists are undertaking the majority of the work
- Integration with secondary care is important [33]

All of the models have moved to "Stepped Care" in terms of the primary mental health projects.

In 2007, Nelson Bays PHO and Kimi Hauora Wairau PHO were successful in obtaining a Primary Mental Health contract from the Ministry of Health. While the volumes are relatively small, this pilot provides the opportunity for general practice teams to offer extended consultations and if applicable refer to a Primary Mental Health (PMH) Coordinator who will facilitate individual packages of care based on the clients need. This could encompass a variety of interventions for e.g. sessions of Cognitive Behavioural Therapy, one to one support for postnatally depressed patients etc. The model also acknowledges that the pathways to general practice differ for Maori; therefore referrals can be made direct by a Maori Health Provider to the PMH Coordinator. In addition, there is also the opportunity to advance the Practice Nurse role within the initiative.

PATHS (Providing Access to Health Solutions) is a Ministry of Social Development lead initiative. An intersectoral approach (*including ACC, NMDHB, Te Rapuora o Te Wai Harakeke, PHOs)* provides a service for invalid or sickness beneficiaries to navigate through

systems/services to improve their health with the expected outcome of returning to employment.

The Ministry of Social Development has also considered developing Mild to Moderate Mental Health Packages for a wider range of their clients to enable them to return to employment. This service would be a complementary service to the PMH.

CHALLENGES FOR THE PRIMARY CARE SECTOR

In discussion with the primary health sector, throughout the consultation process a number of challenges were articulated by the sector in terms of meeting the needs of those with a mild to moderate disorder. The following table is a reflection of the major themes:

Challenges	What is needed to address the challenges?
An average 10 to 15 minute consultation timeframe does not allow for a thorough assessment	▪ Extended General Practice consultations. ▪ Readily available self help software. ▪ Practice Nurse capacity development in assessment. ▪ Raising awareness - self help/education programme.
Cost can be a major barrier, not only the consultation fee, but also servicing prescriptions.	▪ Evaluate and if appropriate extend Primary Mental Health Initiative that reimburses general practice for extended consultations. ▪ Have available on the Mental Health website all General Practice fees.
General practice teams may not be able to meet demand, or have the capacity/capability to respond.	▪ Mental Health Brief Intervention Clinical teams established. ▪ Primary Mental Health Coordinator roles extended. ▪ Readily available self help software.
Difficulty in providing a full range of services and interventions across the region.	▪ Ensure there are adequate numbers of GPs in Tasman and Marlborough to improve access.
Physical isolation of some communities	▪ Explore opportunities to utilise videoconferencing equipment. ▪ Establish mental health website. ▪ Explore the provision of telephone supports.
A range of small minority groups require additional supports, such as interpreter services, migrant supports etc.	▪ Establish stronger linkages with migrant centres and widen interpreter support services.
There is a level of fragmentation of services.	▪ Establish mental health website.

General practice teams are unaware of the number of support services available in the community for referral purposes.	▪ Showcase services in General Practice Information Sharing Workshops.
Paradigm that general practice is not the place to go if you are experiencing mental health symptoms, or that the mental health issue will resolve itself.	▪ Marketing campaign developed that encourages attendance to the GP. ▪ Identify GP Champions that can lead and role model implementation of new initiatives.
Not enough Health Promotion resources available if we want to retain wellness of our populations, and reduce stigma and discrimination.	▪ Work with the Ministry of Health and DHB in terms of the development of mental health promotion/education services.
There is a relatively good interface between primary and specialist mental health services. However this needs to be solidified further to enhance the transition/shared care process.	▪ Ensure the pathway and interface between primary and specialist mental health services is clear, robust and well understood. ▪ Develop an agreed tangata whaiora pathway.
It is a challenge to keep up with best practice initiatives and run a viable business. Support is needed to keep up to day and implement best practice.	▪ Best practice information is retained on the mental health website. ▪ Best practice is shared at Information Sharing Workshops.
Maori, Pacific and Children and Youth access to primary health services is low.	▪ Explore extension of Whanau Ora to include primary mental health. ▪ Work with the Pacific communities to develop a Pacific health support service. ▪ Target these three groups as priority areas in primary mental health. ▪ Enhance capacity of primary mental health to the education sectors.
Information collection on mild to moderate mental health incidence in primary care settings is currently unavailable.	▪ Work with the general practice sector to explore opportunities to capture incidence data.

THE WAY FORWARD

INTEGRATED MODEL OF CARE

An integrated model of care is proposed that is client-focused and shows the person in their community, in their environment, and in their 'place'.

The key questions considered important for the model are:

- What are the individual's needs, at this time.
- How can they be best supported to recover, to be well, and to maintain wellness?
- What will keep this person functioning and engaging in their community?
- What does the individual think?
- How do they feel?
- Who is around them to support them?
- What does their family/whanau say? How can they be best supported to 'hold' their whanau member? Do they know who is out there, for them? How are they 'connected?

The model can be adapted to an individual, and illustrate what is able to support them in their respective community.

As well as increased funding for services and programmes, funding should follow the individual, and address their specific and individual needs.

An Integrated Model of Care

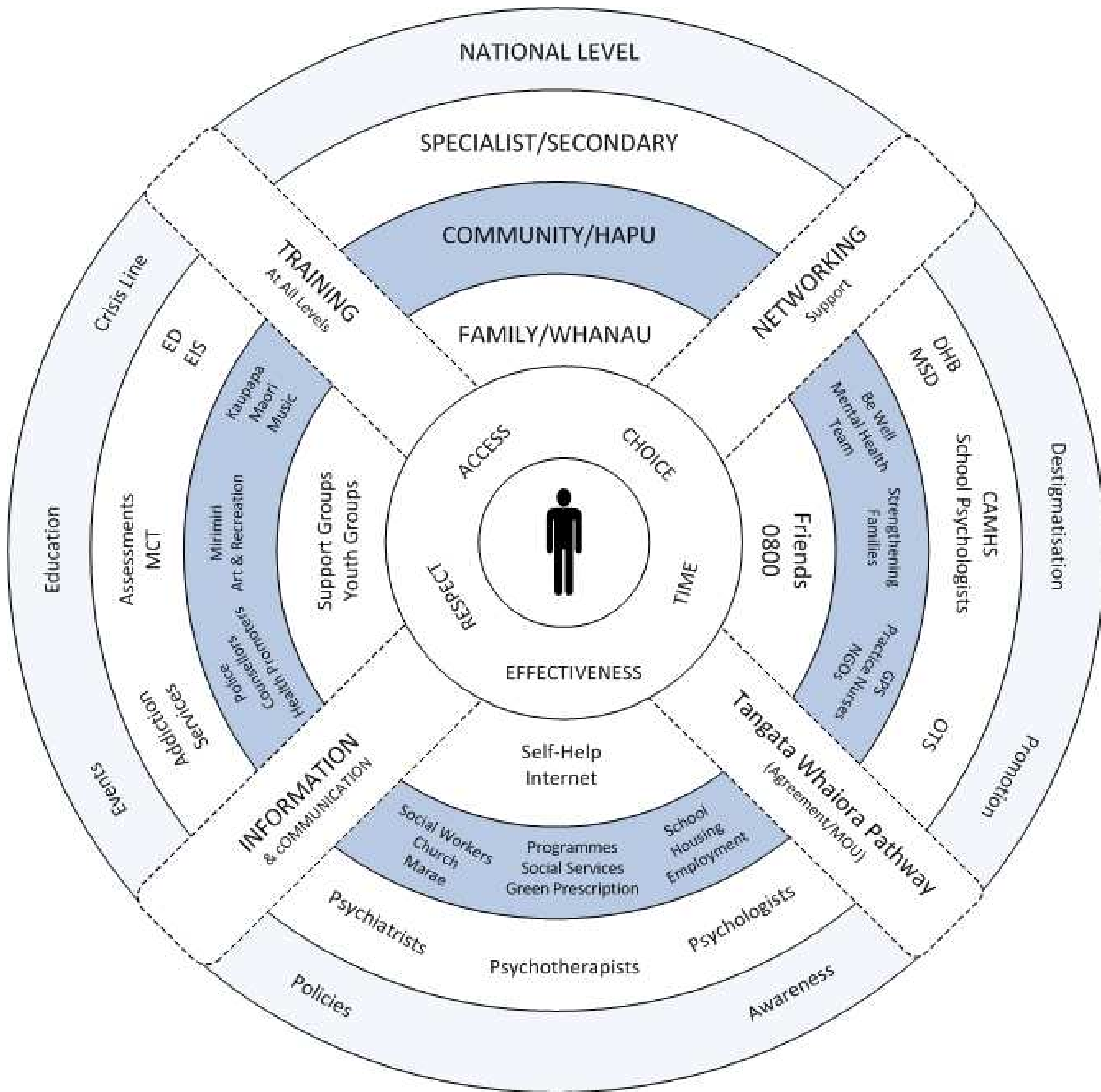


Figure 1 - Integrated Model of Care

The proposed model has the person in the middle of the circle. At a minimum, this person needs to be treated as an individual, to have choice about their options, and to be responded to in a timely and respectful way.

The two circles directly surrounding this person contain the people most closely connected, and most able to support the person in the middle, when and if needed, and as appropriate.

The further circles are made up of secondary and other services that the person will not normally come into contact, unless referred. These circles are less likely to be in regular contact, or as available to the person in the middle. The outer rings play their part, in developing and maintaining effective engagement with the person in the middle, and with the inner rings, as appropriate.

Best practice tells us that the most effective interventions are those that are readily accessible, timely, offer choice and are delivered respectfully.

This model is supported by four poupou, upright slabs that normally form the framework of the walls of the house. These four are also spokes that strengthen and tie together. They are integral to the stability, viability and integration of this plan, and without which, patients will experience fragmentation of services, and gaps in our support.

Support and funding for these poupou is critical, and will need to be shared in a collaborative, integrated, and multi-disciplinary approach.

It is this model that the Primary Care Mental Health Plan is based.

PRINCIPLES FOR ACTION

Information and Communication

- There is a real need to reduce stigma in our community, to improve community understanding of mental illness. This needs to happen at national to local levels, and involves a range of medium to reach whole populations. E.g. National and local “Like Minds, Like Mine” campaign.
- Information and communication systems need to be robust and updated regularly, and able to work quickly when necessary and/or when faced with immediate needs
- Communication needs to be respectful, and appropriate
- It is important that ‘engaged professionals’(with a common client), are able, with consent, to share information and concerns especially within primary health settings

Training at all levels

- Ongoing, and updating training?, for professionals to family members and friends
- GPs need continuing education and the necessary tools to adequately assess, diagnose and treat tangata whaiora (e.g. in Australia GP’s are provide education and support from allied health professionals through the Better Outcomes in Mental Health Care (BOIMHC) programme
- More effective workforce development around Primary Mental Health is required throughout the sector.

Support and Networking

- “Social Connectedness” provides individuals with support, and a sense of who they are and their unique place, in the community.
- Memorandums of understanding and shared training needs to be in place between agencies and organisations.
- Networking and support groups(professional, community, youth and family) need to be supported to establish and operate, throughout the region

Tangata Whaiora Pathway (agreed)

- Provides a framework for best practice management of mental health problems and mental illness in a primary care setting. As agreed by stakeholders, medical professionals, and with input from the community(e.g. the Australian 3 Step Mental Health process)
- Will simplify recognition, treatment and recovery, and strengthen client/patient and practitioner safety

- Agreement on diagnostic and assessment tools (e.g. the Composite International Diagnostic Interview); the Computerized Interview: CIDI-Auto/WHO): and other guidelines(e.g. the National Depression Guidelines)
- Agreement(with client consent) between service providers, to share information

CHALLENGES FOR ACTION: R.E.A.C.T.

CHALLENGE 1 – RESPECT

Voices:

"a service that responds by listening" – a consumer of mental health services

"Participation in community is a precursor to good health" – training provider consumers of mental health services

"We need a good neighbour service" – mental health advocate

"I seek to build a whanau around the Tangata Whaiora, even if they do not have one" – kaupapa Maori support worker

Best Practice:

Protective factors at the individual level for mental health include feeling respected, valued and supported, together with a sense of hopefulness about the future. (34)

Issues:

- **Personalised treatment** – *any and all interventions must be tailored to the individuals unique needs and situation – it is important that any medical intervention is built on 'relationship', and if valued and nutured, this is more likely to yield positive outcomes*
- **Whanaungatanga** – *everyone is 'connected' to someone else, somewhere – a sense of 'belongingness' is a powerful and healthy place to be*
- **Engagement with Whanau/Family** – *crucial to recovery, family/whanau engagement encouraged , with consent – support work to build and maintain support systems, sometimes a 'virtual' whanau, if you will*
- **Culturally appropriate** – *special needs have been identified for some communities including migrant, and the deaf community – both require interpreters, counseling and psychiatric services that are only available to them in bigger urban centres – new technology and video-conferencing can provide a basic level of service to these communities*
- **Maori –** *there is identifiable need to provide an extended Primary Health service to Maori, with the inclusion of mental health services – although the majority of Maori experiencing mental health problems do not receive any form of care, GPs are the leading point-of-contact for those who do.*
- **Children and Youth** – *aim of interventions must be to change the risk - factors, and provide youth with tools, knowledge and support to navigate through life's difficulties – youth often do not present to GPs, and need appropriate and readily-available pathways to access support – depression in children and youth may affect 2-6% with*

a peak incidence around puberty – the prevalence of anxiety disorder is between 2-8% in community samples of children and youth – there is a shortage of youth counselors and psychiatric services

- **The elderly** – *an emerging group of need who can be reached by visiting in their home, being listened to, in (e.g. supergrans group) and through aerobic activity*
- **Consumer groups** – *are proven to be effective in maintaining tangata whaiora in the community, providing a 'place' to support and be-supported*
- **Destigmatisation-** *normalizing mental health is a priority – this needs to be supported at all levels, from consumer of services to health policy-maker, persons unwell and not accessing services, to the person who fears the subject – a shift in community perceptions around the reality of mental health_will be the single biggest change from now*
- **Non-judgmental** – *at present the police in the region are playing an important role in primary mental health care – training around mental health is minimal in police training, in addition the police have not been actively equipped by mental health professionals in the provision of training and clinical support – greater support for police and others would assist better support for those with mental health issues*
- **Humane** – *early intervention for mental health disorders can be justified on humanitarian grounds; it is humane to treat people with first episode mental disorder as soon as possible after(or before) symptoms develop*
- **Education and Prevention** – *everybody deserves to be provided with education and information(whether it be in their school, community, workplace) to proactively prevent and protect themselves and their family/whanau from mental illness*
- **Agreements to treat, and share information** – *consumer participation and 'buy-in' is a core element of all mental health services*
- **Positive empowerment** – *at times we all need advocacy and support, to help us feel empowered in our own lives*
- **Safety** – *while modeling good practice around privacy and confidentiality, safety of tangata whaiora and those around them must be paramount*
- **Societal change** – *as our society changes and grows, so do the pressures – these need to be considered from the standpoint of the tangata whaiora, in an holistic intervention*
- **Climate change** – *this is likely to impact on all communities raising anxiety and coping levels – in the short-term the price of petrol and travel may further isolate, those already isolated – decentralized health centres and rural clinics may ameliorate the impact, in the short to medium term*

R	Challenge: Respect To ensure that tangata whaiora are respected in our community, and in treatment					
	Outcomes	Roles Responsibilities	Resource	Timeline	KPIs	Capability/Improvements
1	There is accessible and appropriate mental health promotion and information in the community	NMDHB Ministry of Health PHOs	Work with the Ministry of Health and NMDHB to explore the development of primary care-based Mental Health Promotion teams, operating in the community. Develop a campaign that promotes General Practice as the place to go for mild to moderate mental health issues.	By 2012	Teams established A campaign is delivered that promotes general practice as the place to go for your mental health.	Better mental health literacy and de-stigmatisation. Improved numbers of patients visiting general practice.
2	There is better support in the education sector to develop awareness of mental health.	NMDHB Ministry of Education PHOs	Work with the education sector to identify best practice pathways for students. Link in with Healthy Promoting Schools to provide advice and guidance around the mental health component of the health curriculum	By 2010	Support and treatment pathways identified. HPS working closely with the sector to provide/distribute information on mental wellbeing.	Proactive awareness beyond the health sector. Higher profile of emotional wellbeing delivered in the education sector.

CHALLENGE 2 – EFFECTIVENESS/RESPONSE

Voices:

"no one knows what works" – mental health support worker

"Never trust a mental' – police saying

"Any health policy needs to be consistent with social policy" – a doctor in general practice

'…nobody knows what others do.' – public health nurse

Best Practice:

Greater connectedness between primary health care providers and mental health services will mean a more holistic approach can be taken to people's needs that will result in better health outcomes (Te Tahuhu).

Primary Care practitioners should endeavour to build a supportive and collaborative relationship with the patient and their family/whanau. This relationship plays a critical role in the assessment and management of common mental disorders. (35)

Issues:

- **Health and Wellness** – *programmes delivered in the community around parenting and awareness are empowering, and provide access to early intervention and prevention of mental illness – such programmes need to be affordable, readily available and professionally-delivered*
- **Holistic services** – *an holistic approach to primary health care necessarily means viewing housing, income and employment as integral parts of a person's well being*
- **Support Groups** – *Access to support groups is a valuable part of any package of care*
- **Psychotherapy** - *psychotherapy practices need to be available, particularly In rural areas, and in support for other community health services – IT and video-conferencing may add options in the provision of mental health support*
- **Pharmacies** – *the ability to provide, and pay for, extended pharmacy consultations, that provides the consumer with more information and confidence*
- **Medication** – *at present there is often different medicine prescribed by GPs(sometimes in the same practice) for mental health conditions – some commonality in approach, and regular independent updates and information to medical professionals is required*
- **Support** – *medical professionals need ongoing and timely support to remain current, confident and effective in their work – in particular, additional services and requirements need to 'add value' to the GP, not add cost and/or be time-consuming e.g. keeping database of up-to-date resources and community services*

- **Networking –** *crucial in Primary Health Care, demanding more mobility and ability to communicate, well – community and specialist networks are often the 'glue' that maintains and promotes connections*
- **Quality assurance and improvement** – *guidelines for the recognition and treatment of mental illnesses need to be available and known, following international examples*
- **Concatenation between sectors and services** – *all mental health professionals need to be fully aware of all options available to their client, in primary and secondary*
- **Research and innovation** – *responsibility for the provision of information and practice in current and 'cutting' research in mental health, rests with the NMDHB as the largest professional health provider in the region – this can be done via training, peer supervision and/modeling of innovations*
- **Nurse Practitioners**– *the increased prevalence of Nurse Practitioners in NZ may provide more service, and the ability to do extended consults*
- **Appropriate** – *men are not as motivated to seek help as women for mental illness – however promotion, programmes and services that are about and for men have proven effective in dealing with emerging mental health issues e.g. the "J.K." campaign.*
- **Intranet** – *the opportunity to develop electronic networking to the extent that medical professionals can, with secure connections and consent, share professional and client information(e.g. Primary Integrated Systems Management /PriSM, West Coast DHB)– this would require some accreditation standard – primary services require better IT software, and be able operate in a compatible environment*

E	**Challenge: Effectiveness and Responsiveness** To ensure that tangata whaiora are supported by an effective and responsive range of professional services, programmes and clinical interventions					
	Outcomes	**Role/Resp.**	**Resource**	**Timeline**	**KPIs**	**Capability Improvements**
1	Demand for mental health support throughout the region is identified.	PHOs	Ensure mental health is screened for during enrolment health checks. This will enable over time the collection of actual incidence data. From the above exercise ensure that general practice has information in terms of referral agencies, self help sites, brochures/leaflets on specific conditions including best practice literature.	By 2011	Screening completed Support mechanisms available.	The population of need is identified throughout the region.
2	Demand for mental health support throughout the	NMDHB PHOs	Establish and operate three Mental Health Clinical Teams (Brief Intervention Coordination),	By 2015	BIC operational	People with identified mental health disorders are responded to

	region is enhanced for general practice teams.		in Marlborough, Tasman and Nelson (1.0 FTE per TLA). Work closely within the chronic conditions framework, to enhance the physical health of service users/tangata whaiora. Enhance/develop the NMDHB Mental Health website to include self help/self management tools. Showcase Mental Health NGO/Specialist Mental Health Services, Voluntary/Community Groups at General Practice Team information sharing workshops. Work with NMDHB to explore opportunities for enhancing the number of General Practitioners operating in the Marlborough and Tasman districts.		Improved physical health of service users. Website operational. Service information/ presentations at each information sharing workshop. Over time, planning for increased GPs implemented.	in an effective and timely manner throughout the region.
3	GP's and other health professionals in the community are supported to meet the demand.	PHOs Mental Health	Up-to-date, regular free training and information is available to health professionals across the region. In the first three years this will focus on depression, anxiety disorders, addictions, opportunities to improve access for Maori, Pacific and Children and Youth. Develop a Memorandum of Understanding with Specialist Mental Health Services that covers the Mental Health Primary Care Liaison roles, BIC interface, and information sharing processes and protocols. This will include the enhancement of a Stepped Care model.	Ongoing	At least three workshops held per annum. MOU solidified.	GPs and health professionals have more capability to manage mental health disorder throughout the region.
4	Robust communication and IT systems are in place to support health	PHOs NMDHB	Investigation into appropriate IT systems that will improve the continuity of care (*and responsiveness)* across	By 2009	IT system explored and if systems achievable, work towards	IT systems developed that supports a stepped care process.

	professionals to work together across primary and secondary sectors.		primary and secondary care.		implementati on.	

CHALLENGE 3 – ACCESS

Voices:

"Running fee for service under primary care defies logic" – a general practice doctor

"people do not get well in hospital' – mental health professional

"There is a lack of awareness where people can access health and social support" – mental health promoter

'..Developing local solutions for local needs.' – training provider for tangata whaiora

Best Practice:

Access to primary health services is pivotal to ensure early assessment, diagnosis and treatment.

Issues:

- **0800 contact** - *needs to be in place throughout the region for crisis referral, health and illness information, local and national contacts and resources – this is a powerful tool in the hands of a motivated family member and is well-used when provided, and promoted – this can be extended to txt options .E.g. for the deaf.*
- **Cost** – *at present cost is the major barrier to the uptake of more mental health services, in particular for counseling – the provision of more primary health care services and support, will cost more – with collaboration with communities cost-saving and cost-sharing is possible*
- **Rural** – *people in rural areas have less access to services and programmes than those in urban areas – this can be improved by rural clinics, especially run in conjunction with local community groups*
- **Community treatment** - *opportunities exist to place services in the community, particularly those that are community-driven – this allows specialist services to centralize with the option of providing outpatient visits in health facilities*
- **Communities** – *our communities are unique – the (non) viability of providing GP services in rural areas provides the opportunity to engage salaried doctors in a growing relationship within rural communities, in particular – the local health initiatives in Golden Bay, Motueka and Blenheim present opportunities to share costs and provide better concatenation between services*
- **Travel assistance** – *distance to travel and lack of transport are barriers to accessing mental health services – the cost of travel needs to be included in any 'package of care'*
- **Adequate Resources for treatments** – *cost is a barrier in the purchase of services and medicine within the region for many (evidence suggests that this may screen an unmet demand for mental health services and programmes)*

- **Schools and education** – *schools particularly in rural communities can be 'hubs', from where people can gain access to a range of primary health and clinical services – schools require resources and expertise to deal with emerging mental health issues – programmes are required, to assist students to deal with emotions and stress – the national website www.thelowdown.co.nz provides an interactive and dynamic response*

- **Internet and self-help** – *internet access should be available to all – access can be negotiated as part of a 'care package', and/or as provided in the community by a local provider of services – self-help CBT and other online resources have been shown to assist in reintegration with community realities, and issues.* [36]

A	**Challenge: Access** That tangata whaiora can access support and clinical treatment, wherever and whoever they are, in our community					
	Outcomes	**Role/Resp.**	**Resource**	**Timeline**	**KPIs**	**Capability Improvements**
1	Better support is available for women who are experiencing post-natal depression	PHOs	Implement the findings of the Post Natal Depression Report as resources become available.	By 2009	At least five recommendations implemented.	Reduced impact of post-natal depression.
2	Rural and other isolated communities including migrant and deaf communities have appropriate access to psychotherapy and counseling services.	NMDHB via contracted agency.	Explore the extension of video-conferencing facilities (*or other IT)* in rural areas. This that would link with medical professionals and other community agencies to assist support tangata whaiora assessment, diagnosis and treatment. Promote access to the NMDHB mental health website.	By 2010	Videoconferencing extended if applicable. Website operational.	Reduced impact of isolation and alienation on the mental health of minority groups.
3	Maori communities in the region have access to culturally appropriate and effective primary care General Practice	NMDHB PHOs	Explore the development of mobile general practice service targeted at the Maori community, designed to improve early access and intervention. Explore the extension of whanau ora services to encompass mild to moderate mental health services.	By 2010	Reports completed and recommendations implemented.	Earlier identification, intervention and prevention for Maori, who have the highest prevalence of mental unwellness.

4	Improve access to primary mental health services for key target groups.	PHOs	Establish stronger linkages with migrant centres and widen interpreter support services. Work with Pacific communities to enhance support and advice for the sector. Work with the Child Youth Expert Advocacy Reference Group to consider ways to improve access to services for children and youth.	By 2013	Linkages established and operational. Pacific supports available for the sector.	Improved access for key target groups who experience access barriers and higher prevalence.
5	Schools have better access to psychotherapy and counseling services.	Ministry of Education NMDHB MSD PHOs Child Youth and Family	Explore a collaborative intersectoral approach with Ministry of Social Development (MSD) , NMDHB, Primary Health Organisations, Child Youth and Family, Ministry of Education in terms of supporting the education sector with students who have mild to moderate mental health problems.	By 2015	Collective approach to psychotherapy and counseling services agreed.	Improved interventions for the education sector.

CHALLENGE 4 – CHOICE

Voices:

"being unwell limits your ability to make positive decisions" – mental health nurse

'..Peoples ability to be in control of their choices....' – employment consultant for tangata whaiora

Best Practice:

Services that are about wellness and choice and are: timely, affordable, inclusive, holistic, ongoing, personalized, respectful, community-based, appropriate, of quality and safety, and providing best practice

Issues:

- **Range of options, interventions and providers** – *counseling and CBT are seen as effective in early intervention but are often not available or subject to time delay – counseling services need to be more available, to more people, and at more times*
- **Self-help** - *o8oo, internet and cell phone options provide improved and dynamic access to resources and communication – the conduits need to be available and accessible, the information/interaction current, and in languages that are understood – a close interface between demand and information source is critical to the efficacy of the 'message'*
- **Health promotion** – *the message needs to be: good health is the business of everybody – promoting good practice and accessible resource is the challenge , shifting emphasis from unwell to wellness – a community service that must work to link local, regional and national levels of education and awareness-raising*
- **Information** – *the ability of health services to inform the community depends on the relevance of the message and the value of the information to the receiver – work is required in targeting resource to specific needs, and specific populations – an example of a user-friendly heath website is the Southland DHB, information and ease of access is easy!*

C	**Challenge: Choice** To ensure that tangata whaiora are empowered to have choice and options, when ill, and in recovery.					
	Outcomes	**Role/Resp.**	**Resource**	**Timeline**	**KPIs**	**Capability Improvements**
1	There is a range of options available to support tangata whaiora and their family	NMDHB PHOs	PHO and NMDHB websites lists the number of 0800 self help numbers and mental health websites available. PHO and NMDHB websites lists the full	By 2010	Website operational	Health sector supports establishment of resources and self-help options.

	whanau.		range of services currently available both specialist and primary health care, community/voluntary organizations. Continue the practice of identifying general practice charges.			
2	There are a range of interventions that are appropriate and accessible	NMDHB PHOs.	NMDHB and PHO's continue to develop the primary mental health initiative in conjunction with the Ministry of Health. NMDHB, PHO and MSD work together collectively to develop PATHS and Mild to Moderate packages of care.	Ongoing	Increased number of packages delivered.	Greater flexibility and better options to meet individual needs.

CHALLENGE 5 – TIME

Voices:

"mental illness does not stop Friday, Saturday, or Sundays" – parent of mental health consumer

'..Actually capture what is going on' – kaupapa Maori mental health professional

"For too long the mild to moderately unwell have been neglected in primary health" – a doctor in general practice

Best Practice:

Picking up problems at the earliest possible time and providing the right treatment in the right setting can prevent distress and suffering, prevent some problems becoming more severe and enhance recovery [37]

Issues:

- **Timely intervention** – *catching 'that moment' is critical in the care and treatment of mental health issues – if the moment is passed the consequences for all involved is likely to be painful, wasteful and expensive – early intervention for all disorders is seen to have a significant positive effect for clients within treatment*
- **Time to follow-up** – *encouragement and follow-up is critical, particularly in the early stages of mental illness*
- **Adequate time for consultation/treatment** – *in the GP environment, time is scarce for extended consults – if an intervention for tangata whaiora is included in a 'package of care', this enables medical and other professionals to attend meetings that actively assist reintegration and recovery e.g. Strengthening Families*
- **Ongoing and 'held'** – *any intervention needs to be consistent and will take time – while in treatment the client/patient needs to be 'held', and monitored(with consent), with the provision of feedback to other engaged services*

T	**Challenge: Time** To ensure that tangata whaiora are provided enough time to address issues relating to their unwellness					
	Outcomes	**Role/Resp.**	**Resource**	**Timeline**	**KPIs**	**Capability Improvements**
1	Appropriate services are made available when required and for as long as needed.	NMDHB PHOs	Develop an agreed Tangata Whaiora pathway that is widely accepted.	By 2010	Pathway agreed.	Greater flexibility and better options to meet individual needs.

2	Tangata whaiora have access to extended consultations with practitioners.	NMDHB PHOs	Ensure tangata whaiora who are eligible have access to extended GP consultations either through PATHS, Primary mental health initiative, chronic conditions packages, MSD mild to moderate, or other packages. Work with the Pharmacy sector to enhance the provision of one to one medication advice. Upon evaluation of the Primary Mental Health Initiative, work with NMDHB and the Ministry of Health to extend and increase the initiatives volumes.	By 2009	Increased access to existing initiatives.	Improvements in diagnoses and subsequent management

CONCLUSION

At present, there is significant unmet need in people with mental disorders. In our region this equates to over 20,000 people who may require assistance from Primary Care to address mental health issues.

There are a number of specific primary mental health services currently in development but with very small volumes. As evidenced in this report, mental health prevalence is high and the primary care sector require further investment and support to enhance access, support and treatment for those members of our community who experience mild to moderate mental health problems.

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APPENDICES

APPENDIX ONE – GLOSSARY OF TERMS

Access – A potential service user's ability to obtain a service when they need it and within the appropriate time

Assessment – A service provider's systematic and ongoing collection of information about a consumer to form an understanding of consumer needs. A clinical assessment forms the basis for developing a diagnosis and an individualized treatment and support plan with the service user, their family, whanau and significant others

BIC – Brief Intervention Coordination

Capability – An individual, organization or sector having the right skills, knowledge and attitudes to deliver high-quality and effective mental health and addiction services

Capacity – An organization or sector having sufficient appropriately trained staff and resources to deliver a high-quality and effective mental health and addiction service

Cognitive Behavioral Therapy – in CBT the clinician teaches the person adaptive coping skills and provides practice opportunities to develop a sense of mastery over anxiety systems or situations that are associated with distress or impairment

Counseling – Is guided discussion with an independent trained person, to help the consumer find their own answers to a problem or issue

DAP – District Annual Plan

DHB – District Health Board

Empowerment – A sense of one's own value and strength, and a capacity to handle life's issues

Evidence-based practice – An approach to decision-making in which the clinician uses the best evidence available, in consultation with the consumer, to decide on a course of action that suits the consumer best

Family – The service user's whanau, extended family, partner, siblings, friends or other people that the service provider has nominated

GP – General Practice

Health Promotion – The process of enabling people to increase control over and improve their health. It involves the population as a whole in the context of their everyday lives, rather than focusing on people at risk for specific diseases, and is directed towards action on the determinants of health

Integrated Approach – An integrated approach addresses the continuum of need and encompasses public health approaches and intervention services

Mental Health – A state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community(WHO 2001)

Mental Health promotion – The process of enabling people to increase control over, and to improve, their health. Mental health promotion is not just the responsibility of the health sector

Mental Health Sector – The organizations and individuals involved in mental health to any degree and at any level

Mental Illness – Any clinically significant behavioral psychological syndrome characterized by the presence of distressing symptoms or significant impairment of functioning

NMDHB – Nelson Marlborough District Health Board

Outcome – A measurable change in the health of an individual, or a group of people or population, which is attributable to interventions or services

Poupou - (noun) post, pole, upright slabs forming the framework of the walls of a house, carved wall figures: (adj) be steep, upright

PHO – Primary Health Organization

Prevention – Intervention that is designed to prevent mental health disorders or problems. Prevention interventions may be:

- Universal – targeted to the whole population (e.g. healthy cities)
- Selective – targeted to individuals or groups at increased risk (e.g. postnatal visits for new mothers)
- Indicated – targeted to individuals with early symptoms (e.g. grief therapy for individuals experiencing the loss of a close relative, partner or friend)

Primary health care – Essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to and a central function of the country's health system, and is the first level of contact with the health system

Psychotherapy – Is a treatment of mental and emotional health conditions, using talking and listening

Recovery – Living well in the presence or absence of mental illness and the losses that can be associated with it. There is a long and generally held view that in the addictions field recovery involves an expectation/hope that people can and will recover from their addiction/unwellness, acceptance that recovery is a process not a state of being, and recognition that the recovery is done by the person addicted/affected, in partnership with the services (in the widest sense of the word) providing help. A challenge faced by mental health sector is the ongoing development of the concept and language of recovery

Service User – A person who uses mental health services

Tangata Whaiora – People seeking wellness; mental health service users

Whanau – **Kuia, koroua, pakeke, rangatahi, tamariki**. The use of the term whanau is not limited to traditional definitions, but recognizes the wide diversity of families represented within Maori communities. It is up to each whanau and each individual to define for themselves who their whanau is.

WHO – World Health Organization

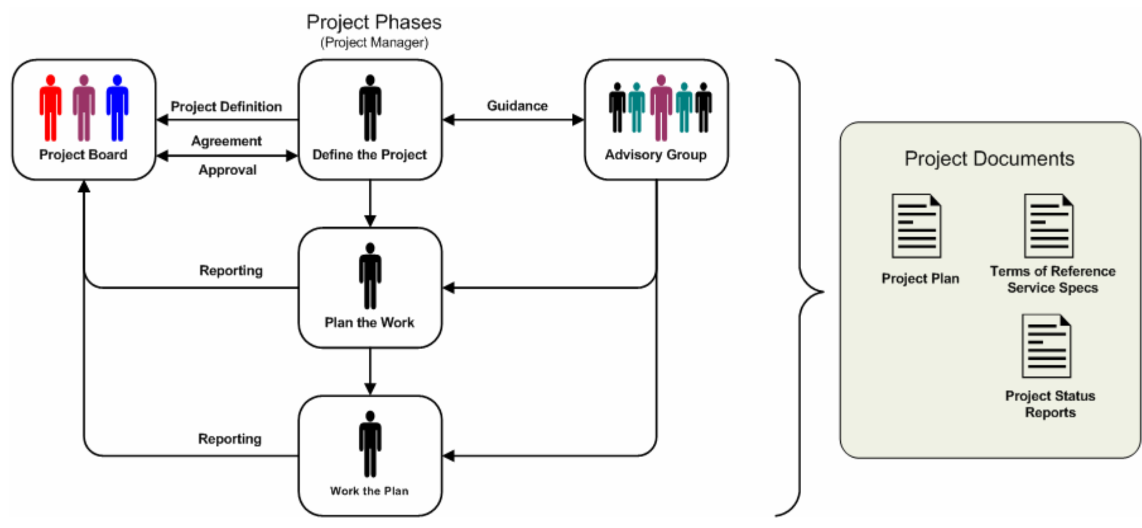
APPENDIX TWO – PROJECT BOARD AND ADVISORY GROUP MEMBERSHIP

Project Board	
Name	**Location/Role**
Andrew Dobbs	Chief Executive Officer - Nelson Bays Primary Health
David Stichbury	Project Officer – Nelson Bays Primary Health
Lorraine Eade	Nelson Marlborough District Health Board
Allie Shaw	Manager – Marlborough PHO

Advisory Group	
Name	**Location/Role**
Lyn Allen	Te Rapuora
John Allen	MCT
Megan McQuarrie	NMDHB
Jude Olliver	Consumer Rep
Jenny Crosbie	Consumer Rep
Maggie Cambra	Family Rep
Vicky Hay	Family Rep
Janie McIntyre	Gateway
Lois Boyd	NMDHB
Jane Haughey	Richmond NZ
Dave Dixon	GP Rep
Andy Dawson	GP Rep

NB. The Advisory Group met twice during the term of this project

APPENDIX THREE – PROJECT STRUCTURE



APPENDIX FOUR – KEY NZ PRIMARY MENTAL HEALTH LITERATURE

Key Mental Health and Policy Documents:

Te Kokiri: The Mental Health and Addiction Action Plan 2006-2015. Minister of Health.2006. Wellington: Ministry of Health

He Korowai Oranga: The Maori Health Strategy. Minister of Health. 2002. Wellington: Ministry of Health

Te Puawaitanga Maori Mental Health National Strategic Framework. Ministry of Health. 2002b. Wellington: Ministry of Health

The Primary Health Care Strategy. Minister of Health. 2001. Wellington: Ministry of Health

Te Tahuhu – Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan. Minister of Health. 2005. Wellington: Ministry of Health.

NZ Suicide Prevention Strategy 2006-2016. Associate Minister of Health. 2006. Wellington: Ministry of Health

Our Lives in 2014: A recovery vision from people with experience of mental illness for the second mental health plan and the development of the health and social sectors. 2004. Wellington: Mental Health Commission

Let's Get Real: Real skills for people working in mental health and addictions – draft for consultation 2007. Ministry of Health. 2007. Wellington: Ministry of Health

Te Rau Hinengaro: the NZ Mental Health Survey. Ministry of Health. 2006

Local Mental Health Documents of Note:

A Paradox in a Paradise: An Assessment of Mental Health Needs and Services in Golden Bay. Dr Struan Clarke

Marlborough Maori experience in accessing Mental Health services via primary mental health care: An exploratory study. Lorraine Eade, 2007.

APPENDIX FIVE – REVIEW OF KEY PRIMARY MENTAL HEALTH INITIATIVES

1. The WIPA primary health care and specialist mental health liaison programme

On-going programme that addressed the barriers to mental health consumers accessing primary health care through an effective transfer process including new roles and funding
Programme was developed with strong involvement from consumers and providers in the governance of the project
Clients expressed a high level of satisfaction with the programme with majority preferring the primary care arrangement to care from specialist mental health services
GP's ambivalent about the value of the programme at first, after 12 months more supportive
Supported by a comprehensive education programme for doctors, practice nurses and practice staff, which was well attended and received positive feedback

2. Newtown Union Health Centre

Provides a primary health care service to people on low incomes
The primary health care service is delivered by the GP and a primary health care nurse based at the centre
Consultations are provided at no charge and each fortnight a consultant-liaison service is provided by a psychiatrist

3. Rural Canterbury PHO – Brief Intervention Coordination Service

Provides adults with mild to moderate mental health concerns up to five sessions of free psychological intervention.
Referrals come from GP teams, where possible clients are seen in GP rooms
Even with high service demand, clients were seen within one month of referral
Has a team of six including Project Manager/Clinical Psychologist
Both clients and GPs very satisfied with BIC service in terms of access, quality of care
Clients particularly rated the service highly in terms of being treated with dignity and respect, and being listened to

4. Mornington PHO – Mental Health Brief Intervention Service

Based in a large GP setting, all under one roof
Uses Kessler 10 scale for assessment
As well as GP referrals now more self-referrals, Plunket, Women's Refuge etc
Has extended hours to cope with demand from people who are working
Only minimal referral onto secondary services, most able to be dealt with within the GP setting
Receiving more and more referral for those under 18

5. South Canterbury PHO – Mental Health Brief Intervention Service

Based in GP settings (28), most of whom are visited once a week
Serviced 2000 clients over 3 years
Increasing number of older people being seen, particularly for grief and loss
Refer on to parenting programmes, Workbridge, Career Services etc
All BIC workers have laptops and receive electronic referrals
BIC team has mix of nurses and social workers, all with a mental health background

Increasing demand from youth

6. West Coast PHO – Mental Health Programme

Started April 2006, and has seen 423 people up to October 2007
Focuses on, and works from the General Practice setting throughout the West Coast
Triaged by one screener for any mental health issue, then on to Brief Intervention Coordination (BIC) Service
Service is integrated with GP teams who are supportive of the initiative and who see real benefit for the patient
Patients are enthusiastic and acceptant of the service
Produced booklet for GPs to educate them on what is available in the community

7. Webhealth(NZ)

A website designed to provide health and well-being information and links to services
It is based on the belief that people have the strength and ability to find their own solutions to issues in their lives when they have access to the right information and resources
Still extending coverage of NZ regions

APPENDIX SIX – INVENTORY OF REGIONAL PRIMARY MENTAL HEALTH INITIATIVES – MENTAL HEALTH POPULATIONS OF NEED REPORT 2008

The following table depicts the number of public health, primary health and specialist providers working across Nelson, Tasman and Marlborough. This was identified in the

	Public Health	Primary Health			Specialist Mental Health and Addictions Providers					
	Health Promotion	General Practitioners	General Practice Teams	Pharmacy	Child and Youth	Adult	Elderly/Kaumatua	Kaupapa Maori	Service Users Tangata Whaiora	Family/Whanau
Tasman	**0**	**30**	**11**	**8**	**3**	**5**	**0**	**2**	**4**	**1**
Nelson	**4.8**	**41**	**19**	**8**	**3**	**4**	**0**	**3**	**4.25**	**1**
Marlb	**2.23**	**29**	**9**	**9**	**3**	**5**	**0**	**1**	**3.25**	**1.2**
Total	**7.03**	**100**	**39**	**25**	**9**	**14**	**0**	**6**	**10.25**	**3.2**

APPENDIX SEVEN – CONSULTATION WITH STAKEHOLDERS

Consultation with Stakeholders:

Michael Lynch – Supporting Families/Nelson
Lynley Murtagh – Nurse Educator/Mental Health, NMDHB
Lorraine Eade - Portfolio Manager - Mental Health
Christine Carr – Community Relations Officer, NZ Deaf Association
Jos van der Pol – Compass and Kotuku
Renee Alleyne – SF/Motueka
Sue Vollmer – Work and Income Case Manager, Motueka
Practice Nurses of Motueka (5 people)
Dee Cresswell – Whenua Iti Trust, Lower Moutere
Lois Boyd – Nurse Consultant Mental Health, NMDHB
Helen Saul – Workstar, Nelson
Sean Delaney – Kaupapa Maori Mental Health Support Worker, Te Awhina Hauora, Motueka
Gethyn Filer – Community Mental Health Nurse, NMDHB
Erin Rowling – Primary Care Liaison Nurse, NMDHB
Motueka Parents Support Group (8 people)
Wendy Earle – Be Well team and Heartlands, Golden Bay
Claire Pearson – Strengthening Families, Golden Bay
Sheryl Nalder – Golden Bay Community Workers
Glynn Rogers – Golden Bay Community Workers
Jo Johnson – Te Whare Mahana, Takaka
Fennella Hemm – Clinical Leader, Plunket, Nelson/Marlborough
Grant Andrews – NZ Police, Motueka
Penny Molnar – Community Nurse, Victory Health Centre, Nelson
Tui Hammond – Community Law, Nelson
Glenn Thomas – Health Promoter, Nelson Bays PHO
Ali Gardner – Manager, Golden Bay Workcentre
Allie Symonds – Social Worker, Outreach, Takaka
Jan Morgan – Convener, Golden Bay Integrated Health Centre
Jackie Stocker – Acting Coordinator, Outreach, Takaka
Paul Marcussan – Pharmacist, Takaka
Golden Bay Medical Centre – 3 Doctors and two Practice Nurses
Tania Craig – Mental health Support Worker, Te Kahui Hauora o Ngati Koata Trust, Nelson
David Hough – Mental Health Promoter, NMDHB
Tipene Taylor – Health Promoter, Te Rapuora, Nelson
Helen Bracefield, **Trisha Colling, Caroline Jones, Charlotte Townsend** – Well Child/Public Health Nurses, Nelson/Marlborough
David Osbourn – Doctor, Richmond
Andrea Taylor – Te Ara Mahi, Richmond
Motueka Practice Nurses (8 people)
Chris Budgen – Chair Pharmacy Advisory Group
Buzz Burrell – Doctor, Blenheim and Havelock
Andrae Gold – Mental Health Promoter, NMDHB
Klem Rosandich – Mental Health Clinician, Te Rapuora, Marlborough
Irene Langham – Primary Care Mental Health Laison Nurse, NMDHB

Meetings and Hui Attended:

Te Roopu Tupu Tahi/Nelson – 30/10/07
Te Roopu Tupu Tahi/Blenheim – 18/9/07
South Island Primary Mental Health Regional Network Meeting/Christchurch – 14/11/07
Life Matters Hui/Nelson – 29/11/07

APPENDIX EIGHT – BIBLIOGRAPHY AND FOOTNOTES

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APPENDIX NINE – ACKNOWLEDGEMENTS

Thank you:

- NMDHB
- the Advisory Group
- Nelson Bays PHO and Kimi Hauora PHO
- Lorraine, Andrew, Allie, David and Martin
- The many people who contributed
- People who experience mental 'unwellness', and their family/whanau, their friends
- Dedicated mental health professionals
- Community workers, doctors, pharmacists, nurses, social workers, kaupapa Maori health workers and police

Kia Ora Koutou

Rob Francis