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

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

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

The context of today’s concerns

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

While PMHIs were successful in establishing a primary mental health capability with clear benefits for those people gaining access to services, the pathway of development to date has clearly had its limitations:
It has been established using a PHO level bottom-up process. Consequently the strategic context for PMHC and its purpose and function within wider primary care or within the continuum of mental health care has generally had little attention. As a result there is substantial variation in focus, approach and equity of access across PHOs, and lack of connection with the wider primary care and DHB services.

The PMHIs have had relatively modest funding. While this has supported the development of a basic level of service in most PHOs or districts it has not been sufficient to develop a broader infrastructure of relationships, leadership, service development and integration that is capable of addressing sustainability issues.

Limited and centrally driven funding has meant that there have been pragmatic choices made in each PHO over targeting their services. Comprehensive population planning and outcomes targeting has been limited. There are unresolved challenges in managing both access criteria and model of care trade-offs between breadth and intensity of services.

The programmatic, ‘packages of care’ nature of the initiatives means they are not well integrated horizontally with ‘business as usual’ primary care (including self care and care for long term conditions), nor vertically with DHB supported community and specialist mental health services.

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

In a partial response this paper articulates the nature of the issues facing clinical leaders, service managers, planners and funders in developing a sustainable primary
mental health capability, with pointers to further development contained in a series of issues focused guides within the Toolkit.

**A framework for current issues**

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

![Diagram of issues covered in essay]
Developing the strategic context for primary mental health

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

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

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

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

Taking this starting point the Toolkit explores the function of PMHC in terms of effective responses to episodic distress and impaired functionality within the person social and cultural context. This provides a strategic platform to engage people and their whānau, clinicians, service managers and funders to ask questions about the
role of primary and specialist services in mental health and how to best utilise the resources and capability used across the whole continuum.

2. Future proofing in a changing policy world

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

- Long term service trends are simultaneously increasing the specialisation of care and emphasising greater shared care; between specialists and wider primary care, and between health services and people and families as co-producers of care. These trends will drive greater integration e.g. the development of mental health services in integrated family health centres and the adoption of variants of stepped care. Similarly there will be pressures for further development of supported self care through e-therapies, peer support and mental health capable community health workers.

- Changes to funding pathways: The tight ring fencing of mental health funding (particularly for secondary and community services) is loosening. This is a challenge in that it will require mental health to justify its priority against competing demands. It is also an opportunity in that it provides greater freedom for rethinking how best to deploy capacity across the continuum of mental health care. Funding pathways in primary care are changing as flexible funding pools, alliance contracting and Whānau Ora funding models will blur the hard boundaries of existing funding streams and place more onus on providers to prioritise and manage resources to achieve better health outcomes.

- Workforce skills shortages and pressures for much higher levels of productivity will generate pressures for developing models of care that make finely tuned use of scarce, expensive resources and that facilitate use of new workforce roles, including those of patients and families.
The same productivity pressures are generating a search for scale and efficiency across health organisations; whether this is PHO amalgamation, regionalisation of DHB services or national shared services.

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

3. Developing population and outcomes focused planning frameworks

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

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

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

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

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

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

5. Creating effective system leadership for primary mental health care

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

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

Developing the service environment

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

1. Choices of population focus

Not surprisingly for a service that has emerged from a pilot capability development background few PMHC services are founded on a comprehensive view of population
need. For pragmatic reasons most have taken a condition focus, (e.g. depression or anxiety), and within this established eligibility requirements that further define the population who can access services. This generates substantial questions of equity and effectiveness, for example;

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

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

2. Choices of models of care

While there is a building of knowledge and an evidence base of effective mental health care in primary settings there is a wide range of variation in the models of care used in practice. For example, the evaluation of PMHIs found nine distinct models in use. These differed considerably in terms of type of capability, workforce and resource required. In many cases the model of care has been driven by availability of providers or therapeutic tradition and differs substantially across PHOs within each area.
Since choice of model of care can have a substantial impact on outcomes, population reach and resource usage, developing consistent and coherent approaches is a critical issue for future sustainability.

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

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

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

3. Addressing social and cultural needs

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

Some services, particularly Māori, are investing in the engagement of a wider circle of whānau within a cultural approach to develop social strength and collective family
capacity. Our observation is that effective services using this model tend to require more time and longer duration of engagement, and therefore require care in the design of programmes, effective targeting and the ability to utilise multiple funding streams. It is important that there is continuing evaluation of services that require intensive funding.

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

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

4. Primary/secondary integration and shared care

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

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

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

- Previous shared care initiatives were largely specialist driven, with implicit assumptions that specialist knowledge and skill transfer was critical. The development of structured PMHC is building a primary care knowledge and
skill base that is effectively handling complex mental health needs. This different, but complementary, primary practitioner capability opens new opportunities to organise care across the continuum.

- Better understanding of the nature of the population and health needs currently served by secondary and specialist funded community services is highlighting that many are not receiving appropriate high quality care. Lessons from initiatives such as ‘Knowing the People Planning’ highlight that many people with severe diagnostic categories are relatively stable with only episodic need for more intensive support. Similarly many people with complex and enduring mental health needs are not receiving comprehensive bio-medical care.

- Ministry of Health policy direction supports the implementation of stepped care and the greater role of integrated primary/community based health services. Stepped care requires a coherent approach to mental health services across the continuum. A critical functional element will be acceptance that responsibility for certain aspects of care remain with the primary team, and that specialist care, including shared arrangements, will be integrated with this.

- Potential of greater flexibility in mental health funding with the relaxation of funding ring fences that could facilitate a whole of system view about how mental health resources and capacity are used.

5. Linkages with long term conditions

Within primary health care settings the co morbidity between physical and mental disorders is a reality that makes separation of responses within artificial clinical boundaries less effective in terms of care and inefficient in terms of duplication of resources and capabilities. This is especially true with the overlap between mental health and long term conditions where co-occurrence is the norm and exacerbates the morbidity burden of each in isolation. On this basis alone PMHC cannot be divorced from services for physical health.
However, responses for mental health and long term conditions have similarities and difference that are important to balance in model of care development and service design. By definition long term conditions are enduring and are likely to require sustained and increasing intensity of support over time. In contrast mental disorders are very largely episodic, needing interventions during periods of relapse or stress combined with support to enhance resilience and capacity for self care.

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

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

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

**Developing a sustainable infrastructure**

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

1. **Aligning funding, service design, contracting and service prioritisation criteria**

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

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

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

This will need to address issues such as:

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

2. Coordination of care

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

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

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

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

Sustainability will require more coordination capability than this approach provides, with requirements to mainstream and integrate some aspects of PMHC coordination
for scale and effectiveness, while increasing focus on the specific aspects that more integrated clinical model will require.

The Toolkit issues guide ‘Coordination of Care’ provides a process for inquiry and design for this critical component of service infrastructure.

3. Roles, teams and capability development

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

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

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

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

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

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

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

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

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

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

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

1. Developing effective relationships and communication

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

- There are challenges in establishing a strategic context for PMHC that is strong enough, so that stakeholders see this as a priority for attention amongst their other competing demands.
- There are substantial differences in paradigms and concepts across practitioners, professionals and managers operating in wider community, primary, NGO and specialist mental health settings, that will need to integrated into a sustainable PMHC system.
- There are organisational and professional interests and investments in particular service configurations that will require adaptation and change as PMHC evolves.
- Building engagement and trust takes time and there are practical issues of enabling participation of key stakeholders where their time is highly committed and where participation is a financial burden on small organisations whether private businesses or not for profit agencies.
An effective change and development infrastructure will require more investment by localities in developing their relationship infrastructure. A clinical leadership network, with a service development role mandated by the key stakeholder organisation in an area, will be an essential component of a change infrastructure.

Since only a few areas currently have this capability in PMHC, the Toolkit issues guide ‘Relationships and Communication’ provides a process for stakeholder analysis to guide the design of an effective relationship capability.

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

2. Sustaining development and managing change

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

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


