Toolkit for Primary Mental Health Care Development:
Part 2: Knowledge Bank

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Knowledge Bank

This section of the Toolkit contains four perspective papers on the following topics:

- **Where next for Primary Mental Health Care? - current issues and opportunities**
- **Diagnosis and management in Primary Mental Health Care: a paradox and a dilemma**
- **Quality in Primary Mental Health Care**
- **Towards the future Primary Mental Health Care: Optimal Model II**

The Toolkit website (see Knowledge Bank webpage) has copies of the following:

- Evidence-based Best Practice Guidelines: Identification of Common Mental Disorders and Management of Depression in Primary Care (July 2008)
- Assessment of depression in adults in primary care (from ‘Best Practice’ July 2009).
- Evaluation of the Primary Mental Health Initiatives
- Te Rau Hinengaro: The New Zealand Mental Health Survey

Other useful links:

- [www.primarymentalhealth.org.nz](http://www.primarymentalhealth.org.nz)  (Ministry of Health’s primary mental health and addiction website)
- [www.nzgg.org.nz](http://www.nzgg.org.nz) (see Guidelines for Identification of Common Mental Disorders and Management of Depression in Primary Care)
- [www.hiirc.org.nz](http://www.hiirc.org.nz) (Health Improvement & Innovation Resource Centre)
- [www.tepou.co.nz](http://www.tepou.co.nz) (New Zealand’s National Centre of Mental Health Research, Information and Workforce Development)
- [http://www.thelowdown.co.nz/](http://www.thelowdown.co.nz/) (The Lowdown - Youth depression website)
**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.
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


Diagnosis and management in Primary Mental Health Care: a paradox and a dilemma

In this perspective paper we examine the issues associated with the diagnosis of mental health problems in primary care in relation to treatment and service provision, concluding that we are moving to formal acknowledgement that problems presenting in primary care are commonly mixed clinical pictures with associated social issues and that purpose designed refinements of current low-intensity treatments will be necessary.

Why do we classify and diagnose?

Diagnosis serves several purposes in all areas of clinical practice. Making a diagnosis requires classifying the clinical problem and gives the clinician a ‘short hand’ way of understanding the clinical problem, in particular what features the patient has in common with others with similar problems, what treatments are most likely to work, and what the prognosis is likely to be (Kendall 1975). Having a diagnosis enables health professionals to communicate with patients about the nature of the problem, and also with each other.

While clinicians have used diagnostic constructs for thousands of years, more recently diagnoses have also been used as part of sophisticated systems to determine what services people should have access to, and how services will be funded. The two main classifications in use, The World Health Organisation ICD system and the American Psychiatric Association Diagnostic and Statistical Manual (DSM), were both initially developed from systems which counted hospital statistics. They are now used not just in public health and research settings, but particularly in the case of the DSM, for health insurance and billing purposes.

Problems with classification and diagnosis

Although classification of psychological problems is important for research and service provision purposes and has become an important part of psychiatric practice, in clinical practice, it can be problematic for several reasons. Psychiatric diagnoses
may be unstable over time within an individual (Baca-Garcia E et al 2007; Ghazan-shahi et al 2009). The psychiatric diagnostic categories themselves are also unstable – for example, in the change from the DSM III (265 disorders in 1980) to DSM IV (279 disorders in 1994), 14 new disorders were introduced, with some new disorders being constructed and others disappearing. In ordinary psychiatric practice many of the treatments are not specific to existing diagnostic categories. Finally, having a psychiatric diagnosis is associated with the experience of stigma and discrimination, with some disorders being stigmatised more than others.

In the primary care setting, diagnosis is associated with these problems but additional issues add to the complexity. The diagnostic systems in common usage (i.e. the ICD and DSM systems) are largely derived from specialist psychiatric practice, and reflect the kinds of sign and symptom patterns that are seen in that setting. Over the years the diagnostic categories have been refined to better reflect the presenting problems and what is increasingly known about their aetiology and underlying pathophysiology. In this process the number of diagnostic categories has increased and the inclusion and exclusion criteria have become more precise. This process has also led to increasing use of the ‘not otherwise specified’ categories as even psychiatrists find the categories cannot accommodate the problems people present with. It led the classification system further away from what is commonly seen in primary care: for example until its current version the DSM system did not have a category for ‘mixed anxiety and depression’, the most common presentation in general practice settings. Furthermore, there has to date been a focus on categories rather than considering symptoms and functioning in various domains as dimensions of experience and observable phenomena. In relation to treatment, there have been increasing attempts to tailor treatments to the more specific diagnostic categories, although observation suggests that this is usually short-lived and that after a period the indications for new treatments tend to broaden out to include more diagnoses (i.e. the treatment becomes less specific).

Alongside all these issues, a fundamental problem for primary care practitioners is that the syndromes that reflect some aspects of problems presenting in psychiatric
practice quite well, do not suit primary care practice. This is because primary care patients usually do not present with such clear cut patterns of signs and symptoms. People often present to primary care with mixed clinical pictures, and syndromes evolve over time. Furthermore, in primary care settings, people commonly present with non-specific psychological distress, i.e. with syndromes that do not meet the diagnostic threshold. Just over one quarter of primary care patients are considered by GPs to have diagnostic sub-threshold problems. These ‘sub-threshold’ problems are common, and are associated with significant suffering and impaired functioning (Collings et al. 2006; Martin et al. 1996; Wagner 2000). For example, many patients in primary care with problem drinking would not reach the threshold for alcohol dependence, but nevertheless create significant problems for themselves, their families and society.

Medically unexplained symptoms (i.e. a combination of psychological and persistent physical problems with no detectable underlying pathology) often represent psychosocial distress and are common presentations in primary care. Many of these symptoms may come to be diagnosed as part of recognised medical conditions such as irritable bowel syndrome, but when the symptoms persist or become multiple in their nature it may be helpful to label them as a psychological problem. These can be challenging to manage as it is not clear which aspect to prioritise, and practitioners are fearful of ‘missing’ a treatable medical condition while also often experiencing frustration in the clinical relationship (Woivalin 2004).

Presentations of non-specific psychological distress associated with psychosocial complexity (e.g. welfare, housing or family/whanau issues such as violence) are common and do not lend themselves to simple diagnostic frameworks or responses (Dowell, Garrett, Collings et al. 2009).

These issues mean that both the diagnosis and treatment options for patients presenting in primary care are less clear-cut than in secondary care. From a classification perspective primary care does not fit well with the existing diagnostic systems. From a prognosis perspective, there is less evidence about the course of
these mild-moderate mixed picture syndromes, but it we do know that a high proportion are eventually self-limiting (Jackson 2007).

**Mental health problem identification in primary care**

Most management of mental health problems takes place in primary care settings (Hornblow et al. 1990). Despite the problems with the utility of psychiatric diagnosis, primary care practitioners manage mental health problems frequently as part of their day-to-day work: over one third of adults attending primary care are likely to have met the criteria for a DSM disorder over the previous 12 months (MaGPlie Research Group 2003). How are the complexities outlined above resolved in practice?

We suggest that GPs are more interested in detecting psychosocial problems than diagnosing them. Although it has been suggested that GPs fail to diagnose mental health problems, we suggest that this claim is an oversimplification. GPs are effective at detecting mental health problems. The MaGPlie study showed that GPs identified psychological issues in the past 12 months in 70% of people who had already presented within the 12 month period and who had a diagnosable mental disorder during that time, but in only 33% of those who had not been seen in the previous 12 months. That study also showed that higher frequency of consultation was associated with problem detection (MaGPlie Research Group, 2005; Bushnell and MaGPlie Research Group, 2004). This suggests that continuity of care is an important element of problem detection. The same study showed that GPs consider functioning as well as symptoms when detecting psychological problems (Collings and MaGPlie Research Group 2003), suggesting that GPs do not use the same diagnostic frameworks as used in secondary care.

The clinical practice context is an important determinant of whether a primary care practitioner will decide that a psychological problem is present, and whether a decision to actively manage it is appropriate at any given time. For example, having detected a psychological problem, the practitioner may choose to address other more pressing problems in that consultation if the patient has minimal functional
impairment (Klinkman et al. 1997). Furthermore there are almost always other constraints such as time and resource issues (Klinkman 1997).

**Links between problem identification, diagnosis, clinical management and service provision**

Because health resources (both money and skilled staff) are finite, there is a need to systematically determine what problems ‘qualify’ for treatment and what treatment options will be made available. The use of clinical diagnoses to determine access to treatment and other services is widespread in health services internationally, and ranges from tightly prescribed options such as those common in Managed Care settings in the USA, to clinician determined options which are common in secondary and tertiary mental health services in New Zealand.

Funding and service delivery in New Zealand primary mental health care (PMHC) is currently predicated on being able to define clinical problems using the general diagnostic fields offered in the DSM and ICD systems, and on being able to distinguish ‘mild-moderate’ from ‘severe’ problems. However, even outside mental health, GPs are known to use widely varying practices in relation to diagnostic coding (Brown et al. 2003). Add to this what is known about the specific frailties of psychiatric diagnosis, and the uncritical use of a purely diagnostic approach in day-to-day primary care clinical practice must be open to question.

Although the DSM and ICD diagnostic systems themselves are probably rarely used in PMHC in New Zealand (Dew et al. 2005), the screening instruments that have come into common usage as part of the process of determining eligibility for primary mental health services (e.g. the PHQ-9 and the K-10) are strongly linked to these diagnostic frameworks (Kessler et al. 2003; Kroenkek 2002). The choice to use these instruments was a consequence of the thinking that simple and brief tools were needed to determine eligibility for treatment.

We contend that this was easy to adopt in the PMHC setting because PMHC development in New Zealand was already being driven in part by secondary mental health service thinking and philosophies. Two simple examples support this
assertion. The first relates to the default and even articulated age limits on most of the PMHC programmes running in New Zealand at present. Very few cater for children or people over the usual working age, replicating the age-based service divisions seen in secondary mental health services but not primary care. The second example is that most PMHC services essentially replicate the secondary care model, where people with certain kinds of problem, in this case mental health problems, are referred out of the practice to be treated or managed by a person with ‘specialist’ skills such as a counsellor or psychologist. Associated with this are potential barriers to treatment and good clinical management, including waiting times, possibly having referrals declined, having to locate and attend an unfamiliar treatment setting, poor communication between treating and referring clinician and administrative problems (Mathieson, Collings & Dowell 2009).

We know that in New Zealand GPs take a very pragmatic approach to problem classification and management (Dowell, Garrett, Collings et al. 2009). Diagnosis is not always (or maybe even often) seen as a necessary step in arriving at a clinical management plan. Many GPs have been reluctant to ‘pigeon hole’ their patients with psychiatric labels, particularly if there are, for example, insurance company implications (Dew et al. 2005). Primary care practitioners will more often use generic labels such as anxiety/depression. They tend to be ‘lumpers’ when it comes to classification rather than ‘splitters’ who create multiple sub-categories. Practitioners are aware of the impact of psychosocial issues and are prepared to classify accordingly. In some parts of the country service provision is dependent on a psychiatric or DSM diagnosis, and where this is the case then GPs will tailor a diagnostic category to ensure access to treatment. In other cases, the practitioner only has to provide a ‘diagnosis’ of ‘mild/ moderate mental health problem, to obtain services for a patient.

The apparent paradox of PMHC is that while most mental health care is provided in primary care settings and this is usually done without a formal psychiatric diagnosis, treatment can be very effective at reducing symptoms and improving functioning (Dowell, Garrett, Collings et al. 2009). This brings with it a significant dilemma for
those working in policy, planning and funding, for whom the accurate estimation and forecasting of clinical activity and associated budgets is critical. While funders may recognize the reality of primary care practice, they find it hard to commit funding to programmes that appear loose in their prescription.

Figure 1 on the next page illustrates the elements of the primary care practitioner’s process for detecting and characterising mental health problems. This is adapted from our previously published work (Dew et al. 2005) to highlight the introduction of screening for the determination of eligibility to receive services. During the course of a consultation, the clinician weighs up the options around focussing on one problem, or one aspect of a problem, over others. Note that the determination of eligibility to receive primary mental health services outside the routine consultation can occur at any time and is not contingent on a formal diagnosis being made. In some cases the practitioner will have decided early on that additional help for the psychological or psychosocial issue is warranted and will construct the diagnostic or other eligibility criteria to ensure the person receives help.
Figure 1: The primary mental health assessment process, which is reiterated over multiple consultations: mindful prioritising between multiple competing issues.
An interesting aspect of PMHC development in New Zealand is that there is an upper threshold for eligibility. The original Primary Mental Health Initiatives were required to be designed so that those with ‘severe’ disorders were not seen but were referred on to secondary care. This created some interesting scenarios where it was known by GPs that the local secondary services would not accept the referral. as although screening scores (e.g. K10 scores) were at the severe end, the person was neither psychotic nor at risk of suicide. These people were commonly kept in the PMHC service and often managed effectively.

The dilemma around treatment provision in primary care is compounded by inconsistent links between the type of clinical problem and treatment. In primary care there appears to be a lack of a tight linkage between problem type (or diagnosis) and clinical management. At the high level of the Primary Mental Health Initiatives Evaluation, it appeared that brief non-specific treatment approaches made a clinically important difference for most people (Dowell et al. 2009). Even at a more specific level, treatments for mild-moderate depression are effective for patients with mild-moderate anxiety. There was no real difference in the proportional benefit between patients with anxiety or depression and those in whom social factors were prominent in their assessment. Regardless of the combination of problem and treatment, up to 80% of patients showed some overall improvement and 58.1% showed an improvement of at least 20 percentage points on their outcome following intervention (equivalent to a change of 8 points on the K10).

However, for problems which are mainly characterised by depressive symptoms of mild to moderate severity, both drug and psychological therapies are effective (NICE 2004; De Rubeis et al. 2005; de Mello et al. 2005). This makes the dilemma more acute for service planners and funders, as while psychological therapies may be better tolerated (NICE 2005) and may have a more sustained effect (Ma & Teasdale 2003; Teasdale et al. 2000), they may be less accessible due to cost and skill availability. The patient with moderate depression could be treated for six sessions of CBT or given a prescription for an SSRI with very similar treatment outcomes, and
significant difference in health care costs. This scenario needs to be tempered with the knowledge that there is some suggestive evidence that for mild-moderate disorders, talking therapies may be better than medication and that medication is definitely more effective with more severe than with moderate disorders.

**Towards a resolution**

The fundamental purposes of diagnosis are to ensure the patient has the most appropriate effective treatment and can be given an account of how they can expect to be in the future, so they can actively participate in the management and prevention of future episodes where possible. It is therefore important that primary care practitioners portray an accurate picture of the way they themselves are framing the problem. For example, it is quite appropriate not to give, say, a simple diagnosis of depression, but tell a patient that a particular presentation is a common kind of psychological problem where depression and anxiety are mixed.

Both assessment and management should be pragmatically geared to the working environment of PMHC and the kinds of problems that present. At the international level the ICD and DSM classifications are currently being revised, and both will address general practice and primary care working practices. The outcome is likely to be a smaller number of broader groupings that cover the main problems seen in primary care.

For planners and funders at DHB and PHO level, funding and management needs likewise to be geared to broader groupings and not tied to specific diagnostic categories. Funding and services need to be inclusive of the wide range of problems seen in primary care and to fund the social components of management options.

Because of the large numbers of potential patients services need to be tailored to relative efficiency. This means that we may see a reduced range of specialised psychological therapies being offered within the PMHC frame, accompanied by the development of more available generic low intensity interventions specifically designed to be delivered in primary care for problems as they present in primary
care (Collings, Mathieson, Dowell et al. 2009). Such interventions will fit in between self-help and more specialised therapies in the treatment menu, and are likely to become one of the standard treatment options in New Zealand PMHC.

References


Quality in Primary Mental Health Care

Introduction

This Primary Mental Health Care (PMHC) Toolkit is intended to help organizations and professionals consider the most effective ways to deliver quality care and achieve quality outcomes. Quality in PMHC is challenging to measure and assess although it is possible to determine some of the elements of a ‘quality’ service. With this in mind, all the content of the Toolkit could be described within a quality framework. In this essay we define aspects of quality as they relate to PMHC and encourage you to develop activities within your organization or role which will evaluate the quality of care provided to those who use PMHC. We build on the Primary Mental Health Initiatives Evaluation and use our recent refinement of our ‘Optimal Model’ for PMHI (Dowell, Garrett, Collings et al, 2009) to develop a quality framework to support New Zealand PMHC development into the future.

Quality in health care

The Institute of Medicine in the USA defines Quality in Health Care as “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”. ¹

There is an extensive literature both internationally and locally on this important topic and while definitions may vary in different settings, some themes, mainly relating to the clinical domain, such as safety, effectiveness and patient experience, are common to most quality frameworks.

Other themes such as efficiency, capacity and value for money are less common in quality frameworks but are all associated with the economic or resource allocation aspects of services. As such they are linked to service integrity and sustainability, and are also important elements to consider from a DHB and PHO perspective.

The processes and activities involved in establishing and maintaining quality in health care fall into two broad and overlapping groups: Quality Assurance (QA) and Continuous Quality Improvement (CQI) (Berwick 1989). The first Quality Assurance (QA) developed out of time and motion and efficiency study and has at its heart monitoring and the measure of performance. The second, Continuous Quality Improvement (CQI) had its origins in production line industries and the belief that quality can be improved if all those involved in an activity look at ways of improving the overall quality of the system they are working in.

The most enduring model or framework for understanding quality in health care was developed by Donabedian (1998), who divided quality processes, activities and measurement into structure, process and outcome domains with each component having an effect on the next. We will use this framework for our discussion of PMHC quality. Structure refers to provider attributes (e.g. therapist /patient ratio, Number of clinics in a given locality), process refers to the care given to the patient (e.g. the type of psychological or drug therapy), and outcome is what happens to the patient (e.g. improvement in psychological rating scale). These three types of measures have their unique strengths, but each is also associated with conceptual, methodological and practical problems. The choice often falls between process and outcome measures.

**Quality in Primary Mental Health Care**

While the central role played by primary care in the recognition and delivery of care for people with mental health problems is now widely acknowledged, ensuring the quality of primary mental health care remains a challenge in both developed and developing countries (Shield 2003). There has thus far been little formal assessment of service quality in PMHC settings. Within the UK Quality and Outcomes framework (QOF) there are a number of measures relating to mental health care, though as will be discussed later some aspects measuring performance and outcome in this area are challenging. Valid indicators of mental health care are important in assessing and improving quality of care as they can show variations in care, including suboptimal care (Seddon 2001). However, there are few indicators available for quality
assessment of primary mental health care, and few that can be applied at the system level—for example, practice or primary care organisation—rather than at the level of the diagnostic group (such as depression or anxiety) or that reflect the views of key stakeholders in the primary mental health setting, particularly patients and carers (Shield 2003).

General Practice and primary care inherently include service attributes that would usually be considered as indicators of high quality health care provision. The personal contact and continuity of care offered in primary care means that there are many opportunities for mental health issues to be addressed and many opportunities for a bio-psychosocial approach that supports good clinical outcomes. Moreover the family oriented perspective of primary care is enabling as far as mental health care is concerned.

In practice however a number of factors potentially compromise quality. In many countries including New Zealand the time allocation for individual consultations is brief and the competing demands in each consultation mean that mental health issues may not be prioritized. While the MaGPIe study demonstrated that GPs were more likely to recognise mental disorder if they knew their patients well, recognition and management were less likely to be optimal if the patient was seen in an acute care setting (MaGPIe 2004). There has also been much debate about disparities in recognition and outcome with some evidence that the mental health care needs of Maori and Pacific people are less well addressed (MaGPIe 2005). In addition there are widely acknowledged quality issues to be addressed at the primary-secondary care interface including appropriate communication and referral pathways.

As has been discussed elsewhere in the Toolkit, there are major gaps in PMHC service provision for some groups such as children and adolescents, and people over usual working age (Dowell et al. 2009). While those with problems of extreme severity may be able to access some services at times, an underlying lack of service provision means that there are very likely to be important quality issues when
services are provided, as there is essentially no infrastructure in terms of organizational or professional capacity to support the work.

In the last few years the introduction of targeted funding for PMHC through the Primary Mental Health Initiatives has provided new imperatives to assess the quality of the care being provided.

**Different perspectives on Quality**

In any organization quality improvement can be seen from a variety of different perspectives, and activity on a number of different scales or levels. At DHB or PHO level the planning, implementation and assessment of mental health quality could potentially be focused on systems efficiency within the DHB, efficacy of PHO initiatives, the training needs of primary care teams and so on. There are many aspects of care and service delivery that contribute to overall quality and hence a ‘mixed economy’ of different quality initiatives will be appropriate. In theory, quality measures can drive improvement in a number of ways. One model described by Don Berwick is the ‘change’ ‘selection’ and ‘reputation’ pathways (Berwick 2003). In the change pathway, quality measures act on the intrinsic professional motivation of clinicians and organisations to improve in areas where they see potential for improvement. In the reputation pathway, the publication of quality measures that compare performance between individuals, teams and organisations drives change through a desire to protect or improve reputations relative to others. Particularly in a North American context the selection pathway suggests that patients drive improvements by using measures to make choices between providers, incentivising providers to improve quality.

There are key quality issues in primary care, which can be explored within a mental health service context. These will include issues of access to care, workforce development and training and the use or otherwise of indicators of quality in a mental health care context.
In terms of the primary health sector engaging in quality initiatives the first and most important measures of quality are generic and challenging.

**Time:** There is no protected time in General Practice and much of primary care for anything other than patient care and contact. The single biggest improvement that organizations could make to further quality work is to fund time for quality activities.

**Teamwork:** There is a strong evidence base for the presence of good teamwork being linked to improved quality across a wide range of aspects of primary care clinical activity (Crampton et al. 2004). In addition there are effective means of measuring teamwork such as the Team Climate Inventory. We suggest that at DHB and Primary Care Organisation level, consideration is given to the measurement of teamwork effectiveness and promotion of effective teamwork in mental health care.

**Information technology:** Present primary care information systems were developed through small vertical markets with a focus on billing and prescribing functions. There were not designed for audit, evaluation or population health assessment. Moreover secondary care IT systems in many DHBs are idiosyncratic and isolated from other DHBs or primary care.

**Primary/secondary care integration:** Many quality issues present across the primary care interface including problems in communication and referral pathways. An important function of DHBs is to assess the effectiveness of work across the interface and support quality initiatives in this area.

We realize that working on these issues carries resource implications and that any quality indicators in this area are aspirational. The success or otherwise of other more specific indicators is dependent on them.

In addition there are other quality themes that apply to the primary mental health field.
As a starting point we suggest the DHB should have considered the following:

- Overall access to primary mental health care and to what extent there are disparities within local areas.
- The local working arrangements for primary mental health teamwork, together with training needs.
- The patient journey and some assessment of the patient experience.

As will be discussed below, for quality to be appropriately built into the work of the DHB and PHO there must be measurement of quality activity. How formal or incentivized this measurement becomes is a trade-off between trying to get accurate measures of quality activity and the compliance costs of data collection and follow up.

**Use of Performance indicators and measures of quality**

There is ongoing debate about the appropriateness or otherwise of performance indicators in primary mental health care (Crampton et al. 2004). Considerable work has been undertaken internationally on the development of mental health indicators, particularly in the United States. However this work is focused on addressing issues related to discrete disorders. In primary care the focus is appropriately centred on the concept of a group of less well defined Common Mental Disorders (CMD). For indicators of quality to be successful and accepted they must be able to reflect the complexity of the primary care environment, and avoid creating perverse incentives.

As those working in DHBs and PHOs are aware the current performance indicators in primary care stem from the PHO performance management programme (PPP). Until now mental health indicators have been absent from this programme, and it has been difficult to see how relevant indicators could fit into the current incentivized framework.

Some of the challenges in indicator development include a lack of agreement over illness terminology, lack of consistency of data collection and uncertainty over the
meaning of any outcome measure trends. Antidepressant prescribing rates provides a good example of the difficulties in developing an indicator in this area. A low rate of prescribing might mean a prudent use of pharmacotherapy and access to psychological therapies. Conversely it might mean under recognition and under treatment for patients who would benefit. The local and regional variation in prescribing added to the lack of a gold standard for appropriate prescribing rates mean that while this indicator would be excellent for stimulating debate it should not be used for benchmarked target setting.

Despite these challenges there is the potential to utilize indicators of primary care quality and performance which could have significant educational value in peer group discussions to raise quality of care.

We emphasise again the need for a strong element of ‘aspiration’ in any mental health quality indicator development. There has been a great deal of enthusiasm in the last few years to promote primary mental health care, and it is important to retain the positive commitment of the sector. Many quality initiatives fail in their potential because the bureaucratic demands of monitoring overtake the initial professional desire to improve quality in a particular area.

The indicators described below are examples of potential quality themes for primary mental health care identified as a result of discussions between the College of General Practitioners and the Ministry of Health (Perera et al. 2010).

a) Measurement of the Prevalence of common mental disorders in (i) adults and (ii) children.

This indicator is frequently suggested in the international literature. The overall aim is to capture the extent of practice level activity in relation to mental health. Exploring this issue with practice teams brings up the question of avoiding recording a diagnosis of CMD (as a result of a patient request or health professional choice), and the fact that current coding systems do not capture well the complexity of mental health presentations in primary care.
b) Referral to other primary care providers for the management of common mental disorders.

One of the challenges in primary care practice is enabling access psychological therapies for patients at a cost they can afford. Exploring referral pathways for psychological therapies is a good high level systems indicator of quality.

c) Prescription of selective serotonin re-uptake inhibitors for the management of common mental disorders.

As described above exploring patterns of prescribing is a useful marker of quality because there are no gold standards of prescribing rates.

These indicator themes and others would fit well within an educational framework of peer review. They do not lend themselves well to benchmarked target setting.

As well as the important generic indicators of quality and the more technical potential indicators above, we believe that organizations should support and promote the identification of quality initiatives and indicators that are important to primary care teams and practices. Getting practice teams to identify the aspects of quality that ‘make the heart sing’ from the provider perspective is likely to be both empowering and helpful in creating constructive relationships between practice teams and DHB/PHO.

**Evaluation of the New Zealand primary mental health initiatives: a step towards quality**

In this section we consider the main outcomes from the primary mental health initiatives evaluation in relation to service quality. The evaluation of the first wave of 41 initiatives identified a number of major themes which provide ‘lenses’ through which we can consider and debate the quality of PMHC (Dowell et al. 2009).

Most notably, there were nine different models of care, each deemed to be appropriate for the local context and each of which had features often associated with quality health services. The evaluation team defined an ‘optimal model of care’ (which we refer to here as ‘Optimal Model I’) based on all the observed facets of
care and service provision. No single model or organization contained all the elements of optimal care or service provision, although the majority included access to a wide range of mild to moderate mental health problems, a focus on mental health workforce development and the use of both psychological and pharmacological therapies.

Other issues relating to the ‘typical’ conception of service quality were:

- targeting of services to high-needs populations
- having both Kāupapa Māori and mainstream options available
- the use of clinical outcome measures was encouraged as a clinical tool

While there were many examples of effective interdisciplinary teamwork, the involvement of practice nurses was not always facilitated. In addition, there was no structured training or education programme for PMHC that included all disciplines.

Observations relevant to a broader conception of service quality included: the observation that no service delivery model offered inherently superior value for money, or an inherently more cost-effective service compared to others; up to 80% of service users benefited from the variety of interventions offered; and well-defined criteria for determining clinical eligibility for care are important.

In relation to access for the whole population, the initiatives provided access to Māori in excess of their proportion in the enrolled population. Although, given the higher prevalence of some common mental health conditions among Māori, it is likely there was still some under-utilisation of services by Māori. There was under-utilisation by Pacific peoples and significant under-utilisation by Asian people. The mental health needs of children and young people overall were not sufficiently met, and over half did not offer services to this group; and few PMHIs offered services to service users over 65 years of age.

Based on these observations figure 1 summarises the main structural elements that could potentially be markers of quality at DHB or PHO level. It might be an advantage...
for example that there is congruence between DHB and PHO mental health initiatives and that there are clearly identified markers of integration between primary and secondary services.

Figure 2: Optimal model for Primary Mental Health Initiative (PMHI) Source: Evaluation of the Primary Mental Health Initiatives; Summary Report (Dowell et al. 2009).

Further markers of quality can be identified by looking at process components of primary mental health illustrated by patient pathways through the health system (figure 2). Quality issues might be identified for example in identifying the rationale for the use of particular psychological therapies and the deployment of particular types of staff.
Figure 2: Service user pathway (in the context of figure 1) Source: Evaluation of the Primary Mental Health Initiatives; Summary Report (Dowell et al. 2009).

****** A task for you ******

Looking at the diagrams above – write down which elements of quality you think are most prominent in your service.

What elements are missing from the diagrams?
The evolution of Quality frameworks

It is important that quality evolves. As a result of our work on this Toolkit project we have reviewed and revised some of our previous perspectives on what would constitute the optimal delivery of quality within a primary mental health care service. We have refined our thinking from the original optimal model and created a new version – Optimal model II.

One significant omission, for example, from the previous optimal model was absence of specific services for children and young people. This is particularly important if a service is taking a long term perspective on quality.

Further discussion about this evolution of quality is found in the next perspective essay titled ‘Towards the future Primary Mental Health Care: Optimal Model II’.
References


Towards the future Primary Mental Health Care: Optimal Model II

As part of the evaluation of the Primary Mental Health Initiatives, some of us developed a conceptual scheme for an effective ‘generic’ initiative. This became known as the ‘Optimal Model’ (Dowell, Garrett, Collings et al. 2009). This model was based on the positive features of the nine different models of service provision we observed during the evaluation. Because it was limited to observations made about very new services, and because it was untested, it was in a sense a draft model. Nevertheless it achieved a significant degree of traction because it was highly congruent with the services that existed, and it provided overall guidance to new services setting up as the primary mental health care (PMHC) programme was rolled out across the whole country.

One of the aims of the current project was to refine this draft optimal model to enhance its relevance to sustainability and quality improvement in New Zealand’s PMHC environment, and to embed the idea of building on existing capability and capacity. Specific issues highlighted for future consideration in Optimal Model I included primary care practitioners developing a new skill mix better orientated to PMHC. Particular skills that required development or reorientation included: clinical assessment, motivational interviewing, self-management support, brief psychological interventions, understanding of medication and use of outcome measures.

Synthesising these points with the lessons from the research partners, insights developed within the research team and consultation with the stakeholders engaged by the research partners, we have produced Optimal Model II (see Figure 1). Optimal Model II has retained some of the key features of the first version.
District Health Board

Prioritise primary mental health care
- Funding: following removal of ring fence of 'Mason' protected mental health funding, prioritise primary mental health programmes
- Infrastructure
- Clinical champions

PMHC is congruent with DHB programmes

Prioritise policy and practice linkages to:
- Secondary mental health
- Health promotion
- Primary prevention
- Other secondary care programmes

Philosophy of PMHC service
- Services for any person with mild-moderate mental health needs
- Explicit service provision for Child & Youth; over 65s
- Clear inclusion/exclusion criteria based on explicit values

Elements within PHO/PHO network

Philosophy of PMHC service

Culturally appropriate services available

Evidence-led constraint to programme variety
Adaptation to local need within clearly articulated constraints led by policy guidance

Infrastructure: prioritise linkages
- Patient management system
- Information technology
- Platform
- Links with community

Whānau ora based approaches as appropriate and where possible

Formalised links with
- Government agencies e.g. WINZ, Education
- NGOs e.g. Salvation Army, Foodbanks, self-help groups
- Other services provided by a range of social entrepreneurs
- Contracting to be managed to ensure it is not burdensome and services are experienced as

Workforce development
- Mandatory initial training funded by external body
- Uniform training across nation
- Rolled out in a timely way using existing courses
- Interdisciplinary
- To be delivered by educators in current clinical and research practice in primary care
- To cover evidence-led key competencies for the new roles: technical expertise in diagnosis, management including drugs and psychological treatments in evidence-led models
- Train psychological therapists specifically for low intensity brief psychological treatments
- Work towards a variety of modified roles in secondary care, orientated to primary care

Workforce
- Sufficient staff with appropriate knowledge and skills i.e. new roles of specialists in PMHC
- Career path

Links with other primary care programmes including alcohol & drug

Continuous Quality Improvement

Infrastructure: prioritise linkages

Local PHO or PHO grouping primary mental health clinical champion, working within & supported by distributed leadership

Figure 1: Optimal Model II

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Specific points of difference are:

**The addition of Whanau Ora based approaches to the core elements of PMHC.** As specific Whānau Ora programmes are not yet rolled out, we could give more detail about this. However, it is clearly a potentially important development of major scale and high relevance to PMHC for Maori and, in some cases, non-Maori. One of the key attributes of the Whanau Ora programme is that it puts the social context of the person (specifically but not solely whanau) in the foreground of consideration of their problems. Giving priority to the relevance of context is an important aspect of mental health practice which is commonly neglected as services come under increasing pressure. Whānau Ora programmes are an opportunity to embed this into PMHC practice so that it becomes the norm. This approach is entirely consistent with the general philosophy of primary health care.

**Evidence-led constraint to programme variety.** This is a modification to the broad promotion of adaptation to local need as seen in Optimal Model I. While it is important to have some flexibility we have concluded that it is essential to have a degree of consistency in services across the country. There is already a good deal of variation introduced by the availability of skilled staff. For the next steps in PMHC development in New Zealand it is important to have policy guidance on what are the expected core elements of PMHC. We suggest this should be evidence-led and cover broad types of treatment as well as general service structure and functioning.

**Links with other primary care programmes.** We have increased the status of this in the revised model, and included alcohol and drug explicitly. There are two main benefits (of equal importance) to this. First, it is an opportunity to increase the effective resource available to PMHC (see issues guide *Mental Health and Chronic conditions*). Secondly, the high prevalence of co-morbidity between mental health problems and chronic conditions such as diabetes and heart disease means that quality of care and overall clinical outcomes would be improved by better links across programmes.
Primary mental health (clinical) champion. This was a key feature of the original model but we have added the suggestion that it is might be important for this person to be a clinician. The services in which we have seen most momentum develop and be sustained have been those in which a) there has been an effective champion, and b) often this has been a senior clinician. There are a number of reasons why this might be the case. Often managers have a faster turnover than clinicians, and while one manager may prioritise mental health, a new manager might not. Additionally, much of the change work to be done is actually with clinicians, and it is possible that change messages may be more palatable coming from another clinician. In our view, the primary mental health champion will be most effective if working in a distributed leadership setting (see perspective paper titled ‘Where next for Primary Mental Health Care? – current issues and opportunities’).

Workforce. Optimal Model II emphasises the need for sufficient staff with appropriate knowledge and skills and focuses heavily on the training needs of these practitioners. During the evaluation of the first wave of initiatives we observed the emergence of a ‘new’ mental health professional. A nurse or other professional with a background in, say, secondary care, who re-positioned their career as a primary care mental health professional. It was common for these roles to end up running as a kind of ‘parallel’ secondary service, and this was especially the case when referrals for psychological therapies were out of the practice. While this increased access to services for people who would otherwise miss out, it was perhaps not a truly primary care model. There were problems with communication back to referring doctors, for example, which is a classic secondary care problem. It is our recommendation that the expanded workforce working in PMHC becomes better integrated with primary care practice so that it is a core part of it rather than an ‘add on’. This can be achieved through via workforce development programmes that have this as a stated goal. The clinicians delivering treatment also need more support for skills development in low intensity brief interventions, and this should become a core component of all mental health and primary care professional training. Finally, secondary care professional roles need to be modified so support for PMHC is enhanced.
**DHB level.** The ring-fence around mental health funding has been formally removed, although prior to this DHBs had a variety of ways of undermining it. There needs to be a renewed focus on ensuring this mental health resource is protected so it can be channelled to PMHC services.

**Links with other agencies.** The key change here is that contracting needs to be done in a way that is less burdensome to NGOs and other agencies, and services are experienced as ‘seamless’ by those using them. Currently professionals in organisations are very constrained by contracts, and may be told by managers not to engage in clinical activities which are outside a specific contract. This contributes to people ‘falling through the cracks’.

Regarding the service user pathway (see figure 2), we have made fewer changes. However, we would like to see the provision of psychological services brought more fully into the primary care setting rather than have such as strong focus on referral out of the practice.
Service user identified (through General Practice or other route - e.g. Māori health provider)
Initial assessment including clinical indicators and appropriate assessment tool(s) e.g. K10

Inclusion criteria met?

Yes

Clinical/social intervention

- Clinical coordinator assessment
- General Practitioner/Practice Nurse: extended consultation

Treatment interventions
Examples: talking therapy, pharmacological prescription (from GP), lifestyle interventions, self-management

Provide treatment within practice as much as possible

Monitoring and follow-up (over extended period) including appropriate assessment tool
GP/PN/Coordinator: phone, text, email, face-to-face

No

Select from usual range of GP interventions e.g. pharmacological intervention; lifestyle advice

Secondary referral

Referral to other organisations

Figure 2: Service user pathway (in the context of the structure of Figure 1)
Adapted from Evaluation of the Primary Mental Health Initiatives (Dowel et al 2009).

References