CLOSING THE LOOP

A PERSON-CENTRED APPROACH TO PRIMARY MENTAL HEALTH AND ADDICTIONS SUPPORT

www.closingtheloop.org.nz
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New Zealand needs a fundamental shift in the way mental health and addiction services are delivered. Significant and sustainable change is required to transform a reactive, transactional system of treatment to a holistic, person-centred, responsive system of care and support.

Too many people currently do not have access to timely and integrated care and support that would enable them to achieve the best possible outcome for their individual circumstances.

In *Closing the Loop* we have articulated a future vision of primary care-based mental health services that draws together the skills, capabilities and resources of all relevant agencies.

“I believe primary care is a critical part of addressing increased pressure on mental health services. Supporting primary care to do this will be a key focus moving forward,” Minister of Health, Jonathan Coleman, Royal New Zealand College of General Practice conference, Auckland 2016.

We are grateful for the wealth of experience and expert opinion that has informed this revised framework, following the publication of our initial draft in late 2015. We hope this final document reflects more strongly the need for co-design, leveraging capabilities and local partnerships. We also know that there are already many examples of local innovation and good practice and we hope that the dialogue created around *Closing the Loop* can help share and embed those successes.

We recognise the scale of the change needed and the collective courage involved in challenging the status quo. This is not the end of the conversation; hopefully it is the beginning of a new journey where we collectively create better outcomes for people and their whanau needing mental health and addictions support.

*Martin Hefford*, CEO, Compass Health  
*John Macaskill-Smith*, CEO, Pinnacle Midlands Health Network  
*Vince Barry*, CEO, Pegasus Health  
*Steve Boomert*, CEO, ProCare Health

*Closing the Loop* has been produced by Network 4, a collaboration of New Zealand’s four largest Primary Health Organizations (PHO): Compass Health, Pinnacle Midlands Health Network, Pegasus Health and ProCare Health. Collectively, Network 4 is responsible for the primary care needs of almost two million New Zealanders.
EXECUTIVE SUMMARY

At least one in six New Zealanders will be diagnosed with a mental health disorder at some point in their lives. Many more experience mental distress or issues with addiction, without a formal diagnosis or actively seeking help. There are also notable inequities, with young people, Māori and more deprived populations experiencing higher rates of mental health need. (New Zealand Health Survey 2012/13).

We know that more needs to be done to address people’s needs in a holistic and meaningful way, to promote access and early intervention, and to combine social support with mental health and addictions care and support.

There has been considerable progress in the development of mental health and addiction services in primary care in recent years, but much of it has been ad hoc and uncoordinated, leading to variation in services and a multitude of different providers working independently.

Current policy, as highlighted in the Ministry of Health’s Rising to the Challenge (2012) and the Mental Health Commission’s strategy Blueprint II (2012), focuses on building services around the needs of the person through a collaborative, multi-agency approach. The Health Strategy (Ministry of Health, 2016) provides further traction, emphasising the need for a ‘one team’ approach to the delivery of ‘people-powered’ services. And while current funding models do little to incentivise integration, the Government’s emerging thinking on social investment means there is greater appetite for flexibility and innovation in approaches to funding.

This document paints a picture of what that future state might look like.

It describes a person-centred, integrated system where people can easily access the full range of mental health and addiction care and support, from the first point of contact through to an outcome that is right for them. It proposes a model where coordination and collaboration between services is the norm, where services are consistent and seamless for all populations, but tailored to individual needs. It outlines a holistic approach to health and social care that enables people to self-manage, stay well, lead more effective lives, and reduce the likelihood of needing specialist care.

Our proposed model anchors care close to home, with better integration of primary, community, Non-Government Organizations (NGO) and specialist services, facilitating early intervention and support in a familiar and trusted setting.

This model would be underpinned by an appropriately trained multi-disciplinary workforce, targeted evaluation and research, effective use of technology, better leadership at all levels and funding models that ensure services are designed around people rather than organisations.
CLOSING THE LOOP SETS OUT FIVE KEY THEMES

These five key themes frame the changes we believe are necessary to achieve this fundamental shift:

A mental health and addictions system that achieves meaningful outcomes tailored to populations needs: including addressing physical health needs, as well as mental health and addictions issues, housing, employment and connectivity to communities.

A person-centred, place-based model of support that enables self-determination and wellness: a model that enables convenient access and early intervention and promotes outcomes appropriate to a person from their initial contact with the system.

Enablers that effectively support the model: including having the right workforce capability and capacity, making good use of technology, ensuring ease of access and having appropriate funding and commissioning structures in place.

Well-resourced research, development and evaluation: to monitor change, promote innovation and develop mechanisms that allow us to collectively learn in order to achieve better outcomes for all.

The right system leadership: at national, regional and local level bringing all the relevant agencies together to enable transformational change and sustainable improvement.

As a result the changes proposed we believe we can create a system of care that:

'Supports me to support myself; offers meaningful help when I want it and achieves sustainable positive outcomes that matter to me, my family/whanau and society, at the first time of asking.'

Our recommendations have been discussed and developed with input from a wide range of organisations involved in the full spectrum of health and social support (See Appendix B).

WHERE WE’RE AT NOW

New Zealand has higher rates of mental health need than the global average: The New Zealand Mental Health Survey conducted in 2006 found that two in every five people had been affected by a mental health disorder, compared with a global rate of one in every four people. Almost half of these report having more than one disorder. While there has been significant progress, mental health outcomes remain variable and we are still failing to adequately support many people with their mental health and addiction needs.

"If you’re experiencing an episode of mental health or addiction it can be really hard to get to more than one place. There’s too much else going on to manage all of that. If you had to go to multiple appointments and places, it may just not be something you can cope with. The idea that everything is there and at your fingertips and not difficult to navigate is really important."

Carolyn Swanson, Service User Lead, Te Pou
In recent years there has been growing recognition of the need to improve the range of primary mental health and addiction interventions and a stepped care model has been adopted, with interventions matched to service user needs. An increasing number of innovative community-based services and providers have emerged with the aim of early intervention and avoidance of dependence on acute mental health and addiction services.

*Rising to the Challenge*, the Government’s five year mental health and addictions development plan ([www.health.govt.nz/our-work/mental-health-and-addictions/rising-challenge](http://www.health.govt.nz/our-work/mental-health-and-addictions/rising-challenge)) has been a key driver for progress since its publication in 2012. Its 100 actions focus on integration, social inclusion and improving access.

However, despite progress over the past decade, the development of mental health services in primary care has been ad hoc and patchy without the leveraging of the potential scale. Too often, providers work in silos rather than focusing services around the needs of the individual. Current funding models do little to incentivise integration, separating budgets for people with severe needs from those for people with high prevalence and episodic (mild to moderate) needs. Service provision remains inconsistent and integration continues to be more aspirational than commonplace.

“People continue to report that because they are identified as having mental health issues, their physical health concerns are not being taken seriously.” *NGO*

“Māori and Pacific struggle to achieve access to the appropriate services. They resort to others who have managed to navigate the system in order that they too are able to access the required supports.” *GP*

**KEY STATISTICS**

- One in six New Zealand adults (16 per cent, or an estimated 582,000 adults) are diagnosed with a common mental disorder at some time in their lives (including depression, bipolar disorder and/or anxiety disorder). Women are approximately 1.6 times more likely to have been diagnosed with a common mental disorder than men. Youth, Māori, and more deprived populations experience higher rates of mental health need. (*New Zealand Health Survey 2012/13, Ministry of Health 2014*).

- When including undiagnosed problems or self-reporting, the prevalence of mental disorders and substance use is much higher – *Te Rau Hinengaro: The New Zealand Mental Health Survey conducted in 2006 concluded that 40 per cent of the population over 16 had experienced a mental disorder (including substance use); 20 per cent had experienced a mental health problem in the previous year.*

- In 2013, a record number of people accessed specialist mental health and addiction services (154,378 people, or 3.5 percent of population). 91 percent of specialist service users accessed only community mental health services. (*Annual Report of the Director of Mental Health 2013; Ministry of Health, 2015*).

- The social cost of drug-related harms and intervention was estimated at $1.8 billion in 2014/15 (*The New Zealand Drug Harm Index 2016, Ministry of Health, 2016*).
• At least one in five New Zealand adolescents experience some form of psychological or social morbidity. (Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence; Prime Minister’s Chief Science Advisor, 2011)

• In 2013, a record number of people accessed specialist mental health and addiction services (154,378 people, or 3.5 percent of population). 91 percent of specialist service users accessed only community mental health services. (Annual Report of the Director of Mental Health 2013; Ministry of Health, 2015)

• 564 people died by suicide in New Zealand in 2014/15, compared with 529 the previous year; a rate of 12.27 deaths per 100,000 population and one of the highest in the OECD. Almost 76 percent of suicides were male. (Chief Coroner provisional statistics 2015)

• There were 3,031 intentional self-harm hospitalisations in New Zealand in 2012. Two-thirds of these were female. (Suicide Facts: Deaths and Intentional Self-Harm Hospitalisations 2012; Ministry of Health, 2015)

• People with a severe mental illness have much poorer physical health and have a life expectancy up to 20 years less than the population average. (Chesney E, Goodwin G, Fazel, S: World Psychiatry, Volume 13, Issue 2, June 2014)

• New Zealanders who experience a mental health illness and/or addiction have more than twice the mortality rate of the general population. This rate increases to three times for people who have a psychotic disorder (Cunningham R et al: NZMJ, Volume 127 Number 1394, May 2014)

• Funding for primary mental health initiatives increased from $5 million in 2005/06 to $29.3 million in 2015/16. The $29.3 million per annum covers the enrolled population focused on Māori, Pacific and/or low income ($24.3m) as well as the youth component ($5.0m). An additional $12 million over four years was allocated in Budget 2016 to establish a mental health triage response and a mental health consult-liaison function will be part of this.

WHAT IS PRIMARY MENTAL HEALTH?

Primary care for mental health pertains to all diagnosable mental disorders, as well as to mental health issues that affect physical and mental well-being. Services within the definition include:

• First line interventions that are provided as an integral part of general health care; and

• Mental health care that is provided by primary care workers who are skilled, able and supported to provide mental health care services.

World Health Organization and World Organization of Family Doctors (Wonca) 2008.
USER VOICES

“WHAT I WANT FROM SUPPORT IS …”

“…..to feel I can trust or can build trust with the person I am working with.”

“…..honest, genuine relationships, someone brave enough to call me out on stuff.”

“…..a welcoming, informal, ‘safe’ and relaxing environment.”

“…..validation, being listened to and not judged. Relate to me as a person.”

“…..recognition that I am the expert in my life; ask me questions about what I need and think.”

“…..reassurance. If I’m feeling really anxious, I might leave. Make it OK that I can come back and build a relationship.”

“…..an option to choose the person I work with. I choose my hairdresser because I know she’s good at working with curly hair, I choose my gym person because I know he likes to work with ordinary people.”

The FOURTH WAVE

Renowned psychiatrist and academic Sir Mason Durie summarised the stages (or waves) of development of New Zealand’s mental health and addictions system: ‘The first stage, lasting for more than a century, was the establishment of large institutions for the mentally ill. It was followed in the mid-1970s by a transitional stage of deinstitutionalisation with wholesale discharge and the eventual closure of all mental hospitals. The third stage, now in progress, has seen the development of community-based mental health services, especially for those who have severe needs’ (Collings et al. 2010).

The fourth wave is a more flexible and holistic system, encompassing the wider social needs and wellbeing of individuals. It offers an opportunity for the mental health and addictions sector to work in partnership with people, their family/whanau, community-based service providers, district health boards, government agencies, policy developers and funders to co-create support.

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Theme 1

A mental health and addictions system that achieves meaningful outcomes tailored to population needs.
THE CHALLENGE
Over the years the Ministry of Health and individual DHBs have invested in a number of different services in primary care that support people with mental health and addiction needs.

However, this has resulted in considerable variability in standards and delivery models across the country. There is a real need to establish mechanisms at a national level that specify the type and standards of service people should be entitled to expect.

We need to put people first - designing support based around varying needs, but delivered in a way that is relevant and achieves outcomes that are meaningful to the individual.

*Rising to the Challenge* (2012) and the Mental Health Commission’s strategy *Blueprint II* (2012) both emphasise that future service development should combine an understanding of both person and population need in a multi-agency environment. The *Health Strategy* (Ministry of Health, 2016) reinforces this approach, emphasising the need for services to be ‘people-powered’ and based on collaboration across a range of providers and settings as ‘one team’.

Our services need to:

- Offer greater support to those who may have a lower level of need, but whose mental health and/or addiction issues impact significantly on their overall health or ability to function in society.
- Focus on a person’s life-course, responding earlier so that we can more effectively improve people’s lives, avoid negative impacts and reduce need for services at a later stage.
- Focus on vulnerable populations and address inequities for populations such as Māori, Pacific, refugees, rural communities, people with disabilities and those with long-term conditions.
- Cater to the needs of specific at-risk populations such as vulnerable children, those people returning to the community from prison or people on long-term benefits.
- Offer support appropriate to the needs of the local population, with different services for children, youth, adults, mothers and older people.
- Focus on population wellbeing.

PRINCIPLE: A system of support that understands and is relevant to me and my family/whanau.

THEME 1
A mental health and addictions system that achieves meaningful outcomes tailored to population needs.
OUR VISION

To achieve these goals we need a framework that facilitates collaboration across multiple sectors, government agencies and non-government agencies at all levels, providing strategic oversight and accountability.

We need commitment to shared goals and contracts, aligned to achievement of collective outcomes, designed with and for service users and their families.

We need to support populations at different levels while also enabling local flexibility and diversity – the whole population; the at-risk or vulnerable including those who are socially excluded or identified through screening opportunities; those experiencing problems and unable to cope; young people; older people; Māori and Pacific people.

National service specifications need to be developed to provide a consistent framework for locally-tailored models of care and support that increase user satisfaction and ensure positive and comprehensive population outcomes, including housing, employment, social wellbeing and equity of access and opportunity, as well as reduced morbidity and mortality. When published, the Ministry of Health’s commissioning framework and mental health and wellbeing outcomes framework will make a significant contribution to those national standardised arrangements.

Working within nationally standardised arrangements, PHO networks, DHB specialist services and NGO providers would work as integrated teams with flexibility in planning and delivery for local populations and with appropriate input from agencies such as Whanau Ora commissioners and service providers, Ministry of Social Development, Housing New Zealand, Department of Corrections, schools, Plunket Society, Ambulance Services and others.

More structured relationships between agencies at a local level could be achieved through a range of mechanisms, including partnerships, sub-contracting and service level agreements, with shared service models and collective responsibility for clinical governance, quality and safety, performance management and service improvement.

Local health alliances have the potential to provide the basis for those enhanced local relationships, provided all relevant agencies are involved in decision-making and the setting and allocation of budgets.

CASE STUDY

Health Psychologist on-site at Pukekohe practice – meeting the local needs of the population

Pukekohe Family Health Care ran a psychology shared care pilot on-site in their large rural general practice funded through the Ministry of Health in partnership with ProCare and in association with Counties Manukau Health’s At Risk Individuals project for patients with long-term conditions.

GPs and nurses were unanimous in their perceptions of unmet mental health needs among patients who didn’t fit the existing secondary care Chronic Care Management (CCM) Depression criteria (i.e. quintile 5, Māori and Pacific Island, PHQ9>15). They recognised that the cost of psychology sessions was a barrier to those who did not fit the criteria, that stigma around mental health and rurality were barriers to off-site attendance, that physical health needs often came with underlying or associated mental health issues, and the rural location made transport to support groups untenable.
A ProCare Psychological Services (PPS) health psychologist was based in the general practice one day a week to receive nurse or GP referrals of patients for up to three brief intervention sessions. The focus was on those with illness behaviours limiting progress towards improving their health; those with a recent significant diagnosis; or those with anxiety disorders (e.g. undiagnosed stomach pains). Support centred around psychoeducation, cognitive behaviour therapy, anxiety management and support.

The pilot was very successful with positive feedback and results reported by patients, GPs and nurses. The practice has now integrated on-site psychological support as part of their practice’s ongoing flexible funded approach to patient services.

**CASE STUDY**

**Hauora Tairāwhiti – removing barriers and increasing integration**

Pinnacle Midlands Health Network is working with Hauora Tairawhiti to offer new integrated mental health care services to deliver a higher level of care and eliminate gaps in service.

The first step is the establishment of a single point of access for referrals to mental health services which would reduce complexity for referrers and ensure people are seen by the right service with as few barriers as possible.

The Equally Well’ initiative (Te Pou, 2014) identified that many people who have been seen by a secondary mental health team also have higher physical health needs. Pinnacle worked with Tairawhiti DHB to provide funded access to general practice for this group of service users to ensure their physical health needs are cared for in the most appropriate setting - primary care.

A service was also developed for clients transferring back to general practice for long-term mental health care. This service funds the development of a comprehensive care plan developed by staff within secondary care and general practice, to ensure a successful transition to primary care and ultimately discharge from secondary services.

**WE RECOMMEND:**

- Development of a nationally consistent set of service specifications for primary mental health support underpinned by local service level agreements between agencies and robust commissioning structures – national standards, local solutions
- Creation of alliances, partnerships and collaborations that are capable and responsible for the achievement of local population outcomes in mental health and addictions
- Development of shared service goals and outcomes-based contracts to underpin activities and foster real integration, shared commitment, shared accountability.
A person-centred and place-based model of support that enables self-determination and wellness.
THE CHALLENGE

Successful models of person-centred care and support are emerging for a range of long-term conditions such as diabetes. These models are based on a whole-of-person approach, promoting wellbeing, self-management and self-directed outcomes.

We need mental health and addictions services to adopt those principles of holistic, planned proactive care closer to home. The model needs to meet the varying needs of our diverse population through early identification, assessment, coordination, navigation and support to sustainable outcomes.

Support services need to be as close as possible to being a one-stop-shop, with co-location where it is feasible and appropriate, but as a minimum, being able to coordinate care and connect all the relevant providers and agencies, whether it is referring to brief intervention support, e-therapy or group therapy to signposting to social services (e.g., food banks, housing advice or employment support).

Our services need to:

• Offer greater support to those who may have a lower level of need, but whose mental health and/or addiction issues impact significantly on their overall health or ability to function in society

• Focus on a person’s life-course, responding earlier so that we can more effectively improve people’s lives, avoid negative impacts and reduce need for services at a later stage

• Focus on vulnerable populations and address inequities for populations such as Māori, Pacific, refugees, rural communities, people with disabilities and those with long-term conditions

• Cater to the needs of specific at-risk populations such as vulnerable children, those people returning to the community from prison or people on long-term benefits

• Offer support appropriate to the needs of the local population, with different services for children, youth, adults, mothers and older people

• Focus on population wellbeing.

OUR VISION

The model we propose is ‘place-based’, anchored in a person’s local community. This model would deliver services tailored to individual need, through an alliance of partners with shared goals and accountability.

PRINCIPLE: A model that achieves a meaningful outcome for me and my family/whanau from the first point of contact.
for a local population, operating within nationally consistent service specifications.

This means organising stepped care to support people’s mental health and addiction needs earlier and closer to home by reinforcing the first line of support - integrated centres with close cooperation between general practice, NGOs, and other appropriate community agencies - and increasing co-operation and integration with secondary support, including more availability of secondary care staff in primary care settings. Stepped care would be enabled through person centered shared care plans that would be able to activate and coordinate support across the care continuum.

We believe the local model should be based around the concept of the Health Care Home and its principles of equity, shared care, ease of access, being patient/whanau centred and utilising a multi-disciplinary team.

The Health Care Home is a single place that connects people with the broader health and social system. Anchored in the local neighbourhood, it offers a team-based, person-centred, integrated model of health and social care.

While the Health Care Home is centred around general practice, it is much more than general practice and goes beyond the traditional models of providing 15 minute appointments in a general practice. It aims to develop a good understanding of people’s problems, intervene early, and plan care in partnership with the patient, advise, educate, promote self-care, provide brief interventions, prescribe and refer to specialist services when needed, connect people with appropriate social support and coordinate follow-up.

The Health Care Home features triage by health professionals, including telephone consultations where appropriate, to ensure that demand is managed appropriately and effectively. It offers easy access to a range of services and support through a single point of patient contact, integrating with national tele-health services, electronic portals, e-prescribing, Accident and Medical Centres, hospital services, NGOs and residential and social care providers.

The model is now being adopted in general practices across New Zealand, with rollout planned over the next three years and a national collaborative providing oversight and standard setting.

This model is one of a community hub offering holistic care and support based around individual needs, with continuity and accountability underpinned by a shared care record.
Access to services available from the community hub would be facilitated through any of the agencies involved in providing local services. Overcoming barriers to access to a general practice-based Health Care Home can be achieved by enhancing engagement and integration with the places in the community where people seek support for mental distress such as maraes, churches and schools. Services would be available face-to-face and virtually, planned and navigated based on individual need.

The model has the potential to increase the range of support available, including brief interventions, group therapy, e-therapy, talking therapies, family therapy and addiction services, drawing in social and community support and specialist services when needed. It will ensure that communities that are more vulnerable, such as those in rural and remote areas, can benefit from collaboration, coordination and continuity not always found through traditional models of referral.

The hub and associated teams would also be a centre for health promotion, mental health literacy, community wellness development, advice and education with a strong focus on enabling self-management.

Each hub would develop according to local needs and resources, with co-location of services where feasible and appropriate, but as a minimum would offer:

- Timely screening, assessment of need (inclusive of wellbeing, physical health, mental health and addictions and social need) and triage
- A whole-of-person shared care plan that is responsive to a variety of support needs and capable of activating support across the continuum of care
- Care coordination, navigation and support pathways that enable stepped or layered care
- Monitoring, review and performance against agreed goals and outcome assessments, exit planning and advice on how to re-enter if needed
- Access to support and education to enable wellbeing and self-determination
- Brief interventions

Our model is designed to ensure that the physical health needs of those people with mental health issues are not neglected. A 2014 meta-analysis showed that the life expectancy of people with a serious mental health problem was reduced by 10 to 20 years, greater than the reduction attributed to heavy smoking (Chesney, Goodwin, Fazel, World Psychiatry, Vol 13, Issue 2, June 2014).

Cause of death is not as a result of mental illness, but from the most common causes such as heart disease and cancer.

People with a mental health or addictions problem may not be so willing or able to seek help for physical conditions, while vague symptoms may not be so readily investigated. Conversely, conditions such as cardiovascular disease, diabetes and cancer are commonly associated with depression and anxiety which may go untreated.

Planned proactive care in an integrated environment creates opportunities for screening, monitoring and engagement to identify and manage physical and mental health and addiction needs in tandem.

"At the end of the day it’s about choice, both cultural and clinical. We shouldn’t automatically assume that Māori services are the most appropriate pathway for all Māori that suffer from mental health issues."

Te Kani Kingi, Associate Professor, Massey University
MULTIPLE POINTS OF ENTRY

Self-direction; Justice; community NGOs; ACC; family/whanau; support phone/website; housing; education; MSD; corrections; other

SINGLE POINT OF COORDINATION

IDENTIFICATION
Can you support me?

OUTCOME SUSTAINED
I’ve got this!

OUTCOME ACHIEVED
I reached my goals

NAVIGATION
How is my plan going? What needs to change?

COORDINATION
These are my goals. Who is my team?

ASSESSMENT
I need help with this...

Outcome assessed, transition plan developed and check in’s arranged.

Support sought or identified.

First contact with support

Outcome sustained or identified.

Activation, deployment and coordination of support roles.

Level of support identified.

Level of support provided.

Outcome sustained.

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Outcome sustained.
A stepped care approach

This approach involves:

- Using the least intrusive treatment required to meet presenting need
- Making available interventions with differing levels of intensity
- Matching people’s needs to the level of intensity of the intervention
- Entry and exit at any point
- Using robust tools to routinely collect outcomes data to support people’s journey into, through and out of services
- Having clear referral pathways between different levels of intervention
- Supporting self-care as an important aspect of managing demand across primary, community and specialist care settings.

Addictions

Addictions services generally focus strongly on individual responsibility, building resilience and self-awareness looking at cause, harm reduction and early intervention as part of the recovery journey.

There is a strong evidence base around screening and brief interventions, engaging people in the moment. Primary care agencies, including general practice, are ideally placed to be able to identify substance use issues and to intervene, potentially before a crisis is precipitated.

Brief intervention and motivational interviewing is an accepted part of general practice, but more needs to be done to boost capacity and skills and to strengthen the connections between health professionals, specialist addiction services and community-based social support.
Alcohol screening and brief advice is being conducted in Compass Health practices with the assistance of the DASHBOARD software. Strong international evidence shows that screening and brief interventions in primary care settings are effective in reducing total alcohol consumption and excessive drinking among hazardous drinkers. In particular ABC style brief interventions delivered by primary care general practice teams are an effective way to motivate patients to reduce alcohol intake.

Practices can track results within the quality indicator report available via the clinical tab on the provider portal. 18-25 years olds are the target group although it can be utilised for all age groups.

## CASE STUDY

### Caring for physical as well as mental health

The Equally Well initiative developed by Te Pou in 2014 was endorsed by Compass Health and used as a basis by Compass for development of a programme to address the poor physical health outcomes experienced by people with a serious mental illness.

Users of specialist services and primary care had given feedback on the lack of integration across services, with mental and physical ill needs typically managed separately.

Using the strength of their PHO data, a list of all those within the patient population on antipsychotics and mood stabilisers was developed by Compass Health. This was used to identify a cohort of patients who were targeted to receive a funded annual physical examination. Each general practice in the area now has a list of these patients, with changes to online forms to improve the reporting of patient information.

The outcome of this project will be a consistent approach within primary care to monitoring and treatment of physical health and mental health for those with mental illness.

## CASE STUDY

### Taranaki DHB Maternal Mental Health Pathways

Many new mothers experiencing mental distress don’t need specialist psychiatric and pharmaceutical therapy, but talking therapy, which can be provided by GPs and NGOs. Better integration can help ensure that women’s maternal status is automatically considered alongside their mental health status so the appropriate assessment and services can support their pregnancy and post-pregnancy journey.

Taranaki District Health Board has implemented a pathway to allow midwives, Plunket nurses and GPs to all understand the process around standardised assessment and support for women’s perinatal mental health needs.

The result of using this approach has been a 50% increase in referrals, reflecting previously unmet maternal mental health needs. This increased demand on the DHB’s mental health services has been challenging and reinforced the identified next step which is to improve integration with primary health.
Services for Māori

The 2012/13 New Zealand Health Survey confirmed rates of psychological distress among Māori were 1.7 times higher than non-Māori, with 10 percent of Māori adults reporting mental distress in the previous four weeks compared to 6 percent of the overall population (6 percent).

And although the number of Māori seen by specialist mental health services has increased significantly, access rates for Māori are still lower than expected. (Mental Health and Addiction Service Use 2012/13, Ministry of Health, 2016). There is a clear opportunity to improve engagement and facilitate better access to services by looking beyond the health system to reach those who are in need.

With social factors playing a significant part in the predisposition and experience of mental ill health and addiction, integration and outreach through other parts of the health, social, justice and welfare system has the potential to improve access, encourage early intervention and ultimately improve wellbeing and outcomes. Many of the most vulnerable are disengaged with mainstream services and may only access wider help as a result of opportunistic, sometimes casual, contact with social support agencies.

Conversely, while Māori providers have an important role to play, many Māori access mental health and addictions support through mainstream services and are not closely involved with Iwi and culturally specific services.

We need to develop better relationships between agencies including Whanau Ora service providers and to encourage local co-design to ensure that the full spectrum of Māori mental health and addiction needs are met.

CASE STUDY

Rural services – bringing services closer to home

Rural Health Alliance Aotearoa New Zealand (RHĀNZ) is establishing a framework to help improve mental health and addictions outcomes for rural New Zealanders. It aims to provide strategic guidance to the many involved in mental health services in rural communities and will build on current health, psychological, social support and wellbeing programmes to promote best practice, peer support and mentoring, and innovative approaches to increasing service reach, continuity and quality.

Suicide statistics for rural communities are high yet the rural capacity and channels for support are challenging in remote locations. Partners who can support the mental health needs across rural communities can be different from traditional urban players - for example the Ministry for Primary Industries’ stock agents and vets have an important role in recognising and channelling mental health and addiction services for farmers.

Creating a framework will help identify who the key players are, promote opportunities to build better relationships between them and inform the development of services that will help keep the community well in addition to ensuring that rural and remote families can access support before a crisis happens.
Services for young people

There is clear evidence that many mental health problems begin in youth and that there is continuity of disorders as well as the potential for risk factors to be evident in early years. There are opportunities as part of health assessments, such as Plunket and Before School checks to screen and identify potential issues at an early stage and to share information appropriately between agencies.

This necessitates strong local relationships based on trust and sharing of records and information, as well as involving the young person fully in decisions about interventions and desired outcomes.

Appropriate school-based support with advice from counsellors and nurses and more awareness of mental health literacy in the school curriculum has been shown to have major benefits.

CASE STUDY

Odyssey Addictions – growing the connection; NGO, specialists, primary care

Odyssey delivered and evaluated a successful primary care demonstration programme in 2014/16 to improve addiction interventions.

It focused on providing training, telephone and face-to-face engagement, screening and brief intervention to support discussion and management of substance use within the primary care setting. They worked alongside primary care professionals on-site at Health New Lynn, a large medical centre in West Auckland, and with associated primary care professionals including social workers and nurses.

This workforce development approach enabled 43 professionals to be upskilled in screening and brief intervention around addictions. On-site support enabled addictions training to fit within a busy general practice environment; built a collegial relationship with the Alcohol and Other Drugs (AOD) specialist and greater understanding around addictions and the referral agencies available; and improved the system and responsiveness when specialist support was needed.

Overall the programme was seen to have raised the profile of addictions services in the primary care setting, and led to primary care professionals being more likely to ask questions about patients’ AOD use.

Patients reported increased motivation to make change and reduced AOD related harm after a conversation with their health professional. Health professionals reported enhanced clinical outcomes.

“There’s little evidence that Māori are biologically predisposed to mental health problems but the issues that precipitate mental ill health are largely socioeconomic and behavioural factors that impact more on the Māori population.”

Te Kani Kingi, Associate Professor, Massey University
WE RECOMMEND:

- Growing PHO, NGO and other relevant primary care and community-based support services so that they can offer stepped care through virtual and face-to-face assessment, coordination and navigation, working within a place-based framework.

- Provision of greater access to talking therapies, NGO services and specialist mental health services directly from primary care, underpinned by comprehensive shared care planning.

- Co-designed standardised pathways that offer flexibility and choice from first contact to a meaningful outcome.

"You look at the whole person and figure out together what’s needed in terms of social outcomes not just health. You don’t just ask what are your symptoms; you ask what’s going on in your world and who are your significant others...... so if the answer is “Right now I’m worried about where to sleep tonight”, you can say “Let’s pick up the phone or go down the hall to talk to the housing people.”

Terry Huriwai, Advisor, University of Otago

CASE STUDY

Enhanced school-based health services in Auckland

Under the governance of the Youth Service Alliance Leadership Team, ProCare Health provides nurses, GPs and psychologists in ten decile 1-3 and special character schools in the ADHB area.

Uptake of DHB-funded access to psychology services for young people had previously been low but having a psychologist on-site in schools has reduced the barriers to access by avoiding the need for a GP referral.

Any professional, such as a teacher or school counsellor, can refer a student and having extended services on-site within schools reduces the stigma, increases awareness of the support available, allows ease of appointment-setting, and provides confidential access within school hours. Referrals to specialist mental health services or alcohol and drug youth services are available when needed.

Results have shown that uptake of the services is aligned with local demographics, with the 50 percent of student population who are Pacific Islanders having a matching 50 percent uptake in services while 14 percent service use has been Māori students where Māori students make up 17 percent of the population. In the last financial year there has been a 72 percent increase in packages of care delivered by the school-based services and funding has recently been extended for a further three years.
THEME 3

Enablers that effectively support the model.
By focusing on key enablers we can ensure a model that will allow the development of individualised and holistic support pathways from first contact. The key enablers we have identified are: a single point of coordination; workforce; technology; and funding.

**ENABLER 1: Multiple avenues leading to a single point of coordination**

**THE CHALLENGE**

Early recognition and treatment of mental health and addiction issues can significantly reduce the negative impact on people, their families/whanau, communities and wider society.

We need to widen access for all populations in a way that does not create financial barriers and is cost-efficient, as well as widening provision of services to include wellness promotion, self-management, education and a wider range of therapies. We also need to break down barriers around referral between primary care, NGOs and DHB provider services.

We need to ensure multiple avenues lead to into a system of integrated care, encompassing physical health, mental health and addictions and social needs. This will require nationally consistent mechanisms to connect people to the support and services needed for their individual goals and outcomes.

Services need to be available close to home and access points need to be culturally appropriate, welcoming and engaging to improve access to services for Māori, Pacific, Asian and specific populations including rural communities, young people and new mothers.

**OUR VISION**

We envisage the creation of multiple routes to a single point of coordination. Where a need for support is identified, a person would be quickly and seamlessly connected to a single coordination point, regardless of their initial contact with support.

Physical access in many cases is likely to be through a provider who is part of a community hub, such as a GP or NGO service. This needs to be supplemented by virtual access through phone or online services, such as the National Telehealth Service, to connect people to the same comprehensive range of supports. There may be local variation in the number and type of access points—a community setting, midwife, marae, online portal or self-referral—any door is the right door.
MENTAL HEALTH TRIAGE SERVICE

The development of coordinated virtual access will make significant progress over the next year, with the introduction of a mental health triage system to build on the existing 24/7 National Telehealth Services, including the Depression Helpline, Alcohol and Drug Helpline, Healthline and e-therapy tools.

People experiencing a mental health crisis or distress who contact emergency services or health, social and community agencies by phone or online will be connected through to the service which will offer expert mental health advice.

A further non-acute virtual mental health expert advice service will also be made available to support primary care and social services, helping professionals to support people to address their issues before they escalate into more serious concerns.

A local mental health pathways programme will map existing services so people can also be directed to help in their local community.

Part of the $12 million additional funding for primary mental health services allocated in the 2016 Budget, the service is scheduled to be fully implemented across New Zealand by the end of 2017.

WE RECOMMEND:

Creation of a single point of coordination at a local level to provide support for mental health and addictions, accessible both physically through a community hub and virtually through digital channels (e.g. websites, social media and telephone service).

ENABLER 2: Workforce

THE CHALLENGE

Significant effort is needed to increase the capability and capacity of our mental health and addictions workforce, especially in primary care.

We need a flexible and multi-disciplinary workforce that can provide integrated care to the unique needs of each community, with the capability to work across the full range of agencies and services, supported by appropriate alliancing and funding arrangements.

Despite the prevalence of mental health need presenting in general practice, GPs and practice nurses are not necessarily resourced or equipped to deal with the scale and complexity of their mental health and addictions workload.

OUR VISION

We need to make use of the full range of roles such as nurse practitioners, social workers, community pharmacists and psychologists.

We need to ensure better connection between general practice teams, NGOs and specialist services, knowing what is available, as well as having direct access to each other’s services in arrangements that feel seamless to service users.
We need to maximise the expertise and knowledge across the range of NGOs, to connect health services with navigation to agencies such as housing, self-management education, mindfulness, group-based programmes, peer support and general practice.

Earlier access to specialist services, directly commissioned from primary care, is also crucial. The skills and expertise of mental health specialists, should be available earlier and closer to home to encourage sharing of expertise and strengthening of relationships, while improving access and coordination.

This will require a workforce with the skills to work in multi-disciplinary teams, across service boundaries, at the top of their scope and in a person-centred manner. To achieve this a competency framework and associated training and development needs to be developed.

“The old days of nine to five are over. We go to where people are at. We meet them in their home, at their church or whatever feels right for them. We talk online with the whole family dialling into a Skype call. We empower families to not need us and to be able to manage themselves or know when and how to access primary care when they need it.”

Naomi Cowan, Chief Executive, Equip Mental Health Services and Chair of Platform Trust

Our primary mental health workforce should:

• Have access to appropriate training to develop service capability and capacity within a range of settings
• Have greater access to a nationally consistent specialist liaison service
• Be able to deliver culturally appropriate interventions

• Have increased capability to be more responsive to different populations including children, youth, adults and older people
• Have a competency framework and associated training and development programmes that support multi-disciplinary practice
• Support a whole-of person approach and value self-determination.

**CASE STUDY**

**Psychiatrist based in general practice – building GP expertise**

Health New Lynn, in collaboration with Waitemata DHB and ProCare Health, has implemented a consultation liaison model of care.

This provides a secondary care psychiatrist and specialist mental health nurse on-site within the GP practice to provide timely specialist advice and expertise to GPs to help them better support their patient’s mental health and addiction needs.

The aim of this approach was to build GP capacity and confidence in treating people’s mental health and addiction needs in the community in primary care, and to demonstrate a way for secondary care to provide sustainable and scalable support to primary care.

While 80 percent of the psychiatrist’s work has involved face-to-face consultations with patients, the focus is on understanding the mental and clinical health needs of patients and designing their treatment journey, rather than providing hands-on psychiatric treatment. The remaining time has been working directly with GPs...
providing expert advice and upskilling them in recognising and responding to mental health and addiction needs.

Patients benefiting most have been those with GPs who recognise their mental health and/or addiction needs which can’t clearly be articulated to meet a threshold for accessing secondary services. Intervention and support can be initiated early, rather than risk under-treatment or a less holistic approach to individual needs.

WE RECOMMEND:

An integrated workforce development strategy be developed that enables the creation of an appropriately trained mental health and addictions workforce, with a focus on primary care, holistic support and person and family/whanau wellbeing.

ENABLER 3: Technology

THE CHALLENGE

In support of the proposed model we recommend that a technology strategy and associated implementation plan is developed with a focus on facilitating access, coordination, integration and e-therapy tools. We need technology that enables:

• A virtual single point of coordination for mental health and addiction services
• Collaborative care when that support is activated
• Further development of an evidence-based suite of virtual support tools, available nationally to broaden access to effective therapeutic interventions and smart data sharing to ensure we are being effective and efficient

• An electronic patient-held care plan that can be created, used and shared across NGOs, primary and secondary care.

OUR VISION

Virtual access

We need to facilitate virtual access points so that multiple sources can easily channel people into an appropriate pathway. Enabling telephone and web-based access to a single point of entry would allow any agency or service that detects need - such as General Practice, NGOs, schools, Corrections, Housing New Zealand, ambulance services the National Telehealth Service - to connect to an integrated virtual and face-to-face support pathway quickly and easily.

Collaborative care tools

Collaborative care tools would integrate health and social support, enabling relevant agencies and support staff to access and contribute to a person’s care plan electronically and include the person being able to access their shared care plan, should they want to. It would also include functionality to triage, navigate to services, review plans and report on outcomes. A key feature would be having access to an up to date information hub including a directory of services available within the community.

Virtual tools

To meet the needs of a wider group of people we need to create integrated access to a range of digital support including tele-therapies and e-therapies that are evidence-based and approved nationally.

There are a wide range of tools already available and we need to consolidate those, ensuring we build on the successes and ensure quality and standardisation. With a relatively small sector and the speed of innovation in technology, we need to offer tools that can combine safety
Closing the Loop

THEME 3

and integration as well as personalisation. Local successes such as The Journal can be enhanced and developed to be fully integrated with face-to-face service delivery. Emerging evidence supports improved outcomes in the use of digital tools alongside face-to-face and virtual consults in the New Zealand context.

“Some of the most successful programmes combine self-management modules with personalised support services, it can be as simple as phone-based coaching support and access to e-tools and support for self-management. When you start logging in to lessons your coach has full visibility. Health coaches/e-coaches don’t need to be nurses or psychologists, but be able to safely navigate a person through the journey.”

Anil Thapliyal, Chief Executive, Health TRx

CASE STUDY

Gambling Helpline – The effectiveness of telephone interventions for problem gambling

In 2012 AUT undertook the largest Gambling Helpline Randomised Controlled Trial (RCT) in New Zealand investigating the effectiveness of telephone interventions for problem gambling.

First time Gambling Helpline (NZ) callers were randomly assigned to four groups. The groups were given different interventions:

1. Helpline standard care
2. Single motivational interviewing session (MI)
3. Single motivational interviewing session plus cognitive behavioural self-help workbook (MI+B)
4. Single motivational interviewing session, plus workbook, plus four follow up motivational interviews (MI+B+W)

The interventions provided as part of the study were delivered by Gambling Helpline (NZ) staff who were trained by Abacaus (Clinical leaders in Problem Gambling Training).

The key findings were:

• Clinically significant outcomes were similar between the groups and sustained over time except for the MI+W+B which had improved outcomes in problem gambling severity and quitting or reducing gambling

• Results were similar across the groups at the 12-month interval but people in the MI+W+B continued to improve between the 12-36-month period

• At the 36-month interval the percentage of problem gamblers was lower in the MI+W+B group (24 percent) than the other groups (41-48 percent)

• At the 36-month interval the median Problem Gambling Severity Index (PGSI) score for the M+W+B was 1 (low risk) compared to the other groups with median scores of 3-7 (moderate risk)

These findings have resulted in a shift to the Gambling Helpline’s service delivery model with a workbook now forming part of the support package.
**Smart data**

In its review of how government agencies can provide more effective social services, the Productivity Commission makes the case for better targeting of at-risk populations through smarter data sharing arrangements and focused collective actions for outcomes (More Effective Social Services, Productivity Commission, 2015).

We need to strengthen the connectedness and usability of mental health and addictions data to enhance practice and inform better decision-making for the planning and delivery of services. Data from PHOs, DHBs and other major access points such as The National Telehealth Service needs to be connected and analysed so that we can understand population utilisation, demand and need and develop intelligence driven interventions.

**WE RECOMMEND:**

*Development of an e-mental health and addictions technology strategy and implementation plan to enable a single point of coordination, collaborative care and greater provision of virtual care leveraging existing infrastructure and capability e.g. patient portals, National Telehealth Service, PHO and DHB population data systems.*

**ENABLER 4: Funding and resources**

**THE CHALLENGE**

Recognising the constraints on funding and the exponential increase in demand for services, we need to combine innovative ways of working and of securing new funding to enable primary care to support more people more effectively and efficiently.

This includes funding enablers such as workforce development and improved technology as well as better care navigation, enhanced clinical and medication management, extended consultations, a wider range of psychological therapies closer to home and creating scope for early and easy access.

We need to develop innovative funding models that allow us to afford the developments needed in primary and community care to improve outcomes for the wider population.

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**FOUR MAIN ELEMENTS OF SOCIAL INVESTMENT**

(What is social investment? Social Investment Unit, 2016)

- Using data to better understand people’s current and future needs
- Systematically measuring the effectiveness of services in meeting people’s needs
- Measuring long-term outcomes for people over their lifetimes and feeding back into decision-making
- Understanding the fiscal implications of better outcomes and help to manage the long-term costs to government.

We need:

- Commissioning models that support and incentivise multiple services and agencies to align to make a collective impact on outcomes
- Policy and associated funding shifts that give mental health and wellbeing parity with physical health
- Greater investment in the capacity and capability of primary care to develop a workforce that can deliver early intervention
and increased clinical management for a wider range of people

- Investment in research and evaluation
- Nationally consistent service specifications and outcomes-based funding arrangements
- The ability to measure and demonstrate a long-term return on investment
- To empower frontline clinicians in primary care to make decisions around resource allocation in partnership with service users.

**OUR VISION**

We envisage two avenues through which greater funding and resources can be made available to primary care: the adoption of the investment approach by the mental health and addictions sector and devolving more decision-making around the current resources available.

In its recent publication, *Mental Health Services Productivity Improvement: Best Practice Review*, the Health and Disability Commission highlights that the burden of disease in developed countries due to mental illness and addiction (in Disability Adjusted Life Years) now exceeds cardiovascular disease and cancer. It outlines how a focus on integrated mental health and physical health responses in primary care offers potential for significant cost savings and enhanced productivity across the wider health sector.

Populations that could benefit from better primary mental health provision include those returning to the community from time in prison, young mothers who have a mental health concern and families with complex problems, as well as people experiencing long-term unemployment - a significant proportion of Ministry of Social Development (MSD) clients having a medical deferral from employment are experiencing mental distress and/or addiction issues.

Better, more responsive and more expansive primary mental health and addictions provision can also positively impact on the costs being incurred by other government agencies having to respond to urgent or unmet mental health need. NZ Police’s annual report for 2015 reported that every day police are dealing with more than 100 people suffering from mental distress or who are suicidal.

The social investment approach that has been adopted by MSD in recent years and that has been promoted by the Ministry of Health in the 2016 *Health Strategy* has real potential to transform the delivery of mental health and addiction services.

Devolving more commissioning decisions to community and primary care services offers the greatest opportunity for cultivating true person-centred care planning as well as efficiencies. The point of coordination needs to be empowered to, and be accountable for, making the right choices locally for the patient and the wider system.

Comparative funding models, where greater control over the allocation of system resources has been given to non-mental health primary care services, have already been shown to work well. This includes the management of radiology access and chronic disease management where point of care resource stewardship has improved access to the right interventions earlier, while also ensuring resources are efficiently managed.

**WE RECOMMEND:**

- *Early investment, under the health investment approach, should be targeted at developing primary mental health care’s ability to respond to the needs of vulnerable population groups*

- *Greater access to mental health and addictions resources, including those within DHBs and NGOs, be made available directly from primary care.*
THEME 4

Well-resourced research, development and evaluation.
THE CHALLENGE

Developments need to be informed by data and information, with a strong evidence base to inform decision-making. We need to invest in research, incorporating action learning and person-centred design to enable continuous improvement and the development of new approaches.

We need to systematically share learning and develop robust metrics and capabilities for evaluating outcomes.

We know there are areas where we need to commission or collaborate in new research including addictions, the emerging use of e-therapies and measurement of outcomes emerging from new models of care.

As a small sector, with extremely limited funds for evaluation and research, we need to ensure effective collaboration of these scarce resources and enable the sharing of learnings across New Zealand and from international experience.

We need institutions, such as universities and the Health Research Council, to work more closely with the mental health and addictions sector to evaluate and inform practice with evidence-based recommendations and action learning research techniques to maximise the potential for positive impact.

Our research and evaluation system needs to:

- Involve service users
- Make better use of data and analysis to assess population needs and the effectiveness of different models and interventions for people as well as our economy and society
- Be able to demonstrate the contribution that a range of agencies and services are making to collective outcomes
- Make better use of evidence-based practice, continuously evaluating new ways of working and specific interventions and finding ways to share and embed knowledge
- Support greater understanding of collaborative practices and how multiple agencies can work collaboratively.

PRINCIPLE: A system I and my family/whanau can trust to be high quality, safe and committed to ongoing improvement.

THEME 4

Well-resourced research, development and evaluation.
OUR VISION

We need to develop a broader knowledge of what works in primary mental health and addictions care that takes account of emerging practice and involves a closer relationship between research institutions and service providers.

We need a greater focus on human centred design and research methods to enable the system to provide support that is relevant to those that use it.

Through the consultative process of developing Closing the Loop we also heard a strong case for building on existing research resources.

We need to develop research supported by a range of partners that includes:

- Researching evidenced-based models and interventions
- Evaluating the implementation of new delivery models, interventions and ways of working
- Developing tools and resources to enable the development of effective support models.

"Lifting the effectiveness of social services in New Zealand will require a system that learns over time about what works, then selects the successful approaches and winds down the approaches that fail to achieve good results."

Productivity Commission, 2015

WE RECOMMEND:

- Building on existing expertise in research and evaluation through establishing formal learning and development networks that enable scaled collaboration between the formal mental health and addictions sector and the research community in New Zealand.
“Even with the favourable changes that have been reported in New Zealander’s attitudes to mental illness (ie, as a result of the Like Minds Like Mine campaign), service users still report that they find themselves excluded from many aspects of life – from jobs, recreational opportunities, housing, proper health care and community life. Given that social exclusion is detrimental to good health outcomes, the workforce needs to be involved, to a greater or lesser extent, in delivering public health approaches to mental health. This could mean being involved in advocacy, building community capacity, or supporting education or contact strategies that are aimed at influencing the perceptions, attitudes and actions of others.”

Platform Trust & Te Pou o Te Whakaaro Nui (2015).
THEME 5

The right system leadership.
THE CHALLENGE

We need courageous and trusted leadership at all levels with the ability to support and embed change and to bring people and services together to collaborate, co-design and innovate.

Strong consumer leadership needs to be developed to guide the provision and development of community and primary services.

OUR VISION

Through the consultative processes that the Ministry of Health has undertaken in developing recent key policy documents such as the Health Strategy, Mental Health and Addictions Commissioning Framework and Mental Health and Wellbeing Outcomes Framework, as well as discussions undertaken in the development of Closing the Loop, and other key documents such as On Track, a significant movement for change has been created.

The success of initiatives such as Equally Well have also generated dialogue and ideas, and created a momentum to bring together agencies and individuals committed to better outcomes and experiences for people using mental health and addictions services and their families. There is a clear desire for improvement and collaboration.

The current activity needs to be harnessed, creating an opportunity to develop collaborative and distributive leadership of primary mental health and addictions services. Annual or bi-annual symposiums should focus on progressing service development, incorporating progress in the implementation of new policy and initiatives, development of new policy, oversight of the commissioning of research and sharing of learning and good practice.

The sector needs an online sharing network and repository for cultivating discussion around what works in supporting mental health and addictions across New Zealand. This will allow access to learning and development of best practice, the fostering of bottom-up innovation and the sustaining of momentum for change.

The formation of a national leadership group for mental health and addictions would enable the wider system to co-design, implement, monitor, evaluate and continuously improve. A leadership body would provide system stewardship, support workforce development, oversee research, evaluation, service improvement initiatives, sharing of good

PRINCIPLE: A system where we are all taking responsibility for our roles to develop and deliver the best support.
practice, be accountable for development of nationally consistent service specifications and contribute to policy development and consumer leadership and co-design.

Local leadership collectives would bring together service users, planning and funding, clinical services, NGO, Māori and Pacific leadership, local government and all relevant agencies with a stake in providing support and improving outcomes including major education providers and employers. These collectives would inform district mental health and addictions alliances, comprised of DHB, Iwi, PHO and NGO representatives who would have oversight over local mental health and addictions service provision and performance.

At an individual level we need to ensure that people are supported to lead their own support journey. The foundation of a sustainable, valuable health system sits with the capacity of the individual to be engaged and activated in maximising their own wellbeing. Individual leadership can occur through increased mental health literacy, increased choice over support options and by giving equal importance to people’s experience of service delivery alongside the outcomes that are achieved.

WE RECOMMEND:

- **Formation of a national mental health and addictions leadership group drawn from a range of backgrounds and sectors who can drive and support leadership at all levels**

- **Formation of strong local leadership arrangements through dedicated mental health and addictions collectives and alliances**

- **We recommend that people’s experience is given equal importance to their outcomes in the measurement of service performance.**
THEME 1
A mental health and addictions system that achieves meaningful outcomes tailored to population needs.

Principle: A system of support that understands and is relevant to me and my family/whanau.

Recommendations:
- Development of a nationally consistent set of service specifications for primary mental health support underpinned by local service level agreements between agencies and robust commissioning structures – national standards, local solutions
- Creation of alliances, partnerships and collaborations that are capable and responsible for the achievement of local population outcomes in mental health and addictions
- Development of shared service goals and outcomes-based contracts to underpin activities and foster real integration, shared commitment, shared accountability.

THEME 2
A person-centred and place-based model of support that enables self-determination and wellness.

Principle: A model that achieves a meaningful outcome for me and my family/whanau from the first point of contact.

Recommendations:
- Growing PHO, NGO and other relevant primary care and community-based support services so that they can offer stepped care through virtual and face-to-face assessment, coordination and navigation, working within a place-based framework
- Provision of greater access to talking therapies, NGO services and specialist mental health services directly from primary care, underpinned by comprehensive shared care planning
- Co-designed standardised pathways that offer flexibility and choice from first contact to a meaningful outcome.

THEME 3
Enablers that effectively support the model.

Principle: A system that empowers me and is capable of responding to mine and my family’s needs

Recommendations:
Enabler 1: Multiple avenues leading to a single point of coordination:
- Creation of a single point of coordination at a local level to provide support for mental health and addictions, accessible both physically through a community hub and virtually through digital channels (e.g. websites, social media and telephone service)
Enabler 2: Workforce:
- An integrated workforce development strategy be developed that enables the creation of an appropriately trained mental health and addictions workforce, with a focus on primary care, holistic support and person and family/whanau wellbeing.

Enabler 3: Technology:
- Development of an e-mental health and addictions technology strategy and implementation plan to enable a single point of coordination, collaborative care and greater provision of virtual care leveraging existing infrastructure and capability (e.g. patient portals, National Telehealth Service, PHO and DHB population data systems).

Enabler 4: Funding and resources:
- Early investment, under the health investment approach, should be targeted at developing primary mental health care’s ability to respond to the needs of vulnerable population groups.
- Greater access to mental health and addictions resources, including those within DHBs and NGOs, be made available directly from primary care.

**THEME 4**

Well-resourced research, development and evaluation.

**Principle:** A system I and my family/whanau can trust to be high quality, safe and committed to continuous improvement.

**Recommendations:**
- Building on existing expertise in research and evaluation through establishing formal learning and development networks that enable scaled collaboration between the formal mental health and addictions sector and the research community in New Zealand.

**THEME 5**

The right system leadership.

**Principle:** A system where we are all taking responsibility for our roles to develop and deliver the best support.

**Recommendations:**
- Formation of a national mental health and addictions leadership group drawn from a range of backgrounds and sectors who can drive and support leadership at all levels.
- Formation of strong local leadership arrangements through dedicated mental health and addictions collectives and alliances.
- We recommend that people’s experience is given equal importance to their outcomes in the measurement of service performance.
APPENDIX A
NEW WAYS OF WORKING

There are already many examples of innovation in primary mental health across the country – we have outlined a few here which we believe offer opportunity for learning and scalability.

Te Pikinga: A project to support a marginalised group – Canterbury

Te Pikinga (TP), meaning Steps to Change, is a Settlers Health Centre (SHC) project that commenced in June 2010 to assess health and provide treatment for people who have had limited input from the health system and who are at risk due to factors relating to lifestyle, addictions or imprisonment. Referrals are received from three social service providers.

Clients, the majority of whom are male and of Māori or Pacific background, have been released from prison or are court-ordered to undergo alcohol and drug intervention programmes.

Each TP patient is actively encouraged to participate in their own care and take responsibility for their own journey. During the first visit, service users are encouraged to complete a tailored health assessment with the nurse before seeing the doctor for an extended consultation. Te Pikinga has developed an assessment tool that includes measurements, blood tests, hearing/ vision assessments, personal/family medical history, and social/ emotional/wairua (spiritual) history.

Not all patients choose to complete the nurse assessment, some because they are in need of immediate medical care, some due to disorientation or stress upon leaving prison. He Waka Tapu (NGO) clients undergo part of their assessment at He Waka Tapu before their first visit.

The doctor, client, and an accompanying support worker discuss the clinical decisions made and care strategy at the end of each consultation. Input from the support worker ensures the client has another person who understands what care decisions have been made and who can provide support to follow through with actions.

Practice-based primary mental health coordinators – Wellington

Following a significant increase in referrals for therapy, Compass Health PHO has changed the way it provides services for people with mild to moderate mental health disorders.

Previously all referrals were triaged and then referred to contracted clinical providers for up to 12 sessions of therapy. However, as referrals increased to more than 3,300 in 2013/14, without a comparable increase in funding, new solutions were sought.

The PHO has employed mental health practitioners with therapy qualifications who provide assessments and brief interventions within practices, with no referral needed.

GPs access the practitioner’s calendar in the patient management system to directly book their patients in, accompanied by clinical notes. People are seen promptly in the practice setting, always within two weeks and on the same day if the coordinator is available.

Clients, whanau and GPs have all given very positive feedback on this change.

Tamaki Mental Health and Wellbeing – Auckland

The Tamaki Mental Health and Wellbeing initiative was developed in 2013 by Auckland
DHB, its PHO partners and the local community to re-design, in partnership with the local community, how mental health and wellbeing was supported in the Tamaki local board area.

It seeks to put the design of mental health services in the hands of those who use and work in them, in a bid to ensure as many needs as possible are met.

The Tamaki initiative draws on person-centred design and is the first to use a ‘social lab’ approach, which encourages members from different sectors, including government, local people and diverse local providers to work together to develop supports from the ‘ground up’.

Workstreams are based around whole-person/whole-of-life care, ensuring general practice can access dedicated NGO resources, facilitating integration between primary and secondary care, linking health and social support and cultivating community wellbeing.

www.tamakiwellbeing.org.nz

At Risk Individuals - Counties Manukau

The At Risk Individuals (ARI) programme uses a risk stratification algorithm to identify those at risk of hospitalisation as part of a planned proactive approach to care.

The aim is to intervene early with patients through proactive identification, engage in partnership with the individual through shared care planning and activate the person to take charge of their condition through focused self-management programmes.

Each patient has an individualised care plan and a named care coordinator to help them identify and achieve their goals. The programme allows resources to be allocated to support the individual care plan, ranging from items such as shoes to help encourage physical activity to services such as transport to attend appointments. The programme has not yet been fully evaluated but is being praised by both patients and clinicians anecdotally for the outcomes it is achieving.

Whole of system integration in South Auckland

A commitment has been made to transform the mental health and addictions system in Counties Manukau, with effective integration across primary care, specialist mental health and addictions and NGO provision. Through a process of co-design the plan is to develop a mental health system that builds effective relationships focused on primary care clusters.

Named individuals from specialist mental health and addiction services are assigned to clusters/hubs, working in a way that moves past the traditional approach to referrals. Outreach will take services into the community and engage with partners such as schools, marae and churches.

NGO partners will be a core component of local provision, ensuring that each locality has access to a range of services that are responsive to their needs.

Alongside locality-focussed provision, there will still be a number of specialist services, such as eating disorders or maternal mental health combined with a strong focus on building community resilience and providing education and coaching around self-management.
APPENDIX B

ACKNOWLEDGEMENTS

Feedback summary
Feedback on the Closing the Loop discussion document published in December 2015 was received from a wide range of organisations and individuals. In addition to targeted discussions and interviews with key stakeholders including DHBs, NGOs and Ministry of Health officials (more than 20 written responses were received to the dedicated e-mail address) a large number of people attended meetings in Auckland, Hamilton and Christchurch and we presented at many key sector forums.

We would like to convey our warm appreciation for everyone’s valued contributions to this work and a special acknowledgement to Phillipa Gaines and Sonya Russell for their contributions in the development of this document.

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### Written Feedback and Case Studies:

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