Northern DHB Support Agency

On behalf of
Network North Coalition

Stocktake of Primary Mental Health Care
Initiatives and Workforce in the Northern
District Health Boards Region

September 2006

Prepared by:
Centre for Mental Health Research, Policy and Service Development

Contributors:
Frances Hughes
Anthony O’Brien
Fiona Moir
Kate Thom
Patrick Firkin
Research Team

Frances Hughes is a Professor of Nursing and Director of Centre for Mental Health Research, Policy and Service Development. She practices as a mental health nurse and also provides clinical advice and consultancy to the Director of Mental Health at the Ministry of Health. Previous research experience includes nursing workforce, policy formation and mental health.

Tony O’Brien is a Senior Lecturer who teaches in the postgraduate programme at the University of Auckland, and practises in Liaison Psychiatry at Auckland City Hospital. Previous research experience includes clinical indicators for mental health nursing standards of practice, nursing workload measurement in acute inpatient units, post entry clinical training for mental health professionals, effectiveness models of crisis intervention, and legal issues in mental health nursing.

Fiona Moir is a Senior Lecturer with a background in general practice who coordinates postgraduate papers in primary mental health, and teaches communication skills and motivational interviewing at the University of Auckland. Outside of the university she teaches communication skills to health professionals and works in project management.

Kate Thom is an Assistant Research Fellow for the Centre for Mental Health Research, Policy and Service Development at the University of Auckland. Previous research experience includes the development of a national framework for mental health nursing, review of post entry clinical training for mental health professionals, and media depictions of mentally abnormal offenders.

Patrick Firkin is a Research Fellow with the Centre for Mental Health Research, Policy and Service Development at the University of Auckland. He has a diverse research background having worked on a range of projects in areas such as mental health; alcohol screening and brief intervention; employment and labour market dynamics; clinical practice; housing; and provision of local authority community services. Most recently he has been involved in work with the World Health Organization around mental health in Pacific Island countries.
Acknowledgements

The research team would like to thank all participants in this study, including representatives of Primary Health Organisations and District Health Boards.

We would also like to thank the reference group that advised on the design of the study.

The research team acknowledges the funding and support provided by the Northern DHB Support Agency.
Contents

Research Team.................................................................................................................. iii
Acknowledgements ........................................................................................................... iv
Contents ............................................................................................................................. v
Executive Summary ........................................................................................................... 1

1. Introduction .................................................................................................................... 3
  1.1 The Global Context of Primary Mental Health ......................................................... 3
  1.2 Primary Mental Health Services in New Zealand ....................................................... 4
  1.3 New Zealand Policy Context ..................................................................................... 4
  1.4 Structure of the Report ............................................................................................. 6

2. Literature Review .......................................................................................................... 7
  2.1 Prevalence of Mental Illness in the Primary Health Care Setting ......................... 7
  2.2 Models of Primary Mental Health Care ..................................................................... 8
  2.3 Current Workforce Issues for Primary Mental Health .............................................. 9
  2.4 Primary Mental Health Initiatives and Workforce Development ......................... 10
  2.5 Conclusion ................................................................................................................ 10

3. Methodology ................................................................................................................ 12
  3.1 Study Design ............................................................................................................. 12
  3.2 Data Collection Methods ......................................................................................... 13
  3.3 Data Analysis ........................................................................................................... 13
  3.4 Limitations of the Research .................................................................................... 13
  3.5 Ethics Approval ....................................................................................................... 13

4. Results .......................................................................................................................... 14

4.1 Northland Region ....................................................................................................... 14
  4.1.1 Whangaroa PHO ............................................................................................... 15
  4.1.2 Hauora Hokianga Integrated PHO ....................................................................... 16
  4.1.3 Te Tai Tokerau .................................................................................................. 17
  4.1.4 Manaia Health .................................................................................................... 19
  4.1.5 Kaipara Care ...................................................................................................... 20
  4.1.6 Tihewa Mauriora ............................................................................................... 20

4.2 Waitemata Region ....................................................................................................... 21
  4.2.1 HealthWEST ..................................................................................................... 22
  4.2.2 Harbour PHO ..................................................................................................... 23
  4.2.3 Te Puna PHO ..................................................................................................... 24
  4.2.4 ProCare Network North ..................................................................................... 24
  4.2.5 Waiora Healthcare Trust .................................................................................... 27
  4.2.6 Coast to Coast PHO .......................................................................................... 27

4.3 Auckland Region ......................................................................................................... 28
  4.3.1 Tamaki PHO ....................................................................................................... 29
  4.3.2 Tikapa Moana PHO ........................................................................................... 30
  4.3.3 Procare Network Auckland ................................................................................. 31
  4.3.4 Auckland PHO Ltd ............................................................................................. 32
  4.3.5 AuckPac Health Trust Board ............................................................................ 32
  4.3.6 Langimalie - Tongan Health Society Inc ......................................................... 32

4.4 Counties Manukau Region ......................................................................................... 34
  4.4.1 East Health Trust ............................................................................................... 36
  4.4.2 ProCare South .................................................................................................... 37
  4.4.3 Ta Pasefika .......................................................................................................... 38
  4.4.4 Te Kupenga O Hoturoa Charitable Trust ............................................................. 39
  4.4.5 Peoples Healthcare Trust .................................................................................... 39
  4.4.6 Mangere Community Health Trust ................................................................. 40
  4.4.7 Total Healthcare Otara ....................................................................................... 41
Executive Summary

This report examines two areas related to mental health service provision within the context of primary health care. It provides a stocktake of planned and current mental health initiatives in primary health care, and the capacity of the primary health care workforce to provide mental health care within primary health care services. The report is the result of a study funded by the Northern District Health Boards Support Agency as part of its role in supporting the District Health Boards to provide mental health and disability support services. The report will contribute to a greater understanding of the current provision of mental health care by the primary health care sector, and will assist in the development of the sector’s capacity and responsiveness.

The study sought responses from nominated representatives of the twenty-five Primary Health Organisations and the four District Health Boards in the northern region. Information was generated from semi structured interviews that were conducted by telephone or face-to-face. Relevant documents on planned and current mental health initiatives, and workforce capacity were reviewed. Data collection took place between January and March 2006. Twenty-two representatives from the Primary Health Organisations agreed to participate. All District Health Boards participated. The results are presented in the body of this report in a narrative format and are accompanied by tabulated summaries located in Appendix Two.

The results indicate a high level of awareness of mental health issues within primary health care. There were, however, mixed views on how the sector should respond to these issues. In regions where Ministry of Health funded projects are in place, particularly initiatives across the whole District Health Board area, there has been a considerable shift to provision of mental health care within primary health care services. An extended range of services are available in some areas, including alcohol and other drug programmes, chronic care management, cognitive behavioural therapy and services for the specific population groups of adolescent, Maori, and Pacific. The Ministry of Health projects are currently being evaluated in a separate project. In addition, District Health Boards have utilised existing funding streams to develop programmes aimed at improved integration between secondary and primary services.

When the sector is seen as a whole, a wide range of initiatives is apparent. These include a variety of health promotion activities, from community development to promoting lifestyle change and healthy lifestyles through exercise and nutrition programmes. There were several initiatives aimed at youth through school outreach. It is likely that some mental health promotion was undetected because it is embedded in wider health promotion programmes. Each DHB region has some initiatives aimed at shared care between primary and secondary services, transfer of care, improved detection and effective treatment for mild to moderate mental disorder and improved access to primary health care services for secondary mental health service consumers. However, these services are not provided evenly across DHB areas.

A significant finding was that development of mental health responses in primary care is highly variable, with a range of reasons given for the limited response in some areas. These reasons include funding issues, especially the funding model that constrains primary care consultations to fifteen minutes, lack of knowledge and skill, and a perception that specialist mental health services are already funded to provide mental health care. Another reason that was suggested is that the governance models of some PHOs do not allow those PHOs to be fully responsive to population needs.

The study found that few PHOs employ specialist mental health staff apart from those who facilitate the Ministry of Health funded projects. The need for workforce development and
training in mental health for PHO and primary providers’ staff was widely acknowledged. Currently, the most common response is to prioritise mental health as a topic within the existing commitments of continuing medical education programmes. Most PHOs are presently conducting training needs analyses with their primary providers and aim to implement training accordingly.

The results are consistent with findings of a number of reports and studies of mental health in primary health care in New Zealand (Durie, 1999; MaGPlE Research Group, 2005a, p.110; Ministry of Health, 2001). While the primary health care sector has recently developed its capacity to respond to mental health issues, developments among the four northern regions are uneven. Further, some individual practices enrolled in particular Primary Health Organisations exercise considerable autonomy in terms of the range of services they provide. This can limit the ability of the Primary Health Organisation to design and manage programmes that encourage responsiveness to mental health issues.

The funding of primary health care services has undergone considerable change in the past decade. The complex nature of the current funding streams contributes to a uneven provision of primary health care services across and within different regions, including those provided for mental health problems. Comments from representatives of the Primary Health Organisations indicate that the current emphasis on mental health, together with provision of a range of contracts for mental health services has led to development of mental health care being linked to increased funding.

Overall, the level of awareness of mental health issues in primary health care is encouraging. There is, however, room for considerable development to improve the responsiveness of the primary health care sector to mental health issues. It appears that no one approach will be adequate to meet the needs of those with mental health illness across the northern region.
1. Introduction

The Ministry of Health is committed to mental health service provision in the primary health care sector. The Northern District Health Boards Support Agency (NDSA) was established to work with District Health Boards (DHBs) to progress the health and disability support services in the Northern Region. The NDSA is a limited liability company owned by the three Auckland Metro DHBs (Auckland, Counties Manukau and Waitemata) in their roles as health and disability service funders, for areas of service provision identified as benefiting from a regional solution. The NDSA also provides services to Northland DHB as a client.

The establishment of Network North Coalition in 2003 provided an opportunity for the Northern Region District Health Boards (DHBs) and key stakeholders, to identify their key priority areas for service development and improvement. Six Workstreams were established to identify the key issues that informed the development of the Northern Region Mental Health and Addiction Services Strategic Direction 2005-2010.

These Workstreams are – Older Adult, Adult, Child and Youth, Alcohol and Other Drugs, Primary Health and Information Systems. Each Workstream identified their key areas for service development and improvement, these have informed the commissioning of a number of projects. This project is one of the strategic priorities of the Primary Health Workstream. The Northern DHB Support Agency (NDSA) has undertaken Project Sponsorship on behalf of the Network North Coalition for this project. This report will contribute to the development of effective service delivery models and a skilled workforce that can provide mental health services in the primary health care environment.

The report provides a stocktake of current and planned primary mental health initiatives in the Northern region. A Primary Health Organisation (PHO) workforce profile in the area of mental health, and the training needs, support and resource requirements for that workforce were identified. There were three objectives for the project:

1. To determine the current and planned primary mental health initiatives in the Northern region;

2. To determine the current PHO mental health workforce in the Northern region; and,

3. To identify the PHO workforce training, support and resources needed to encourage workforce development in primary mental health in the Northern region.

The overall goal of the project was to develop a picture of current and planned service provision and of workforce development needs.

This chapter provides a policy background and contextual overview of the development of mental health service provision within the primary health care setting. The chapter concludes with outline of the structure of the report.

1.1 The Global Context of Primary Mental Health

The shift from institutional to community based mental health care in Western countries since the 1960s has increased the importance of treatment and care for people with mental disorders within the context of primary health care (Rogers & Pilgrim, 2001; Tansella & Thornicroft, 1999). A recent study conducted by the World Health Organisation (WHO) in 14 countries
concluded that one in four people who consulted a general practitioner (GP) had a mental health problem (World Health Organization, 2004). The report explained that primary health care is the first point of contact people have with the health system and that primary health care consultations can help reduce stigma associated with seeking help from mental health services, facilitate early detection and treatment of mental disorders, and increase the possibility of care in the community.

WHO have also illustrated, however, that the treatment and care of people with mental disorders at the primary health care level is variable across European countries and poorly developed in low-income countries (World Health Organization, 2001). The complexity of mental health problems presenting in the primary health care setting, has introduced new competency requirements for health professionals. In many European countries, responses have been limited with insufficient workforce development for primary health care workers (World Health Organization, 2001).

1.2 Primary Mental Health Services in New Zealand

The role of the primary health care setting in the provision of mental health care has become increasingly important recently, with figures indicating that 20 percent of the general population experience some form of mental disorder within their lifespan (Ministry of Health, 2004, piii). The new national mental health and addictions plan (Ministry of Health, 2005a) identifies primary care as one of ten key areas in the development of mental health services in New Zealand over the next decade. In New Zealand, GPs are the first port of call for most people with mental illness. Several New Zealand studies have shown that mental illnesses such as anxiety, depression, and substance-abuse are prevalent amongst people attending general practices (MaGPIe Research Group, 2003). Over a decade ago a Christchurch study revealed that one quarter of those who received treatment obtained it from specialist mental health or addiction services, while the remaining three quarters of treatment was delivered by GPs (Hornblow, Bushnell, & Wells, 1990). There are considerable advantages from GPs appropriately providing mental health services at a primary care level. By addressing the needs of people with mild to moderate mental illness, primary health care services can reduce the progression of illness and prevent significant disabilities (Harrison, Henare, & O’Hagan, 2005). The next chapter will review the current research related to mental health service provision in the primary health care context.

Funding for consultations in primary health care was revised as part of the establishment of PHOs, with the aim of increasing access. Access funding is provided to those PHOs classified by the MOH as having populations with high needs. Access funding is initially targeted at PHOs with high needs populations; this level of funding is to be extended to all PHO enrolees in the future. To qualify, a PHO must have 50% Maori, Pacific, or living in Decile 9 areas. There is some scope for extension of this formula to other PHOs. For Access funding co-payments must be low, and agreed with the DHB in service agreements. Interim funding targets individual patients within a PHO, rather than all patients. As with Access funding, for Interim funding co-payments must be low, and agreed with the DHB in service agreements. In addition to the Access and Interim funding formulae, there are a number of other funding mechanisms such as Services to Improve Access (SIA) and CarePlus.

1.3 New Zealand Policy Context

The New Zealand Health Strategy (Ministry of Health, 2000), along with other strategies relating to primary health care, mental health, Pacific and Māori, provides an overall framework for service provision and specific policy for priority areas. The population focus of the Health Strategy, combined with the reinforcement of the public health system over the
past five years, has implications for the care of people with both moderate to severe mental illness and/or people with mild to moderate mental disorders. Primary health care services and mental health are service priority areas addressed in the Health Strategy.

In particular, the Health Strategy identified better mental health services as an essential part of the government’s strategic direction. The special relationship between Māori and the Crown under the Treaty of Waitangi is also central to the strategy. Health inequalities are specifically targeted, and strategies to ensure accessible and appropriate services for Māori and Pacific peoples and those from lower socio-economic groups are outlined. Within the Health Strategy, primary health care is seen as integral to improving health and reducing inequalities in the health status of New Zealanders. He Korowai Oranga (Ministry of Health, 2002a) affirmed that an holistic approach to mental health provided in primary health care is essential to health and well being of Māori.

The Primary Health Care Strategy (Ministry of Health, 2001) signalled a new direction for primary health care and, as with the Health Strategy, focuses on population health. The reorganisation of the primary care sector changed the focus from predominantly private GP led services to services with a broad preventative health focus. The Primary Health Care Strategy outlines the development of PHOs which, funded by the DHBs, aim to provide services organised around the needs of locally defined populations (Ministry of Health, 2001). The document emphasised prevention and health promotion, innovative service provision, and communication with non-health agencies. Workforce development for primary health care professionals that is responsive to the changing population of regions was also prioritised.

The New Zealand Mental Health Strategy (Ministry of Health, 1997) identifies two populations of people requiring involvement of health professionals. The two populations include 17% of the general population who are estimated to experience mild to moderate mental illness at any one time and 3% of the population who suffer from moderate to severe mental illness (Ministry of Health, 1997). The primary health care sector is expected to meet the needs of people with mild to moderate mental illness (Ministry of Health, 2005a), with those presenting with more severe mental illnesses receiving care in specialist services. These populations are not discrete and individuals may move between and out of the two sectors as their needs change (Ministry of Health, 2002b). In addition to these services, mental health promotion is an area of mental health policy that seeks to address mental health needs at a population level (Ministry of Health, 2001).

PHOs provide the infrastructure for mental health to become an integral part of primary health care services (Ministry of Health, 2004). PHOs have the potential to systematically enhance their providers’ capacity to meet the mental health needs of their enrolled populations by providing strategic direction and through linking with community resources to provide promotion, education and prevention of mental illness; recognise mental health issues as early as possible and provide effective treatment; and, effectively link with specialist services to ensure service users’ access to specialist advice (Ministry of Health, 2003).

The report Primary Mental Health: A Review of Opportunities (Ministry of Health, 2002b) considers issues related to the implementation of government strategies for mental health in primary health care. The document notes the various pilot initiatives related to the transfer of lead care for those with severe and ongoing mental illnesses from specialist services to GPs. There is interest from both providers in developing a more co-ordinated approach to such services, however, it is also recognised that those with high and complex mental health needs may not be best served in primary care settings. Further, “the degree to which primary health care providers should be involved in providing mental health services to this group is not clearly identified nationally or internationally” (Ministry of Health, 2002b, p. 13). Therefore,
the development of mental health initiatives within primary health care has come at a time when the sector is undergoing substantial change.

Recently, the Second New Zealand Mental Health and Addiction Plan (Ministry of Health, 2005a) set out priorities to be achieved collectively by services within the mental health sector and outlined further strategic direction for primary mental health care. The report emphasised the importance of strengthening the capability of the primary health care sector to promote mental health and wellbeing and to respond to the needs of people with mental illness and addiction (Ministry of Health, 2005a). The main priority areas for primary health care included:

- To build the capacity of primary health care practitioners to assess and provide care for people with mental health and addiction needs in primary health care settings;
- To build linkages between PHOs and other providers of mental health and addiction services; and
- To strengthen the role of PHOs in communities to promote well being and prevent mental ill health (Ministry of Health, 2005a, p14).

In summary, New Zealand health policy, over the past five years, has developed around the concept of population based health with an emphasis on service provision in primary health care. While there remains a substantial role for specialist mental health services for people with the most severe and complex mental health needs, new initiatives in primary health care provide challenges for the sector to extend its role in mental health, and to develop new models of service delivery. In the Northern region, there are currently 25 PHOs providing health care for enrolled populations of 1,443,856 (Northern District Health Board Support Agency, 2006). PHOs have developed mental health initiatives either through contracts with their respective DHBs, or through specific contracts with the Ministry of Health. Currently there is no overall picture available as to the extent of mental health provision in primary health care, or of the capacity of the primary health care workforce to engage in mental health care.

### 1.4 Structure of the Report

This chapter provides a contextual and political overview of the development of mental health service provision within the primary health care setting. Chapter two presents a literature review outlining the current national issues related to primary mental health care. The research methodology is described in chapter three and the results of the project are presented in chapter four. The report concludes with a discussion of the key issues that arose from the study and recommendations for the further development of mental health care within the primary health care context in the Northern region. Following the main body of the report, a glossary of abbreviations and specific terms, and appendices that provide a tabulated summary of the mental health initiatives and the interview schedules are also included.
2. Literature Review

International literature has recognised the key role that primary care services have in the provision of mental health services, particularly for those with mild to moderate mental illness (Rogers & Pilgrim, 2001; Tansella & Thornicroft, 1999). In addition to the assessment and treatment of those with mild to moderate mental illness, the Ministry of Health expects PHOs to work with specialist mental health services to address the physical health needs of people with severe mental illness and support their recovery (Ministry of Health, 2005a). This chapter reviews research focused on the provision of mental health services in the primary care setting. Current workforce issues are also identified.

Literature Search Process

The articles reviewed for this chapter were accessed through computer searches of a number of medical databases located from the University of Auckland Philson Library. Articles were obtained through searches of Web of Science, Medline and CINAHL databases. Key words such as ‘primary health’; ‘workforce’; ‘mental health/illness’; ‘general practitioners’; ‘community’ were used in these searches. The background information for this project was accessed through on-line searches using the Internet search engine ‘Google’ (www.google.co.nz) and manually on PHO and other websites including the Ministry of Health (www.moh.govt.nz), Mental Health Commission (www.mhc.govt.nz), District Health Boards (www.adhb.govt.nz; www.waitematadhb.govt.nz; www.cmdhb.org.nz; www.nhl.co.nz); and World Health Organisation (www.who.int/mental_health). Material accessed through searches of these websites also informed the results section of this report.

2.1 Prevalence of Mental Illness in the Primary Health Care Setting

The MaGPIe research group conducted a study that identified the nature and prevalence of common mental disorders in the primary setting. Seventy GPs were randomly selected from across the North Island. Fifty adult patients were recruited from the practices of each GP participating in the study. The results indicated that one third of people attending their GP in the last twelve months had a diagnosable mental disorder, with the most common disorders including anxiety disorder, depression, and substance use disorders. Co-morbid disorders were found in half of those with diagnosable mental disorders (MaGPIe Research Group, 2003, p12).

Māori are over-represented in crisis, acute and forensic mental health services (Durie, 1999). Te Rau Matatini has reported that there is a lack of appropriate services for Māori and that interventions for Māori are often too late. Additionally, Māori have a younger profile that non-Māori although services are often accessed at a much later stage in their illness when they are more likely to be seriously ill (Holdaway, 2005). The combination of delayed access to treatment and the trauma associated with serious mental illness equates to poor health outcomes for Māori. Within the primary setting, the MaGPIe research group have reported that rates of mental disorder among Māori who attended their GP to be higher than amongst non-Māori. The study suggested that Māori women who attended their GP were more likely than non-Māori to have been diagnosed with a mental disorder. Particular disorders, including anxiety, depressive and substance use disorders, were reported to be higher for Māori that non-Māori (MaGPIe Research Group, 2005b).

There is limited information on the prevalence of mental illness amongst Pacific peoples within the primary health setting. General mental health statistics have revealed that, like the general population of New Zealand, 20-25% of Pacific peoples living in New Zealand will experience mental illness in their lifetime (Wells, Bushnell, & Hornblow, 1989). More recent
information has indicated that 19,000 Pacific people could expect to experience a mental illness over a six-month period (Ministry of Health, 2005b). The most common disorders that this population experience are mood disorders and generalised anxiety disorders that are likely to be more prevalent in women. The majority of New Zealand’s Pacific people reside in the northern region (Ministry of Health, 2005b).

Studies on New Zealand’s younger generation have indicated alarming rates of mental illness. The Youth 2000 survey provided a profile of the health and wellbeing of a random selection of nearly 10,000 New Zealand secondary school students. The results indicated that females were twice as likely as males (males 9%, females 18.3%) to report depressive symptoms at a level considered serious. Suicidal thoughts were common in adolescents, with 34% of 15 year old girls and 20% of males reporting thoughts of killing themselves in the last 12 months (Adolescent Health Research Group, 2003, p32). Symptoms of anxiety and severe behavioural problems were less commonly reported than depression in both female and males. Other commonly reported issues experienced by the sample included physical abuse, bullying, and unwanted sexual advances (Adolescent Health Research Group, 2003).

The proportion of older adults (65 and over) in New Zealand has been estimated to increase steadily. Projections indicate that by 2010 13% of the population will be in this category; by 2031 this will increase to 22% and by 2051 to 25% (Ministry of Health, 2002c). A minority of the older population have a psychiatric condition that they may have experienced for years or developed in their older age. The majority of mental health services for older people are provided by community geriatric psychiatry or mental health for older people teams (Ahuriri-Driscoll, Rasmussen, & Day, 2004). Ahuriri-Driscoll et al. (2004) report that few Māori and Pacific people access these services because of their small population size and high mortality rates at earlier ages.

2.2 Models of Primary Mental Health Care

The Blueprint (Mental Health Commission, 1998) introduced the ‘recovery approach’ to be used in all mental health services. The Health Workforce Advisory Committee defines ‘recovery’ as happening when “people can live well in the presence or absence of symptoms of mental illness” (Health Workforce Advisory Committee, 2002, p.110). For mental health workers, this involves working in partnership with clients to promote their full participation in society, protecting their rights, and helping to create supportive environments, as well as providing diagnosis and illness treatment services.

While the recovery model is applicable to all people with mental illness, the focus is somewhat different when working with children and young people and their families / whānau (Ministry of Health, 1998). In most cases, a family or whānau member will seek help for their child from primary mental health professionals. People working with children and young people should ensure that the ongoing effect of any mental health problems is minimised and provide services that reflect the physical, social, intellectual, educational, cultural, and emotional needs of the child (Ministry of Health, 1998).

2.2.1 Māori Mental Health

The Government is committed to fulfilling its obligations under the Treaty of Waitangi. Within the health sector Māori play an active role in the development and implementation of health strategies, service provision, and protection and improvement for Māori (Ministry of Health, 2002d). Thirty-eight per cent of Māori referrals to specialist mental health services come from law enforcement or welfare services (Ministry of Health, 2002d). Consequently, the Ministry of Health has argued that primary early intervention services need to be more
accessible and appropriate to the needs of Māori (Ministry of Health, 2002d). Further, Durie (1999) described strategic directions for the development of Māori mental health services, recommending that mental health services should be more closely aligned with primary health care.

The Whare Tapa Wha model incorporates the holistic approach that Māori have traditionally taken to health (Rochford, 2004). The model describes four elements of health that contribute to health and well being. They include: te taha wairua (spiritual aspects); te taha hinengaro (mental and emotional aspects); te taha whanau (family and community aspects; and te taha tinana (physical aspects). Primary health providers should recognise Māori models of practice, and approaches to addressing illness should consider the complex interrelations between social, economic, political, cultural, historical and spiritual factors (Ministry of Health, 2003, p8).

2.2.2 Pacific Mental Health

The Mental Health Commission has reported that mainstream mental health services fall short of providing culturally appropriate and sensitive care to Pacific people. In particular, there is a significant lack of training available for non-Pacific staff to improve their responsiveness to Pacific service users (Mental Health Commission, 2001). Additionally poor regional planning, co-ordination and collaboration have constrained the development of service delivery to Pacific communities (Ministry of Health, 2005b). Research has suggested that Pacific people are more likely to utilise GP services than specialist mental health services. The development and maintenance of links between PHOs, general Pacific health services and the mental health sector is a priority area for the health sector (Ministry of Health, 1999, 2005b).

The Ministry of Health also encourages mental health services to incorporate the ‘Fonofale’ model of health (Ministry of Health, 1995). The Fonofale model incorporates three aspects most important for Pacific peoples: family, culture and spirituality. The concept of the Samoan fale or house incorporates these aspects and the components essential to the health of Pacific peoples. The model incorporates the metaphor of a house, with the roof (cultural values) and foundations (family). The pou, four posts which extend between the roof and foundations, represent spiritual, physical, mental and other dimensions that connect culture and family (Mental Health Commission, 2001).

2.3 Current Workforce Issues for Primary Mental Health

The Ministry of Health report Primary Mental Health: A Review of Opportunities (Ministry of Health, 2002b) identified barriers to effective primary mental health services in New Zealand. The report indicated that mental health care requires a different approach to delivering primary health care with, for example, more time needed for consultation, time-consuming interventions and multi-disciplinary teamwork. However, the current ‘fee-for-service’ funding scheme in New Zealand means that service users pay part of the fee for their consultation and GPs claim for government funding for each individual they see. This funding mechanism is a disincentive to longer consultations. In addition, funding for practice nurses creates limited incentives for the practice nurse to develop the role of autonomous case manager. Consequently, mental health services in primary care have focused on GPs, with only minimal utilisation of nurses and other health professions (Ministry of Health, 2002b). Research has confirmed this, indicating that GPs provide treatment for three quarters of people who have been diagnosed with a mental disorder in New Zealand (Dew, Dowell, McLeod, Collings, & Bushnell, 2005). There is scope for the development of new roles in
primary health care, including roles for mental health nurses and mental health nurse practitioners (Ministry of Health, 2002b; O’Brien, Hughes, & Kidd, 2006).

The MaGPIe research group has reported on the recognition and subsequent management of common mental disorders in general practice attendees. The results indicated that GPs perceived structural aspects of their practice, such as the short length of consultation, as major barriers to the identification of patients with mental health problems. The GPs suggested that more consultation time would facilitate high quality outcomes (MaGPIe Research Group, 2005a). The interface between primary care and specialist mental health services was criticised by the GPs in the MaGPIE study who reported a lack of confidence and difficulties in accessing specialist services for their patients with non-acute conditions. The study also recommended additional training for GPs in appropriate interviewing techniques for assessing patients (MaGPIe Research Group, 2005a).

2.4 Primary Mental Health Initiatives and Workforce Development

The Ministry of Health developed the ‘Primary Mental Health Initiatives and Innovations Programmes’ for PHOs to support the implementation of the Primary Health Care Strategy. PHOs are expected to provide assessment and treatment for people with mild to moderate mental illness and to work collaboratively with specialist mental health services to address the physical needs and recovery process of people with severe mental illness (Ministry of Health, 2005a).

The Government is committed to enhancing mental health funding in the Northern Region. The Northern Regional Mental Health and Addictions Plan outlined priority areas and proposed allocations of funding for primary health care (Northern Regional Mental Health Funding Team and the Northern Regional Mental Health Network, 2003). The plan emphasised the importance of the continued development of Māori and Pacific mental health services as priority areas for the northern region. Holistic models of primary health care were outlined as essential. Other specific population areas of importance for the strategic direction of primary mental health care were that of child and youth, adult, and older peoples’ mental health.

The Ministry of Health funds primary mental health initiatives, which are managed through the DHBs, with the aims of decreasing the prevalence of mental health problems through education, prevention, early intervention and treatment; improving the primary care workforce’s skill mix and ability to respond and manage mental health problems in primary health care settings; and building linkages between primary and secondary mental health care. Currently, throughout the country there is a range of different types of initiatives that address these core issues. These include GP liaison programmes, mobile mental health teams; primary mental health clinical coordinators; chronic care management programmes; medication management programmes; specialist mental health workers; and brief intervention services (Ministry of Health, 2005c; Nelson, Fowler, Cumming, Peterson, & Phillips, 2003). The results chapter of this project will consider some of these initiatives. An evaluation will be conducted by the Ministry of Health in 2006.

2.5 Conclusion

The chapter considered the current literature focused on primary mental health care provision in New Zealand. It reviewed research on the prevalence of mental illness in primary care, models of service provision for primary mental health care and current workforce issues. This literature review provides the background for the development of the methodological
approach described in chapter three. The ways in which PHOs are addressing the key issues will be discussed in the results section of this report.
3. Methodology

The aims of this project were to provide a stocktake of current and planned primary mental health service provision, the mental health capacity of the primary health care workforce, and workforce development needs within the northern region. The project was overseen by the Network North’s primary mental health workstream representing PHOs, DHBs, Maori, Pacific and service users.

3.1 Study Design

The project comprised four main phases: Literature review; development of research tools; data collection and analysis; and development of the report.

3.1.1 Phase One. Literature Review

Literature and policy were reviewed to provide the background to the study and to inform the development of the structured template for the interviews. The search process is discussed in the literature review section of this report.

3.1.2 Phase Two. Development of Research tools

Two structured templates for interviews with PHO and DHB participants were developed in consultation with the primary work stream group and an advisory group developed by the research team (see Appendix One). The advisory group was comprised of DHB, PHO, Maori, and Pacific representatives. The two templates focused on generating data on current and planned mental health initiatives, a workforce profile and the workforce development needs of each PHO in the Northern region.

3.1.3 Phase Three: Data Collection and Analysis

Structured interviews were undertaken with representatives of 22 of the 25 PHOs operating across the four northern region DHBs. Interviews also took place with mental health service managers and/or mental health funding and planning managers in the four DHBs. Interviews were conducted face to face or by telephone. Data collection took place between January and March of 2006.

3.1.4 Phase Four: Final Report

The findings from the previous phases were collated and summarised in a report submitted to the NDSA for consultation.
3.2 Data Collection Methods

The research team used two structured templates to guide their interviews with PHO and DHB representatives. The PHO template required participants to answer a series of questions related to mental health workforce capacity; the characteristics of the PHOs, current and planned mental health initiatives; the profile of workforce development in each PHO for those staff engaged in primary mental health care; and critical issues in relation to providing training and support for primary mental health staff. In contrast, the DHB template attended to current and planned initiatives that involved the DHBs. These initiatives could include mental health programmes provided by organisations other than PHOs, such as primary health care providers, NGOs and community mental health teams. There was space provided in both templates for comments on each of the questions. The interviews with PHO and DHB participants were between 30 and 60 minutes long. Notes taken from the interviews were returned to participants for review. After writing up the results of the study, individual sections on each PHO and DHB were returned to those organisations and confirmed as accurate.

3.3 Data Analysis

The data were collated and summarised separately for each of the four Northern region DHBs. Major findings are presented in the results section of this report. Descriptive data related to initiatives and workforce development are presented in tabular format and accompanied by qualitative comments consolidated into narrative form. The qualitative information supplemented the descriptive data and helped to qualify the participants’ responses.

3.4 Limitations of the Research

Three PHOs did not agree to participate in the study. The research team contacted all PHOs and completed interviews with all those willing to take part. The most common reason given for non-participation was that the PHO was not currently involved in any mental health programmes. The study was also limited by some of the PHO representatives stating that they were not aware of all services provided by the practices within their PHO. Further, particular data on the PHOs’ workforce was not readily available and/or unquantifiable.

3.5 Ethics Approval

The proposal was submitted to The University of Auckland Human Participants Ethics Committee and consent was granted prior to the commencement of data collection.
4. Results

This chapter presents the data generated from the interviews with representatives from the PHOs and DHBs in the Northern Region. The stocktake of current and planned initiatives and the mental health workforce profiles and training needs of each PHO are described. The data is categorised under the four District Health Board regions of Northland, Waitemata, Auckland and Counties Manukau. Appendix Two summarises this information in tabular format.

4.1 Northland Region

Within the Northland region there is a strong relationship between poor mental health and factors such as low income, poor housing, low educational achievement, unemployment and cultural alienation. Many people with high health needs do not access the types of services they require, due to financial, geographical or cultural barriers. This is particularly evident amongst Maori and Pacific peoples. The Northland Primary Health Organisations play an important role in reducing health inequalities (Northern Regional Medical Health Funding Team and the Northern Regional Mental Health Network, 2003). Table one outlines general information on each of the PHOs in the Northland region.

Table One: Northland PHOs

<table>
<thead>
<tr>
<th>PHO</th>
<th>Date Established</th>
<th>Funding</th>
<th>Enrolled Population</th>
<th>Enrolled Practices</th>
<th>High Need Population</th>
<th>Maori Population</th>
<th>Pacific Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hokianga Health</td>
<td>1/07/04</td>
<td>Access</td>
<td>6,360</td>
<td>1</td>
<td>6,290</td>
<td>4,601</td>
<td>42</td>
</tr>
<tr>
<td>Kaipara Care</td>
<td>1/04/03</td>
<td>Access</td>
<td>11,903</td>
<td>1</td>
<td>4,465</td>
<td>2,657</td>
<td>210</td>
</tr>
<tr>
<td>Manaia Health</td>
<td>1/07/03</td>
<td>Access</td>
<td>77,078</td>
<td>32</td>
<td>32,821</td>
<td>17,486</td>
<td>704</td>
</tr>
<tr>
<td>Te Tai Tokerau</td>
<td>1/04/03</td>
<td>Access</td>
<td>42,814</td>
<td>14</td>
<td>20,464</td>
<td>15,258</td>
<td>391</td>
</tr>
<tr>
<td>Tihewa Mauriora</td>
<td>1/04/03</td>
<td>Access</td>
<td>8,677</td>
<td>1</td>
<td>7,771</td>
<td>5,807</td>
<td>203</td>
</tr>
<tr>
<td>Whangaroa PHO</td>
<td>1/07/04</td>
<td>Access</td>
<td>3,064</td>
<td>1</td>
<td>2,332</td>
<td>1,701</td>
<td>17</td>
</tr>
</tbody>
</table>

Source: (Northern District Health Board Support Agency, 2006)

The establishment of PHOs in Northland led to the formation of Northland PHOs Limited (NPHOs Ltd). The six PHOs have combined resources in several service provision areas and demonstrate a coordinated and supportive approach to primary health services. Additionally, the NPHOs are supported by the Northern Rural Consortium, established in February 1998 and funded by the Ministry of Health, to provide continuing medical education and encourage workforce development for the PHOs and their providers. The NPHOs developed the Te Pou Ora o te Piringatahi: Northern Regional Strategy to improve mental health service provision in the primary care setting. This strategy introduced several initiatives that aimed to:

1. Improve the identification, treatment and support for people with mental health and addiction issues in the primary care setting;

2. Provide better follow up and coordination of care to people with mental health and addiction issues in Northland; and,
3. Promote better understanding and prevention of mental health addiction issues in Northland.

In 2005, the NPHOs successfully secured pilot contracts with the Ministry of Health to fund the provision of an integrated regional model for Northland, comprised of specific approaches identified by each PHO as pertinent to their populations’ needs. The integrated model consists of:

1. The development of a new practitioner role;
2. Ensuring a well prepared primary health care workforce;
3. The development of a tailored information technology package;
4. Subsidised counselling;
5. Therapeutic recreation; and,
6. Relapse prevention.

The initiatives are currently being implemented at the PHO level in ways that reflect their respective populations. Client data and service information is monitored through each PHO’s Patient Management System and Northland PHO Management System. The Ministry of Health will also evaluate this initiative in 2006/07. The Ministry of Health funded initiatives and other programmes are discussed below under each PHO.

4.1.1 Whangaroa PHO

Ministry of Health Funded Initiative

Whangaroa has subcontracted this initiative to Te Runanga O Whaingaroa who employs a 0.5 FTE primary mental health coordinator to provide case management and follow-up care for clients with mild to moderate mental illness. The coordinator is employed 0.5 FTE in the same role within the Te Tai Tokerau PHO and is involved in primary mental health initiatives under that PHO. These initiatives are discussed in 4.1.3.

Planned Adolescent Health Services Initiative

As part of the role, the primary mental health coordinator plans to work with young persons at the local college. In 2006, Whangaroa has planned for the mental health coordinator to attend the college’s clinic once a week and develop a service plan with stakeholders from the local college and health services (Whangaroa Health Services Trust, 2004). A referral process for this initiative is in place, and the mental health coordinator is working with the college to increase access to this service.

Workforce Profile

The primary mental health coordinator is employed by Te Runanga O Whaingaroa who is sub-contracted by Whangaroa PHO to deliver the mental health initiative in the PHO service area. The coordinator is the only staff member of the PHO with allocated time for mental health. The coordinator is a qualified mental health nurse and has received support for workforce development through a programme coordinated by the six Northland PHOs and funded from the MOH mental health initiative. This programme has funded course fees, clinical supervision and time off normal duties to attend professional development activities.
Training Needs

Further workforce development needs identified by the PHO include training in alcohol and other drugs and post natal depression. Issues related to gambling, domestic violence and sexual abuse were also recognised as crucial areas for future workforce development.

4.1.2 Hauora Hokianga Integrated PHO

Ministry of Health Funded Initiative

Hauora Hokianga has two strands to their Ministry of Health funded primary mental initiative. They have employed a primary mental health coordinator and a Recreational Therapist commenced work in January 2006. These initiatives are described below.

1. Primary mental health care coordinator: The objectives of this role are to provide screening; brief intervention; advice to clients, whanau, community and primary care practitioners; treatment options; relapse prevention; health promotion; access to culturally appropriate services; liaison with other services; and client follow-up. Part of the position involves engagement in professional development and peer group meetings with other primary mental health care coordinators in Northland.

2. The Recreational Therapist works with individuals by providing treatment, education and recreation services to develop and use creativity, leisure, and recreation in ways that enhance health, functional ability, independence and quality of life. In particular the therapies under this programme are designed to improve mental wellbeing of patients referred by the Mental Health Coordinator, who are suffering from mild to moderate mental illness related to depression and anxiety.

Community Mental Health Services

The PHO provides community mental health services that are facilitated through a mobile mental health team. Funded directly by NDHB, the team is led by the Clinical Operations Manager and staffed by community mental health nurses and two community support workers. Other medical and nursing staff support the mental health team. The team cares for clients with acute and chronic mental illness. This service is supported by a psychotherapist employed on a part time basis by Hauora Hokianga. The service provides some respite care support in its hospital facility and manages ‘packages of care’ for its clients. NDHB provides support through a psychiatrist based in Kaikohe and a visiting alcohol and drug counsellor equivalent to one day per week. Additionally, Northland DHB provides an out of hours DAO cover, supported by the PHO staff.

Community Developmental Team

This team is comprised of community development staff, GPs and other primary health care staff and is focused on public health. The team develops and maintains health education and promotion programmes. As Māori predominately have a poorer health status when compared to non-Māori, many of the activities of the Community Development Team have an emphasis on encouraging Māori to make changes in their lives to improve their health. In relation to mental health, the team works with local schools and primary health care nurses to develop strategies and health promotion activities focused on alcohol and other drug use and healthy lifestyles for young people to prevent mild to moderate mental illness (Hokianga Health Enterprise Trust, 2005). Additionally, the Community Development Team works to support marae and hapu development through facilitating the installation, improvements, and
maintenance of community and marae water and waste water management facilities. These projects are developed using Community Action models. The Community Development Team also engages Maori communities in road safety, by providing driver license education at Marae and through other initiatives.

**Workforce Profile**

The PHO has 1 FTE primary mental health coordinator and 1 FTE primary mental health recreational therapist funded through the Ministry of Health initiative. The community mental health team is comprised of two community mental health nurses and two community support workers. The NDHB provides psychiatric support in Kaikohe and an alcohol and drug counsellor 0.2 FTE. This service is accompanied by a psychotherapist contracted by Hauora Hokianga. The Community Development Team is comprised of 3 FTE community development staff, GPs and other primary health care staff. The proportion of time spent on mental health is not able to be accurately determined as it is integrated into a range of wider health initiatives.

Hauora Hokianga staff have received education and training in mental health care as part of their employment. Hokianga Health Trust provides in-service programmes with a varied programme of training in clinical skills, professional development and self development. Some mental health clinical training topics included health through physical activity, grief and family violence. This training is evaluated by attendees and reported to the executive in order to identify the most effective approach. One community health nurse was supported by the PHO to complete a post-graduate certificate in primary health care (nursing) and another nurse has begun post graduate study in mental health.

**Training Needs**

Training needs identified by Hauora Hokianga related to developing general staff’s confidence when dealing with mental health issues. Hauora Hokianga have found it difficult to provide time off for study leave and to finance backfill for the replacement of staff. Most staff want to be involved in workforce development and training programmes and Hauora Hokianga have found no difficulties in accessing training.

**4.1.3 Te Tai Tokerau**

**Ministry of Health Funded Initiative**

Te Tai Tokerau PHO has two parts to their Ministry of Health funded initiative:

1. Two FTE staff are employed as Primary Mental Health Coordinators, one FTE position is in the Bay of Islands, and the far North role is comprised of two registered nurses each working 0.5 FTE. One of these nurses is also employed in a joint venture with Whangaroa PHO. The purpose of the role is to provide a primary point of contact in the community for clients with early signs of mental illness and/or addiction. The role involves assessment, early detection and liaison with other service providers. The coordinators assist primary health practitioners with referral and follow-up, development of treatment plans; and liaison with specialist services. They also provide support and training opportunities for PHO staff and clients, whanau, hapu and iwi. Health promotion is provided by the coordinators through radio and public symposia that explain the services provided.
2. Relapse Prevention: The primary mental health coordinators provide additional support to 40 people who have been transferred back to primary care from secondary services. Within this service, extra funding is provided to the GPs to provide additional time to see their clients ($400 per person). The physical health needs of people with severe mental health needs are met through this programme.

Adolescent Health Service

This initiative is a SIA funded project that began in the two sites of Taipa (June 2005) and Kaitaia (October 2005) (Te Tai Tokerau PHO, 2005). The programme aims to integrate services by working with existing providers of clinical and social services for adolescents. The programme is supported by the general manager, and PHO nursing integration leader, and resources time of a clinical nurse coordinator, administrative assistant and medical practitioner who work with staff from a range of organisations providing drug and alcohol, sexual health and other services. The objective of the programme is to provide accessible integrated youth focused services that target priority health issues impacting on the health of young people. The two sites are currently operational and provide sexual health, public health, physiotherapy, counselling and social services. Development continues with the targeting of mental health issues and nutritional issues. Limited clinics are offered during school holidays. The vision is to develop comprehensive services that link health promotion with social services.

The programme holds regular case management meetings and aims to have adolescent health providers working in a collaborative way. Aggregate data on demographics, categories of problems, referrals made, and clinical outcomes are continually compiled.

Workforce Profile

The general manager, nursing integration leader, and administrative assistant are employed directly by the PHO. The three registered mental health nurses who fulfil the 2 FTE primary mental health coordinator roles, the clinical nurse coordinator, and medical practitioner involved in the adolescent health service are subcontracted through Maori provider organisations.

One primary mental health coordinator has been supported by Te Tai Tokerau to complete a Masters degree. The PHO covers the course fees and funds travel and other costs.

All Primary Mental Health coordinators regularly attend in-service training on relevant topics, including alcohol and drug issues. The PHO has developed a workforce development strategy to facilitate and support rural workforce retention. This includes funding clinical staff from the providers to attend continuing medical and nursing education relevant to the PHO strategic direction.

Training Needs

The primary mental health coordinators stated that there is a general need for education across all primary providers focused on the identification of mental health issues. It was stated that there is a significant lack of referrals from some providers whilst a substantial number from others.
4.1.4 Manaia Health

Ministry of Health Funded Initiative

Manaia PHO have five branches that comprise their Ministry of Health funded initiative. These can be described as follows:

1. Two FTE primary mental health coordinators: Coordinate the care of people with mild to moderate mental health conditions, e.g. depression or anxiety. This includes assessment and referral to subsidised counselling and/or other services.

2. Subsidised counselling sessions: Counselling is available through referrals from the primary mental health coordinators. This service provides 250 subsidised counselling sessions for a range of individuals who are not currently eligible for support in this area, including persons over 17 years, those with no sexual abuse histories, and people with no referral from the Family Court or Child, Youth and Family.

3. Relapse prevention programme: A mental health nurse from Northland Health Mental Health and Addiction Services is employed 0.5 FTE by the PHO as a primary mental health coordinator to ensure the appropriate transfer of care from secondary services to primary care. This programme is designed to provide care for 100 consumers with a diagnosis of an Axis 1 mental health disorder who have been discharged from secondary services, or are preparing for discharge. It will ensure access to free and holistic care provided by general practice teams with the support of Northland Health Mental Health and Addiction Services. The aim of the service is to prevent consumers needing to be re-admitted to secondary care services.

4. IT component: The developing IT component enables the primary mental health care coordinators to communicate more effectively with General Practitioners - for example, GPs now receive letters and can access assessments completed by the mental health care-coordinator through their practice management system.

5. Workforce development: A training needs analysis was completed and the PHO in collaboration with the Rural Consortium is currently developing an education programme for the next 18 months.

Minimal Methadone Programme

This SIA funded programme aims to enable and support GPs to prescribe a minimal amount of methadone within a structured regime to clients residing within the Manaia PHO region who are on the waiting list for the methadone maintenance treatment programme.

Workforce Profile

The PHO employs three staff members who have a specific mental health focus. This includes two FTE primary mental health coordinators and one relapse prevention coordinator who also works for Northland Health Mental Health and Addiction Services. All three staff members are Registered Nurses and two have post graduate certificates specialising in mental health.

Clinical staff who are involved in subsidised counselling sessions and the methadone programme are not employed by the PHO.

Continuing medical and nursing education is provided by the rural consortium as part of the Ministry of Health primary mental health initiatives. The PHO also have additional training planned that will be provided by the mental health nurses.
The PHO has employed a quality and professional development co-ordinator, part of whose roles is to co-ordinate mental health workforce development. CME sessions are planned with a mental health focus and a modular programme is being developed for practice nurses.

Training Needs

A training needs analysis identified that GPs, primary care nurses, allied health professionals, and Māori health professionals require training in the areas of destigmatisation, coping with challenging behaviour, depression and suicide prevention. However, it was argued that many providers do not have the time and energy to be involved in mental health training.

4.1.5 Kaipara Care

Ministry of Health Funded Initiative

Kaipara Care have three aspects to their mental health initiative, these are as follows:

1. One 0.5 FTE primary mental health coordinator: The coordinator is based in a Maori health service and the role involves providing assessment and follow-up for a small case load of clients. The service aims to ensure correct referrals to counselling and other mental health services are made.

2. Subsidised counselling sessions: Subsidised counselling is available through referrals from the primary mental health coordinator for clients enrolled in the PHO.

3. IT component. Kaipara is developing a website and database to store data on all the mental health coordinators in the NPHOs Region.

Workforce Profile

Kaipara Care PHO employs a 0.5 FTE mental health nurse in the coordinator position. There are no other staff members who have specific allocated time for mental health service provision.

Various continuing medical and nursing training is provided by the rural consortium and Manaia PHO for primary health providers.

Training Needs

Areas for further training suggested were substance abuse and sexual abuse. Providers also need help with managing Medtech and initial assessments. Kaipara Care PHO would also like to have more input into the content of programmes that the Rural Consortium currently facilitate.

4.1.6 Tihewa Mauriora

Ministry of Health Funded Initiatives

Tihewa Mauriora has implemented the Ministry of Health initiative at a local level to meet the needs of the Kaikohe community. They have employed a mental health care coordinator who
works alongside Broadway Health Centre, Te Hau Ora O Kaikohe and the local NGO Northpoint Trust. The different aspects of this role are as follows:

1. Referral and Liaison: The coordinator takes referrals from both health centres and acts as a liaison between the two services. The physical health needs of people in secondary mental health services are also assessed by the care coordinator and liaison with Alcohol and Drug Services also takes place.

2. Workforce Development: Another role of the coordinator is to educate and provide support to practice nurses to improve detection of mental health issues with clients suffering from chronic disease.

3. Health promotion: The coordinator works with Northpoint Trust on a healthy lifestyles programme. The aim is to destigmatise mental illness by bringing the community together with people suffering from mental illness through the provision of exercise classes at Northpoint Trust. The PHO have planned to introduce aqua aerobics in the future to encourage this process further.

Traditional Maori Healing

The PHO works alongside local groups to support traditional Maori health and health promotion. This allows the PHO to gain access to a population that may otherwise have fallen through the gaps. It provides an opportunity to raise awareness of mainstream treatment and breaks down barriers between the PHO and this population group. Concurrently, the liaison increases the awareness of PHO and their enrolled population of traditional Maori health (Tihewa Mauriora Charitable Trust, 2004).

Workforce Profile

The PHO employs 1 FTE mental health nurse in the mental health care coordinator position. The care coordinator has a Bachelor of Arts (Social Science) and a Masters of Health Sciences with a focus on mental health.

All clinical staff enrolled with the PHO attend continuing medical and nursing training sessions with the Rural Consortium. The PHO has also planned in-house training for PHO staff with a psychiatrist on the management of depression in postnatal or pregnant woman. Methods of responding to people with stress will also be covered in these sessions.

Training Needs

The knowledge areas that Tihewa Mauriora would like to develop include suicide prevention, lifestyle changes, brief intervention and smoking cessation, cognitive behavioural therapy and responding to challenging behaviour. DHB in-house training is offered to PHO staff however, it is not tailored to fit primary care workers and the different environments in which they work. The cost of providing study leave, replacement of staff and trainers is a major barrier to the implementation of training programmes.

4.2 Waitemata Region

The Waitemata region has a mix of urban and semi-rural areas that is socio-economically diverse. In the past, integration occurred between primary health care services, secondary care services and NGOs in the Waitemata region through isolated integration projects.
Consequently, the DHB is encouraging PHOs to take a more coordinated approach to the key service areas of older people, children’s health, Maori community health, community mental health and youth health services. Table two outlines the general information on each of the PHOs in the Waitemata region.

### Table Two: Waitemata PHOs

<table>
<thead>
<tr>
<th>PHO</th>
<th>Date Established</th>
<th>Funding</th>
<th>Enrolled Population</th>
<th>Enrolled Practices</th>
<th>High Need Population</th>
<th>Maori Population</th>
<th>Pacific Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coast to Coast</td>
<td>1/10/03</td>
<td>Mixed</td>
<td>12,300</td>
<td>2</td>
<td>2,412</td>
<td>1,874</td>
<td>106</td>
</tr>
<tr>
<td>Harbour PHO</td>
<td>1/07/05</td>
<td>Interim</td>
<td>147,538</td>
<td>41</td>
<td>7,691</td>
<td>4,004</td>
<td>2,088</td>
</tr>
<tr>
<td>HealthWEST PHO</td>
<td>1/01/03</td>
<td>Mixed</td>
<td>137,337</td>
<td>31</td>
<td>42,063</td>
<td>11,872</td>
<td>18,410</td>
</tr>
<tr>
<td>Procare North</td>
<td>1/01/04</td>
<td>Interim</td>
<td>90,913</td>
<td>24</td>
<td>6,481</td>
<td>3,779</td>
<td>1,022</td>
</tr>
<tr>
<td>Te Puna PHO</td>
<td>1/07/05</td>
<td>Access</td>
<td>9,695</td>
<td>1</td>
<td>3,804</td>
<td>2,612</td>
<td>965</td>
</tr>
<tr>
<td>Waiora Healthcare</td>
<td>1/04/03</td>
<td>Access</td>
<td>17,898</td>
<td>3</td>
<td>10,645</td>
<td>5,811</td>
<td>2,840</td>
</tr>
</tbody>
</table>

Source: (Northern District Health Board Support Agency, 2006).

**Planned Ministry of Health Regional Initiative**

All six PHOs in the Waitemata region are developing a care package called ‘Primary Options’ for clients with mild to moderate mental illness. ProCare Network North has been nominated to lead this project and the PHOs are currently working on service specifications.

Primary Options for mental health will consist of a small amount of funding that is given to general practices in order to provide access to mental health support services for their clients with mild to moderate mental illness. Each PHO will be given an allocated number of providers to fund and will make the package available to each of these providers. For example, the programme will fund short-term interventions, counselling and extended consultations. The project will also have a workforce development component.

**4.2.1 HealthWEST**

**West Auckland Primary Partnerships**

‘Primary Partnerships’ is a joint collaboration between HealthWEST PHO and Waitemata DHB Mental Health Services. The target population for this project is people who experience severe and enduring mental illness. Participants in the programme are those currently supported by West Auckland Adult Community Mental Health Services but who could have their long term needs met by a general practice team. This service was initially funded from IPA reserves that were transferred to HealthWEST when it was established as a PHO (HealthWEST Primary Health Organisation, 2004). Waitemata DHB has contributed funding towards project management and support. This initiative has not been evaluated and is still in a piloting stage.

The aim of the project is to improve, through increased access to primary care, the physical health of clients who experience severe and enduring mental illness. The initiative involves GPs, a continuing care team, a project manager, and pharmacist. The service includes free visits for clients with GPs, re-links clients in secondary care with appropriate GPs, facilitates
initial physical assessments with GPs to establish relationships between clients and practices. The pharmacists dispense and monitor medication.

School Based Youth Clinics

HealthWEST has developed a service to increase youths’ access to primary care by providing GP clinics in five low decile West Auckland schools. The programme facilitates personal health and health promotion programmes and will make referrals to mental health services if needed. This is an SIA funded project that involves public health nurses, school nurses, counsellors and a social worker. There are six GPs that deliver the services and they participate in regular peer review and undertake education in youth health. Client data is collected and entered in a Practice Management System. HealthWEST has planned to analyse this data to monitor the services youth are accessing.

Workforce Profile

HealthWEST has one 0.5FTE mental health project manager employed for the Primary Partnership project. All other staff members involved in this project and the school based youth clinics are not directly employed by the PHO and do not have specific time allocated to mental health.

The PHO financially supports their staff to attend training and workforce development programmes. However, HealthWEST often finds it difficult to replace staff while they attend education programmes. The providers enrolled with the PHO attend continuing nursing and medical education together and within their own cell groups. Mental health is included in the yearly calendar covered in these training sessions.

Training Needs

HealthWEST stated that their staff would benefit from additional training for the new services being introduced into the primary care context. Also, the front desk staff located at the primary provider enrolled in the PHO would benefit from training in communication skills.

4.2.2 Harbour PHO

Apart from the proposed Ministry of Health funded ‘Primary Mental Health Options’ pilot programme planned by Waitemata DHB, Harbour PHO is not involved in providing specific support to practices for mental health clients. Consequently, the PHO has no staff members employed specifically to focus on mental health. Areas of increasing prevalence of mental health problems include co-morbidity associated with ageing and chronic illness and alcohol and drug addictions. The PHO noted a lack of time for mental health consultations as primary health care is increasingly based on 15 minute consultations. In addition, it is difficult to access non-medication therapies such as CBT.

As part of its provision of continuing medical education, the PHO conducts training sessions for GPs, covering diagnosis of depression. In common with most primary health care services in New Zealand, diagnosis and management of mental health conditions is considered to be variable across practices and practitioners within the PHO.

The PHO described several training needs relating to mental health. There include several areas of high or increasing prevalence, including alcohol and addiction, depression, anxiety and physical health needs of those with severe mental illness. The planned Ministry of Health
initiative will include educational packages for GPs and the PHO will support their staff to develop their skills in the mental health area.

4.2.3 Te Puna PHO

Iwi Support Programme

From 2005, Te Puna PHO has developed a Ministry of Health funded initiative that aims to provide iwi support for secondary mental health clients. The objective is to support clients from Devonport to Wellsford to live in the community. This project involves 4.5 FTE community support workers who are employed by Tepuna Hauora, the provider arm of the PHO. This project has been audited and found successful in achieving contractual agreements.

All community workers have a Certificate in Support Work from the Auckland University of Technology. One support worker is completing a Diploma in Social Work at the University of Waikato. All staff at Te Puna PHO have also participated in Blueprint Training.

Children, Young Persons and Families Initiative

Te Puna in collaboration with Children, Young Persons and their Families Services (CYPFS) provide services for Māori and Asian populations of low socio-economic status. This initiative is partly funded by SIA funding. Two FTE social workers, one Asian and one Maori provide this service. The two social workers practice collaboratively with three public health nurses and four community support workers working with families in their homes. The public health nurses and community support workers are employed by Te Puna Hauora. Part of their service is mental health related as they often work with clients in domestic violence situations and those presenting with depression and anxiety.

Workforce Profile

The 4.5 FTE support workers are the only staff the PHO have employed specifically for mental health related service provision. The social workers involved in the CYPFS project have some allocated time to mental health related care but this time is unquantifiable.

Training Needs

Te Puna PHO was relatively happy with the current training programmes provided by Blueprint Training. However, it was mentioned that while it is greatly appreciated that the Maori Provider Development Scheme allows practitioners to attend these courses, secondary as well as primary care services are now eligible for this funding. This has meant that the agenda of these programmes is somewhat determined by the DHB rather than the PHO.

4.2.4 ProCare Network North

ProCare was developed in the mid-1990s as an Independent Practitioners Association (IPA) and aimed to encourage better communication between GPs and health authorities and to support GPs to work together in groups rather than individually. In 2001, the ProCare IPAs evolved into three PHOs – ProCare Network North, ProCare Network Auckland and ProCare Network Manukau.
Procare Psychological Services

Procare Health Limited operates a subsidiary company called ProCare Psychological Services (PPS). This service runs across all three ProCare PHOs and provides enrolled GPs with access to psychological interventions and behavioural health programmes for their patients. Twenty (10.7 FTE) registered clinical psychologists and psychiatrists facilitate this service and offer a variety of services to assist individuals, couples and families with psychological difficulties to improve the quality of their lives. Services include:

1. Emotional health services: The PPS team help clients with marital/family/personal/work relationship problems; emotional health problems (such as depression, anxiety etc); and alcohol or drug use problems in liaison with CADS and AA.

2. Wellness services: PPS staff help clients address problems resulting from unhealthy lifestyle habits. This includes programmes to help patients stop smoking, control weight, manage stress, and manage other health problems.

The PPS team also provide professional development programmes for GPs. The content of the education sessions relate to the screening, diagnosis, assessment, treatment and intervention needs for their patients with behavioural health problems. Initial patient outcome data indicates that PPS is achieving an 85% return to functionality after an average of 5-6 sessions with patients.

Community Health Services

In addition to the PPS staff, ProCare Community Health Services (CHS) help facilitate all programmes provided by ProCare. CHS aims to increase health access for all high needs patients with GPs contracted to all three ProCare PHOs.

The CHS consists of a Maori Programme Service Coordinator and CHS Coordinators. The Maori Programme service coordinator maintains relationships within the ProCare PHOs and with all Maori stakeholders including iwi, Maori PHOs, Maori NGOs and government organisations; ensures that tikanga Maori issues are addressed appropriately by health services through cultural training on how to work better with Maori patients; manages Maori health programmes; and develops and maintains a Maori Health Plan for each of the 3 ProCare PHOs.

CHS Coordinators (16 FTE) endeavour to contact hard-to-reach patients in their homes and local communities and coordinate services between patients and their GP, hospital clinics, allied health professionals and secondary care services. The coordinators ensure information is disseminated to patients, GPs and other stakeholders about a wide range of services, including those beyond healthcare such as WINZ, Immigration, budgetary services, IRD, and Housing NZ.

All the CHC coordinators assist patients to access PPS and help facilitate ProCare’s ‘Engage’ Project, Sickness and Invalid Benefit Initiative, Chronic Care Management, and ‘Back to Action’ pilot.

Health Promotion

ProCare publishes ‘Pulse’ which is a newsletter that is distributed to over 100 000 homes. The newsletter is published three times a year and contains a mental health section. ProCare also has a marketing team that provides advice on how to improve health promotion within
practices. Initial suggestions from the team have identified that GP education in mental health leads to better referrals and a health promotion focus.

‘Engage’ Project

ProCare’s ‘Engage’ project for mental health services is a SIA funded initiative for high needs groups within all three PHO populations. Individual practitioners enrolled in the programme provide subsidised extended consultations for their patients at the usual consultation fee and have funded access to PPS services and continuing education programmes for their doctors and nurses. Large one-off training sessions are provided for practitioners who enrol in this programme. ProCare Auckland has received funding to extend this initiative to other population groups, see 4.3.3 for a description of this project.

Post Natal Depression Screening Initiative

This initiative operates across all three ProCare PHOs and encourages GPs to incorporate the Edinburgh Postnatal Depression Scale as a screening tool into their immunisation programmes. This initiative aims to improve diagnosis and treatment of postnatal depression, improve maternal and infant health, and build on the existing teamwork between GPs and practice nurses. The initiative involves practice nurses giving new mothers a questionnaire to complete at two of their baby’s first three immunisation appointments. The questionnaire aims to identify if the mother is feeling depressed and if so, the practice nurse arranges an extended consultation with their GP. The GPs have access to funding to provide this consultation free and they can also fill out a claim form to get reimbursed $10 per screening. When a GP makes a diagnosis of postnatal depression they can access support from PPS and a range of treatment options can be provided. ProCare practices involved in this initiative undergo team education and large group continuing medical and nursing education.

Workforce Profile

ProCare employs 10 FTE psychologists who comprise the PPS and 16 FTE CHS coordinators. The proportion of time spent on mental health is unquantifiable. In addition, two FTE programme managers oversee PPS and other mental health related initiatives. ProCare has a workforce development plan and provides education and training in mental health for staff as part of their employment. All psychologists are New Zealand-registered clinical psychologists and have participated in post graduate education in mental health care. All PPS staff access ProCare funded training and have individual staff development plans.

In addition, all initiatives implemented by ProCare have a training component. GPs and practice nurses complete compulsory training before their practices can be enrolled in ProCare’s programmes. Further, they also identify their own learning needs through their individual continuing education cell groups. There is however, a considerable amount of funding needed to develop and deliver these education packages. It was indicated that further funding would benefit primary health care practitioners who are enrolled in ProCare’s initiatives.

Training Needs

Ongoing training in mental health, communication, and non-pharmacological treatment interventions, brief problem solving, motivational interviewing, supportive counselling and problem solving were identified as priorities for CHS coordinators. It was reported that PPS staff receive appropriate training in their ongoing staff development.
4.2.5 Waiora Healthcare Trust

Apart from the Ministry of Health ‘Primary Options’ planned initiative, Waiora Healthcare Trust do not have any specific programmes for mental health clients and therefore currently have no staff members employed specifically for mental health services.

PHO staff, GPs and practice nurses access training through HealthWEST’s continuing education cell groups. Mental health is included in the yearly calendar of issues covered in training programmes.

4.2.6 Coast to Coast PHO

Coast to Coast PHO declined to participate due to multiple commitments.
4.3 Auckland Region

The Auckland region is characterised by a diverse population requiring primary care services to respond to a range of health needs. Consequently, many of the mental health initiatives described below attempt to address the needs of this diverse population. Table three describes the six PHOs within the Auckland Region.

Table Three: Auckland PHOs

<table>
<thead>
<tr>
<th>PHO</th>
<th>Date Established</th>
<th>Funding</th>
<th>Enrolled Population</th>
<th>Enrolled Practices</th>
<th>High Need Population</th>
<th>Maori Population</th>
<th>Pacific Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland PHO Ltd.</td>
<td>1/07/03</td>
<td>Interim</td>
<td>37,634</td>
<td>14</td>
<td>10,117</td>
<td>1,662</td>
<td>4,751</td>
</tr>
<tr>
<td>AuckPAC Health Trust</td>
<td>1/04/03</td>
<td>Access</td>
<td>31,515</td>
<td>5</td>
<td>17,336</td>
<td>2,576</td>
<td>10,544</td>
</tr>
<tr>
<td>Tongan Health Soc.</td>
<td>1/10/03</td>
<td>Access</td>
<td>5,296</td>
<td>2</td>
<td>5,220</td>
<td>9</td>
<td>5,186</td>
</tr>
<tr>
<td>ProCare Auckland</td>
<td>1/03/03</td>
<td>Mixed</td>
<td>301,159</td>
<td>83</td>
<td>61,506</td>
<td>11,995</td>
<td>27,453</td>
</tr>
<tr>
<td>Tamaki Healthcare</td>
<td>1/04/03</td>
<td>Access</td>
<td>33,902</td>
<td>8</td>
<td>20,510</td>
<td>5,792</td>
<td>10,416</td>
</tr>
<tr>
<td>Tikapa Moana</td>
<td>1/04/04</td>
<td>Mixed</td>
<td>6,100</td>
<td>3</td>
<td>1,961</td>
<td>650</td>
<td>66</td>
</tr>
</tbody>
</table>

Source: Northern District Health Board Support Agency, 2006

Apart from PHO led initiatives, ADHB has developed a strategic direction for primary care liaison within their community mental health teams. This initiative grew out of the shared care pilot at St Lukes Community Mental Health Centre (CMHC). The strategy addresses issues related to the interface between primary health care and specialist mental health care services. It is aimed at the needs of people with moderate to severe mental illness. The initiative covers the following areas:

1. Shared care: Piloted at St Lukes and is now established by a primary care liaison nurse across the ADHB’s four CMHCs. The future goal is to have all key workers providing shared care with the primary care liaison nurse providing an education programme and expert support, advice and consultation for key workers, GPs and practice nurses.

2. Primary care secondary care interface: This is the next planned development for the primary care liaison nurse. The nurse will provide early assessment and brief intervention to prevent long term entry to specialist secondary service by the provision of consultations and advice to GPs and practice nurses. This will include the development of shared care options such as: GPs maintaining clinical responsibility for their client with input from the primary care liaison nurse; access to therapeutic groups or other brief interventions provided by CMHCs; access via primary care liaison nurse to one-off psychiatric consults for client remaining in primary care.

3. Primary care access to psychiatric consultation: GPs will have access to consultation with specialists via the primary care liaison nurse.

4. Education for primary care providers: ProCare will offer access to GP cell group programmes with a focus on mental illness. The primary care liaison nurse will also lead the development of appropriate education packages for GPs and practice nurses.

5. Access to primary care services for clients in relation to their physical needs: Some examples include diabetes screening, basic health promotion on exercise, and
nutrition. Strategies for financial support will also be developed with WINZ via the primary care liaison nurse.

Additionally, ADHB has put a case to the Ministry of Health to use Blueprint underspend to extend mental health services beyond the 3% of the population with severe mental illness to primary care populations. There is also a plan to extend the current Chronic Care Management programme to people with depression, using the same model as Counties-Manukau DHB. This latter initiative will have a built in evaluation.

ADHB is not involved in development of the mental health capacity of the primary health care workforce.

4.3.1 Tamaki PHO

**Ministry of Health Funded Initiative**

The mental health project was initiated in July 2005 and involves 1 FTE project manager conducting a scoping exercise in collaboration with ADHB secondary services and GPs. The project aims to determine the gaps in current services and will provide recommendations on the way forward for the PHO in terms of mental health service provision and workforce development. A survey of the training needs of GPs is currently being developed. The project manager works in collaboration with another staff member who provides psychological services for the PHO (see below).

**Psychological Services**

The PHO has employed 1 FTE psychologist to provide mental health services within their PHO catchment. The project, which has been running since 1995, involves the psychologist taking referrals from primary providers free of charge. Additionally, the psychologist facilitates training in cognitive behavioural therapy and decision-making for GPs and nurses.

**Refugee Services**

This SIA funded project involves 1 FTE social worker providing a refugee package that includes translation services and longer consultations. This group’s psychological needs are extensive and the PHO would like to extend this programme, with additional support of the Department of Immigration, to better meet the needs of the refugee population.

**Training Initiative in Mental Health**

The PHO, in conjunction with psychiatric services at Manaaki House, provides training in mental health for GPs and practice nurses. The training programme aims to provide ongoing up-skilling of primary care staff and to encourage the development of a relationship between primary health care and secondary.

**Workforce Profile**

Tamaki Healthcare PHO currently employs 3 FTE who have a proportion of their time allocated to mental health. The project manager for the Ministry of Health funded initiative and the psychological services provider are registered health psychologists. Both have completed post graduate diplomas in health psychology. One FTE social worker provides refugee services however, the approximate time allocated to mental health is unquantifiable.
The PHO supports staff to develop their skills and the Ministry of Health contracts allow for training and study leave to be funded.

**Training Needs**

The main focus of the PHO for future training and workforce development will become apparent once the Ministry of Health funded needs analysis of GPs is completed. The PHO has planned training programmes for their providers that will be provided by their psychology staff members.

Tamaki Healthcare has experienced several barriers to workforce development for their providers. It was explained that there is sometimes a tension between PHO and providers, with providers viewing the PHO as “eating money” and forcing them to be involved in initiatives, such as mental health, which they may not be enthused to provide. These attitudes were often related to whether the PHO was an owner/operator as opposed to a community based service. These issues will be discussed further in the next chapter.

**4.3.2 Tikapa Moana PHO**

Tikapa Moana is a 50:50 partnership between Piritahi Hau Ora Trust and Waiheke Health Trust and comprises of three practices namely, Ostend Medical Centre, Piritahi Hau Ora and Oneroa Accident and Medical Centre. Ostend Medical Centre and Oneroa Accident and Medical Centre do not have staff with specific time allocated to deal with mental health issues. Although GPs may prescribe mental illness related medication, most mental health patients are directed to the ADHB’s Taylor Centre CMHC. This section, therefore, describes initiatives being provided by the Maori provider arm Piritahi.

**Planned Pilot Psychiatric Nurse Service**

Tikapa Moana PHO is planning a pilot scheme to be delivered by Piritahi Hau Ora to employ a mental health nurse with a focus on early intervention for clients with mild to moderate mental illness. The nurse will also provide training for primary health care teams and the wider community. The specifications are still being developed in collaboration with ADHB.

**Alcohol and Drug Service**

Piritahi Hau Ora Alcohol and Other Drug service is funded by ADHB and operationalised by a clinical team at Piritahi. The clinical team comprises of 1 FTE counsellors, 0.2 FTE medical officer, 1 FTE detox nurse, and a .5 FTE dual diagnosis nurse. The purpose of the programme is to work with people with alcohol and other drug problems and their whanau, with the team providing support, dual diagnosis and detox services. Recovery groups are run three times a week. The programme has been extremely successful and ADHB accreditation was received last year in conjunction with accreditation against the New Zealand Standards for Mental Health and Health and Disability. Reports are made quarterly to ADHB and regular evaluations and feedback from 200 clients are analysed annually. It has been running out of Piritahi for 7½ years and is well utilised with high numbers and good recovery outcomes.

**Domestic Violence Programme**

This programme is delivered by Piritahi Hau Ora and is funded by Ministry of Social Development and Children Youth & Family Services via a .2 FTE social worker and a .2 Maori Community worker, working with 25 community groups to liaise and improve
collaboration. The community groups include organisations such as mainstream health providers, police, mental health support at home, WINZ, local schools and Citizens Advice Bureau. The aim of the programme is to provide clear pathways for referrals and improve access into services for people in domestic violence situations. There have been no completed evaluations of this programme.

**Workforce Profile**

Piritahi Hau Ora has five staff members with allocated time for mental health this includes the 1 FTE counsellors, 0.2 FTE medical officer, 1 FTE detox nurse, and 1 FTE mental health community worker who provide the alcohol and other drug service. The 1 FTE social worker employed for the domestic violence programme provides some mental health related services, but the time is not specifically allocated for this.

**Training Needs**

Tikapa Moana suggested that practice nurses and doctors need improved screening skills as they need to be able to identify mental health issues earlier.

**4.3.3 Procare Network Auckland**

The background of ProCare and their mental health initiatives, training and workforce development that span across the three ProCare PHOs were discussed in section 4.2.4. This section will describe mental health initiatives underway or planned in the Auckland region only.

**Extension of the ‘Engage’ Project**

This project involves the same staff and can be described in a similar manner to the SIA initiative in section 4.2.4. This initiative, however, aims to extend this programme to cover non-high needs populations with mild to moderate mental illness. The programme provides subsidised extended consultations, funded access to the PSS and the CHS team and continuing education for GPs and practice nurses. This project only began in August 2005, thus no evaluations have been completed.

**‘Back to Action’ Pilot**

The ‘back to action’ pilot recently introduced (February 2006) was designed and funded in collaboration with the Accident Compensation Corporation (ACC). The pilot will provide ProCare practice teams with the resources and referral mechanisms necessary to assist their patients to manage their acute low back pain effectively and return to work and normal activities as soon as possible. ProCare developed this pilot in conjunction with psychologists, the AUT School of Physiotherapy and GPs, and is based on ACC’s *Acute Low Back Pain Guidelines*. The programme will provide GPs with electronic decision making tools to assist them in managing patients with acute low back pain. It will also include subsidised consultation fees, and access to physiotherapists and clinical psychologists (at no cost to the patient) specialising in pain management who will teach patients skills to manage their low back problems over the course of their lifetimes. A ‘back two action’ education programme will be offered to practice teams through large group continuing medical education during February and through individual GP and nursing cell groups during March and April. These sessions
will cover the evidence base behind the programme and will also incorporate mechanical assessment and psychological techniques for pain management (Rankin, 2006).

4.3.4 Auckland PHO Ltd

Auckland PHO declined to participate due to multiple commitments.

4.3.5 AuckPac Health Trust Board

AuckPac does not have any funded mental health initiatives in place, but is working with Langimalie and Ta Pasefika on the development of a group mental health project; see section 4.4.3.

Part of the Pacific mental health initiative will be assessment of workforce capacity and training needs.

4.3.6 Langimalie - Tongan Health Society Inc.

Langimalie currently provides some mental health services in primary care and aim only to refer clients to specialist services for the most severe mental illness. Langimalie works closely with secondary mental health services and aims to provide primary care services for low fees.

**Ministry of Health Funded Initiative**

Langimalie is working with AuckPac and Ta Pasefika on development of a group mental health project. Ta Pasefika is the lead provider for this project, described further in 4.4.3.

**Co-location Initiative**

The PHO has a planned initiative to integrate mental health services into primary care. This is, however, still under negotiation with ADHB. This is a co-location initiative that will see some specialist mental health services provided in primary care.

**Chronic Care Management – Depression Module**

The PHO plans to take part in the CCM depression module for which the lead provider is Ta Pasefika; see section 4.4.2 for an overview.

**Workforce Profile**

Currently there are no mental health specialist staff employed in the PHO, but a co-location model is used to provide specialist psychiatry time to the PHO.

**Training Needs**

Part of the Pacific mental health initiative will be assessment of workforce capacity and training needs. However, there is a current need for training of frontline staff in mental health issues. The PHO plans to train all primary care nurses to be able to respond to mental health
issues. There is also a need for training so that all GPs can use the GHQ 12 to screen for mental health problems.
Primary health care is a key priority for CMDHB and successful services delivered by the DHB through the primary sector have taken place. Accordingly, the DHB has invested further into primary healthcare and has encouraged further collaboration between its primary health care providers. Table four outlines the seven PHOs\(^1\) within the Counties Manukau region.

### Table Four: Counties Manukau PHOs

<table>
<thead>
<tr>
<th>PHO</th>
<th>Date Established</th>
<th>Funding</th>
<th>Enrolled Population</th>
<th>Enrolled Practices</th>
<th>High Need Population</th>
<th>Maori Population</th>
<th>Pacific Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Health Services</td>
<td>1/07/03</td>
<td>Interim</td>
<td>74,530</td>
<td>23</td>
<td>3,426</td>
<td>1,246</td>
<td>917</td>
</tr>
<tr>
<td>Mangere Health Trust</td>
<td>1/04/03</td>
<td>Access</td>
<td>11,622</td>
<td>3</td>
<td>9,426</td>
<td>1,024</td>
<td>7,243</td>
</tr>
<tr>
<td>People Health Trust</td>
<td>1/04/03</td>
<td>Access</td>
<td>5,853</td>
<td>3</td>
<td>3,132</td>
<td>1,686</td>
<td>576</td>
</tr>
<tr>
<td>ProCare Manukau</td>
<td>1/01/03</td>
<td>Mixed</td>
<td>251,954</td>
<td>63</td>
<td>121,259</td>
<td>42,424</td>
<td>43,883</td>
</tr>
<tr>
<td>TaPasefika Health Trust</td>
<td>1/07/02</td>
<td>Access</td>
<td>11,524</td>
<td>2</td>
<td>11,329</td>
<td>254</td>
<td>10,869</td>
</tr>
<tr>
<td>Te Kupenga O Hoturua</td>
<td>1/07/02</td>
<td>Mixed</td>
<td>32,798</td>
<td>8</td>
<td>21,636</td>
<td>12,511</td>
<td>5,073</td>
</tr>
<tr>
<td>Total Healthcare</td>
<td>1/01/03</td>
<td>Access</td>
<td>73,089</td>
<td>6</td>
<td>55,205</td>
<td>10,944</td>
<td>37,674</td>
</tr>
</tbody>
</table>


### Adult Mental Health Core Adult Services Project

CMDHB has significantly redeveloped their adult mental health services. They now have four community based mental health centres (CMHC). As part of a wider programme of service development (Core Adult Services Project) work has been undertaken to improve the referral to secondary services of people with moderate and severe mental illness from primary care. Part of this strategic movement involves the development of guidelines for referrals for GPs, this pack includes: Referral forms, eligibility criteria information, maps for all four CMHC (showing their catchment areas), brochures for all four CMHCs for handing out to patients, and contact details for all four CMHCs. Guidelines for community mental health services were also developed to improve their communication with GPs.

---

\(^1\) CMDHB also contract with separately with Otara Union Health Clinic, a practice of Tamaki PHO.
CMDHB plans to extend this project to include the development of a more formalised primary care liaison function within the CMHCs and in time the development of a shared care approach for people with moderate mental illness.

**Planned Physical Health Project**

CMDHB have begun a specific initiative aimed at improving the physical health needs of people with severe mental illness. The objective of this project is to address issues in relation to lack of engagement with primary care services and the potential metabolic side effects of atypical antipsychotic medications.

The key objectives of the project include:

- a) The development and implementation of guidelines to ensure that all people commenced on atypical antipsychotic medications are offered access to health promotion programmes aimed at reducing the risk of the potential physical health complications that can result from these medications;
- b) The development and implementation of guidelines for monitoring and addressing potential physical health complications that can arise as a result of the use of atypical antipsychotic medications; and,
- c) The development and implementation of a pilot programme aimed at improving utilisation of primary health care services by mental health service users with high needs.

This project has not yet been implemented, thus there is no evaluative component designed or completed.

**Providing Access to Health Solutions (PATHS)**

PATHS is a joint project undertaken by CMDHB, the Ministry of Social Development and Work and Income with the aim of assisting people who receive the Sickness or Invalids Benefit to return to the workforce. This service is offered to all Sickness or Invalids Beneficiaries resident in Counties Manukau and is voluntary. The programme utilises a case management model to coordinate and facilitate access to health services for clients who want to work and need additional health services to manage their condition in order to become ready for work. The PATHS programme offers assistance with finding employment via the PATHS work broker and supported employment services. An evaluation is being planned but is not yet completed (Counties Manukau District Health Board, 2006).

**Primary Health Care Workforce Development Plan**

Workforce development in primary care is encouraged by CMDHB. The DHB has developed a *Primary Workforce Development Plan* (2003) that outlines key priority areas for GPs, practice nurses, community health workers and within rural areas. The DHB has also developed the toolkit for developing plans for mental health provision in primary care, however, there is no evidence that the PHOs are going down this track. The Ministry of Health funded coordinators (see section 4.4.1 below) are, as part of their role, going to conduct training needs assessment and initiate workforce development accordingly for their PHOs. CMDHB has also developed guidelines for depression and suicide risk and prevention for primary providers.

CMDHB provides training programmes and funding opportunities in three areas. These include:
1. The South Auckland Health Foundation provides mental health scholarships for people working in primary care. The scholarships cover fees for postgraduate study in a mental health related course for nurses, GPs, and other primary health workers. Applicants must work in a primary care setting in the Counties Manukau region and the course must have 50% content directly applicable to primary mental health.

2. CMDHB provides SIA funded cognitive behavioural therapy (CBT) training for all staff.

3. CMDHB is currently piloting a training programme focused on lifestyle changes, brief intervention and problem solving approaches for primary health care professionals.

4.4.1 East Health Trust

Ministry of Health Funded Initiative

East Health Trust has implemented a mental health specific project within their PHO. There are two aspects of initiative including:

1. The establishment of organisational structures: Entry criteria, methods for measuring service performance, systems and information sharing, and protocols to manage the initiative.

2. 1 FTE mental health coordinator. Role includes: management of client referral, liaison with specialist mental health services, NGOs and community support groups, development and distribution of database of local supports, facilitation of training for GP and practice nurses on mental health and alcohol and other drug issues and identification of gaps in service provision.

The objective of this initiative is to establish and provide a coordinated service for mental health clients with mild to moderate mental illness and promote continuity of care. The service will assist clients to access available primary care services in the community. Ongoing training and upskilling of providers in primary care is also part of the initiative. Gaps in services available will be identified and innovative approaches to the provision of services will be developed.

Care Plus

East Health Trust is part of CMDHB Care Plus scheme which is aimed at people who need to visit their family GP or nurse often because of significant chronic illnesses such as diabetes or heart disease, have acute medical or mental health needs, or a terminal illness. GPs or practice nurses identify patients who could benefit from 'intensive clinical management in primary care' (at least two hours of care from one or more members of the primary health care team) over six months and have two or more chronic health conditions. Those with mental illness have to have two acute medical or mental health related admissions in the past 12 months. Clients enrolled in Care Plus access initial comprehensive assessment when they visit their practice at a low cost. Following this consultation, an individual care plan is developed that aims to set health and quality of life-related goals accompanied with regular follow-ups. The aim of Care Plus is to provide effective management of chronic health conditions, better understanding of their conditions and support to make lifestyle changes. This programme has not yet been evaluated.
Planned Initiatives

East Health Trust have two planned initiatives specifically targeting older persons and child and adolescent health. Both projects are at a needs analysis stage and service specifications will be developed later this year.

Workforce Profile

The Ministry of Health funded mental health coordinator FTE is the only employee of the PHO with mental health associated allocated time. This employee is a registered nurse who has undertaken post graduate studies in mental health.

The PHO provides continuing medical education for GPs and practice nurses. These programmes are ongoing with twelve sessions a year. Topics are planned around current projects and this year there will be a mental health focus. Training is also open to other PHOs.

East Health workforce development programmes are often constrained by “time and money”. The PHO recognises that it has to get better at providing mental health services, and that it has a large Asian population with mental health concerns that they are not addressing well. The perceived remoteness of the academic world and lack of confidence from their primary providers are also major impediments to workforce development.

Training Issues

East Health plans to evaluate how primary providers are with dealing with mental health issues currently. After this is complete, the PHO will put money into mental health and addictions workforce development. East Health anecdotally know that their providers need CBT and they would like to offer CBT to clients because it is often too expensive for them to go private providers. Other areas for future training are related to have Asian populations and gambling and alcohol and addictions screening.

4.4.2 ProCare South

The background of ProCare and their mental health initiatives, training and workforce development that span across the three ProCare PHOs were discussed in section 4.2.4 This section will describe mental health initiatives underway or planned in the Counties Manakau region only.

Chronic Care Management – Depression Module

This pilot is jointly funded by CMDHB and the Ministry of Health innovation fund. ProCare, Ta Pasefika and Te Kupenga O Hoturoa Charitable Trust together with CMDHB have developed a structured care programme for depression in primary care. The depression programme is being piloted as part of the CMDHB Chronic Care Management (CCM) Programme.

The aim of CCM is to improve outcomes for people with depression through improved clinical management in primary care. The programme will provide continuing medical education to GPs and Practice Nurses; fund free GP/nurse consultations for people with depression; and offer a structured pathway for clients with access to a range of treatment options including antidepressant medication, problem solving and cognitive behavioural therapy.
The Disease Specific Advisory group (that includes clinical expertise from PHOs, the DHB and secondary Mental Health Services) has developed evidence based treatment guidelines and education/training requirements. A CCM Depression Steering Group, that also includes representation from PHOs and the DHB, has overseen the operational development of the programme.

To date, the PHOs and CMDHB have developed patient information and wellness plans for clients enrolled in the programme. The information pack describes what depression is, symptoms and different types of treatment and lifestyle changes. The wellness plan is designed to help clients take control of their own health condition and prevent it getting worse over time. The group have also implemented agreed guidelines, audit and feedback reports.

The specific objectives of the Chronic Care Management Depression Pilot Programme are:
- To improve identification by primary care professionals of people with moderate to severe depression
- To improve the quality of care within primary care for these patients through proactive structured care using evidence based treatment guidelines, electronic clinical decision support, and regular reporting on patient outcomes for quality improvement processes
- To improve patient self management through the use of patient held wellness plans, regular support, and regular reinforcement
- To create seamless, and consistent processes, and information for patients through integrated primary and secondary systems.

**Sickness Benefit and Invalid’s Benefit Programme**

This programme is aimed at clients with illnesses or disabilities who want to go back to work. Three employment focused pilot initiatives are currently underway and are provided by ProCare and PATHS (Providing Access to Health Solutions) and Workwise. Two specialist employment brokers help place Sickness and Invalid’s Benefit recipients into employment. The programme provides enhanced case management provided through the Takapuna and Manukau Service Centres (Work and Income New Zealand, 2005).

**4.4.3 Ta Pasefika**

**Ministry of Health Funded Initiative**

The ‘Pacific PHO coordinating group’ initiative is led by Ta Pasefika in collaboration with Auckpac PHO and Tongan Health Society. Ta Pasefika have appointed 1 FTE project manager to develop this project.

There are two objectives to this initiative:

1. To train and develop the capacity and capability of the Pacific primary care workforce to identify the risk factors of mental illness and to facilitate appropriate interventions in a primary care setting.

2. To establish a capacity within Pacific primary care to identify, provide and/or facilitate access to medical and/or other treatment that is available to treat and support a patient in a primary care setting.

This initiative is still in developmental stage and will be evaluated by the Ministry of Health.

**Alcohol and Other Drugs Service**

Ta Pasefika currently provides alcohol and other drug services using SIA funding.
Chronic Care Management – Depression Module

TaPasefika is part of this pilot programme; see section 4.4.2 for an overview.

School Clinics

Ta Pasefika utilise school clinics to promote awareness of alcohol and drug issues.

Depression Screening

Providers are currently using a Pacific version of GHQ (GHQ-9) for depression screening.

Family Support

A family support programme is provided through Well Child contracts, and has a mental health overlay.

Workforce Profile

The PHO employed 0.1 FTE project manager for the Ministry of Health project. The PHO has initiated workforce training from CADS funded by the Ministry of Health with assistance from ALAC to raise awareness of alcohol and other issues in 2005/6, to follow on from ALAC funding provided in 2003/4. Primary providers plan to access training as part of the CCM depression module.

Training Issues

Further opportunities for alcohol and other drug training have not been pursued because there are no current contracts to provide these services.

4.4.4 Te Kupenga O Hoturoa Charitable Trust

Chronic Care Management – Depression Module

Te Kupenga O Hoturoa is part of this pilot programme; see section 4.4.3 for an overview. Currently the PHO has no other initiative specifically related to mental health. The PHO has employed a clinical nurse specialist who works on the CCM project, 0.2 FTE of this work is specifically orientated to mental health issues. Training for this individual is included as part of the CCM programme. Te Kupenga O Hoturoa is supportive of workforce development for their staff but currently have no mental health training programmes in place.

4.4.5 Peoples Healthcare Trust

Mental Health Project

Peoples Healthcare, in collaboration with CMDHB, have appointed a 0.5 FTE project manager. The project manager is a nurse specialist who will case manage clients and develop networks between primary and secondary interface to improve communication. The role will also encompass initiatives to increase the mental health skills of the PHO administration and clinical staff. There will also be a focus around providing emotional and financial support for
low socio-economic and immigrant and refugee populations who have high mental health needs.

**Detoxification Service**

The PHO in collaboration with the Auckland City Mission provide a detoxification service for alcohol and other drug clients. Peoples Healthcare medical staff help provide this service by working with clients to manage their withdrawal symptoms while residing in a support house located in Auckland City. The support house provides a 24 hour residential service for up to ten clients at any one time. The maximum stay is 14 days and there is a cost of $20 per night. The centre also facilitates group educational sessions, provides access to community and recreational services, and runs relaxation workshops. Other possible options are also discussed with the clients. These may include counselling, residential programmes, supported accommodation, and supported groups (Auckland City Mission, 2006).

**Workforce Profile**

The PHO has employed a 0.5 FTE project manager for their mental health project. Other staff in the PHO are currently involved in training programmes that have been financially supported by CMDHB. One staff member is undertaking postgraduate study focused on primary mental health. The PHO struggles to fund staff and there is currently no push to develop workforce/skills because the trust is always running in financial crisis across the board (not just mental health).

**Training Issues**

Peoples Healthcare stated that staff need training in general recognition and screening of mental health problems and brief interventions. There also needs to be strategies put in place to increase the awareness of staff in accessing services to help clients (community and secondary).

**4.4.6 Mangere Community Health Trust**

Mangere Community Health Trust does not have any current or planned mental health initiatives.

**Workforce profile**

The Clinical Director of the PHO is a doctor who has previously worked 8 -12 hours a week as a Psychiatric Registrar for 14 years. Currently, Mangere Community Health Trust has no PHO staff with allocated mental health time.

A significant barrier for Mangere Community Trust is the recruitment issues the area faces, with the PHO and providers constantly being short staffed. It is hard to recruit clinical staff to work in Mangere even if a good wage is offered. Mangere is perceived as “a frustrating place to work”. It was also argued that a closer relationship between CMHC, Middlemore Hospital and local GPs needs to be encouraged. Additionally, there is a need for GPs to be able to have more accessible information about referring processes. The GPs also need further training related to alcohol and other drug issues as many of them currently do not respond to these problems.
4.4.7 Total Healthcare Otara

Total Healthcare Otara declined to formally participate due to multiple commitments. The PHO does not currently have any mental health contracts. They identified mental health as a priority for their population and have made a submission to CMDHB to use SIA funding to provide mental health services but this was declined.
5. Discussion

PHOs are a relatively new development in New Zealand health care (Ministry of Health, 2001), introducing both a population based approach to primary health care and a new model of funding which is not yet fully in place. Mental health has been identified as one of a number of priorities for a primary care sector that is in the process of adapting to extensive changes in its organisation, funding and delivery of services. It is no surprise, therefore, to find that mental health developments are rather uneven. In describing mental health initiatives in this report it must be remembered that the focus of the research was PHOs and DHBs, not primary care practices. Mental health responses vary within PHOs from one practice to another. In some PHOs individual practices exercise a considerable degree of autonomy, and the PHO might have limited scope to influence how services are provided (Crampton, 2005).

The study showed a high level of awareness of mental health issues amongst PHO and DHB managers. It appears that recent developments in policy have been effective in raising the profile of mental health issues within primary care, and in increasing involvement of DHB mental health services in the primary health care sector. However developments are currently uneven within and across DHB areas, and there is a lack of consensus as to how mental health issues are best addressed within primary care. An exception to this finding is Northland, where there is consistency across PHOs in the provision of mental health services, and a close relationship between the DHB and the PHOs. There are examples of exemplary practice in all DHB areas, which should provide confidence in the future development of mental health services in primary care.

Ministry of Health contracts have provided a significant boost in mental health activity. To some extent these contracts have raised expectations that the primary care sector will receive further resources for development of mental health services, expectations that act as a constraint on more immediate development of such services. Similarly, DHB project funding has stimulated development of mental health responses. Some PHOs expressed disappointment that their proposals to develop mental health initiatives had not received funding support, but still expressed commitment to developing mental health initiatives in the future. However the time limited nature of many projects raises issues of how the expansion of mental health provision in primary care is to be bedded down in more sustainable models of primary healthcare services.

Many of the current mental health initiatives discussed in this document are in their early stages and will be evaluated by the Ministry of Health in 2006/07. Other initiatives are at needs analysis stage, and have yet to determine how mental health services can best be developed, or what range of services should be provided. Workforce capacity is an area that appears to need specific attention. Most PHOs do not have workforce development plans, and are under pressure to develop capacity in a number of areas. Mental health must be prioritised as one amongst a number of areas of need.

5.1 Cultural and Community Involvement

When Maori have been involved in the initial establishment of a PHO, the ethos of the organisation (which then dictates the policies and procedures, initiatives and the day to day running of the organisation) is more likely to reflect an underlying Maori approach to health. The study showed that when the organisation of a PHO reflects the Whare Tapa Wha model (Rochford, 2001), that Maori providers are able to work in an appropriately supportive cultural environment. This was especially noticeable in the Northland PHOs. In other PHOs that expressed a specific commitment to Maori health a common response to the question on meeting cultural needs was that these were met through the cultural knowledge and resources
of Maori staff. A similar comment was made in relation to PHOs focused on the health needs of Pacific peoples, where the Fonofale model (Ministry of Health, 1995) provides a framework consistent with a Pacific view of health. Providing mental health care in a culturally supportive environment at the primary level may contribute to increased access to mental health care and may help reduce the previously observed rate of referral through law enforcement and welfare services (Ministry of Health, 2002d).

In cases where Maori are not involved in the initial establishment or governance of the PHO, then the PHO will often attempt to address this by providing cultural training and/or Treaty workshops. This approach may mean that cultural considerations are treated as a separate issue rather than being integrated into the organisation of the PHO.

In a similar vein, when the local community is involved in the initial establishment and governance of the PHO, this creates a sense of ownership and involvement, and commitment to ongoing development and initiatives (Crampton, 2005). The Ministry of Health (2005d) has expressed concern that some PHOs have limited provision for community involvement in their governance processes, and that this limits their responsiveness to community health needs.

5.2 Infrastructure

The Primary Health Care Strategy (Ministry of Health, 2001) envisaged DHBs working through PHOs to achieve population health goals, and there are a number of instances of this relationship leading to the development of primary care mental health initiatives. Examples include shared care and other primary/secondary cooperative ventures, DHB support for training of primary health care staff, and collaboration on development of referral protocols aimed at closer alliance between the primary and secondary sectors.

Relationships between MOH, DHBs, PHOs and providers, and the communication and liaison between them could be improved. Providers commonly feel overloaded and there may be a feeling of being “put upon from the top down”. In some PHOs there is a sense of fragmentation, and staff have commented on repeatedly being asked to provide data for needs analysis, which can create resentment in a time-pressured environment. Several PHO representatives specifically commented on the demands created by multiple policy initiatives and health strategies.

PHOs are not using DHB Mental Health Action Plans, and with the exception of Northland, there appears to be no formalised approach to the development of mental health services in primary care across all the PHOs within each DHB.

When the DHB is able to provide clear strategic guidelines for the PHOs and to coordinate initiatives throughout the area, this can lead to a less fragmented sector (as exemplified by Northland). It would appear that this gives PHO staff more of a sense of direction, and a feeling of cohesive planning and working in collaboration towards measurable outcomes.

5.3 Provider Incentives

There is a difference between “owner-operator” self-employed GPs and those employed by PHOs. The incentives to incorporate programmes into their workload are different for each of these groups, which means that in order to be maximally effective, some PHOs feel they must adopt different “marketing strategies” in order to get both sets of providers on board with new initiatives. From the PHO perspective there seems to be greater freedom to commit to a new initiative if the PHO also employs the GPs. Previous research has noted limitations imposed
by the General Medical Services Benefit which restricts consultations to 15 minutes (MaGPIe Research Group, 2005a). However the problem may go deeper than consultation times. Crampton (2005) has noted that the coexistence of different models of PHO ownership may mean that PHOs have limited capacity to effectively govern their constituent practices.

5.4 Funding

One of the common points raised by PHOs in relation to developing and delivering mental health initiatives was the need for funding for specific initiatives, and the timing of this funding. If the funding were available prior to the development of an initiative, then it is feasible to allocate staff time to develop, deliver and evaluate that initiative. If there is an expectation for the PHO to develop the initiative first, with the possibility of later funding, then such an initiative is less likely to be prioritized.

The Ministry of Health mental health projects show that where specific funding is provided PHOs will respond by developing the appropriate services. Outside the Ministry initiatives, a range of funding mechanisms such as Care Plus and SIA have been used to increase provision of mental health services.

5.5 Training Needs and Workforce Capacity

PHO participants reported the need for workforce development in mental health; however DHB involvement in PHO workforce development is variable. In Northland there is close cooperation between the DHB and PHOs through the Rural Consortium which provides training for doctors and nurses. There are a variety of initiatives in the Auckland metropolitan DHBs, including scholarships for mental health training provided by CMDHB, a joint initiative between a PHO and a community mental health centre in ADHB, support for staff to access postgraduate education programmes, and joint education sessions conducted between DHB secondary services and PHOs. Some of the latter initiatives also occur between DHB secondary services and primary health care practices.

The main areas identified by PHOs as training needs for their staff and the GPs and practice nurses related to the screening and recognition of mental health and alcohol and other drug problems, brief intervention, CBT, and dealing with gambling, domestic violence and sexual abuse issues. Mental health awareness was identified as a training need for administration staff. The training issues identified are similar to those outlined in Primary Mental Health: A Review of Opportunities (Ministry of Health, 2002b).

Presently, training modules in specific identified subject areas are available for primary care staff as part of continuing medical education and continuing nursing education programmes. It is important to note that if there is no ongoing funding for follow up training or to implement new skills, then it is left to individual practitioners to integrate these new skills into their day to day practice.

5.6 Transfer of Care from Secondary to Primary

Transfer from secondary services to primary care is either working very slowly or not working at all. Many participants commented that GPs and practice nurses feel they lack the required knowledge to work with people with long term mental illness, as they have not had much experience of this, and few staff have undertaken specific training to upskill themselves in this area. These findings confirm those of Nelson et al. (2003) who found that transfer from secondary mental health services into primary care can be problematic unless it is undertaken
using a robust model. Transfer of care is limited to those PHOs in which there is interest in this work; it is generally not seen as core work for primary care. Some PHOs are not yet involved in mental health initiatives for those with mild or moderate disorders, and so transfer of secondary service users into primary care is not a priority for them. Findings in relation to shared care are consistent with international literature which is divided on the extent to which care of people with severe mental disorder can be provided in primary care settings (Burns, 2005). The limited interest in transfer of care does not reflect the reality that the needs of people with severe mental illness change over time (Ministry of Health, 2002b), and sets a different standard for mental health consumers than for other patients, who use specialist services for defined periods of time and then return to primary care.

PHO participants gave several reasons for the limited interest in transfer of care initiatives. As well as lack of knowledge, the lack of financial incentives to see mental health patients was noted. It was commented that providers felt that the secondary services were funded to care for people with long term mental illness, and so that is where they should be looked after. With no additional funding, these patients were often not viewed as an attractive addition to a primary care practice.

5.7 Physical Health Needs of Mental Health Consumers

Responses to the physical health needs of mental health consumers are variable, from an absence of specific initiatives to well developed programmes. In some cases physical health needs are met within primary care services, in others these needs are met by a primary care response in secondary services. Programmes such as that proposed by CMDHB target general health needs as well as the known increased risks from atypical antipsychotic agents. This proposed programme involves an integrated approach from the DHB, primary care, and the NGO sector. Programmes aimed at improving interface between primary and secondary sectors were identified in the Waitemata, Auckland and Northland DHBs also address physical health needs. There were no evaluations in this area.

5.8 Mental Health Promotion

Mental health promotion is understood differently by different participants, with understandings varying from any activity aimed at early detection of illness, to activities aimed at community development. Few PHOs identified specific mental health promotion initiatives; however there were a number who described activities with a mental health promotion component. These included some secondary service initiatives. It is likely that some mental health promotion activities were not reported because they are part of a more general health promotion programme. Other initiatives such as ‘Back to Action’, while not a mental health initiative, can be expected to have positive mental health benefits. Examples of mental health promotion activities included a community development team focussed on lifestyle changes, school outreach, community liaison, collaboration with other agencies, a newsletter distributed to homes, media promotion and inservice education in mental health promotion.

5.9 Stigma

The issue of the need for destigmatisation of mental illness was raised, with some PHOs citing the “stigma of mental illness” as one of the main barriers for staff to undertake training in this area. Others simply commented that mental health was not a priority, with a sense that mental health was seen as an optional area of care, rather than an integral aspect of primary health care.
No PHOs or DHBs identified specific anti-stigma initiatives or activities, although it was apparent that PHOs who were moving to develop mental health care provision were attempting to ‘normalise’ mental health issues by acknowledging mental health as one of a range of health needs. Whilst it is clear that there is a desire from some PHOs to separate out specific mental health initiatives with a view to funding and development, there was much discussion around the practicality and implications of separating mental illness from physical illness. There was concern from some that this could contribute to the stigma of mental illness, and create an additional access barrier. Some participants expressed the opinion that mental and physical health are intertwined, citing examples such as substance use and mental illness and the mental health sequelae of chronic physical illness. As previously discussed, those working within models such as Whare Tapa Wha provide a more holistic approach.

5.10 Models of Mental Health Service Provision

Mental health services have developed differently in different PHOs. Some PHOs offer mental health consultations as part of usual care, but no enhanced mental health service or additional services. This remains so even if the PHO is committed to development of its mental health response, with the most frequently cited inhibiting factors a lack of specific funding and workforce capacity limitations. In some cases this may be because an acceptable funding model has not been negotiated. For example one PHO commented that it has a proposed mental health initiative based on SIA funding, but this has not yet been approved by the DHB. For this reason at least a proportion of SIA funding remains unspent. The Procare PHO has developed a model of providing mental health services which appears to be successful in their enrolled populations. The model covers both funding and clinical service provision. However, the Procare model has not found acceptance with other PHOs where it has been proposed as a model for a DHB wide initiative. There are mixed views on this, but even amongst those PHOs which do not favour the model in total, there is recognition that the Procare model has possible benefits. Where there is a clear conflict between the Procare model and the more ‘grassroots’ model preferred by other (especially smaller) PHOs, it seems unlikely that the Procare model will be accepted. The current lack of agreement about a model of funding and service delivery means that consumers in PHOs affected by this do not receive enhanced mental health services.

Another source of variation in the models of mental health service provision is the size of the PHO. Larger PHOs are able to achieve economies of scale not available to their smaller counterparts. Also, in the case of some of the smaller PHOs with large relatively Maori populations, and in those serving Pacific peoples, there was an emphasis on providing mental health services from the same premises as general health services with the objective of improving access by avoiding the need for a separate appointment at a different location.

5.11 Study Limitations

The study was a stocktake, and so did not evaluate either mental health initiatives or workforce development plans other than by review of existing documents or by seeking opinions of interviewees. The data collected related to initiatives, that is activities occurring as part of a specific programme, not the practice of individual clinicians. The full extent of mental health care provided in the primary health care sector would need to take individual clinical practice into account. No consumers of primary health care or mental health services were interviewed, nor were any primary health care or mental health clinicians. In some cases there was limited data, and the quality of data depended on the knowledge of the interviewee rather than any systematically compiled reports. The area of workforce capacity and training needs was the most problematic as in many cases there was no quantifiable data available. In
the case of mental health promotion, some activities with a mental health component may not have been reported if they were not specifically identified as mental health initiatives.
6. Recommendations

The varied nature of the primary health care sector, together with the varied range of initiatives that are already in place means that it is difficult to make specific recommendations that apply equally to all PHOs and DHBs. In addition, it needs to be noted that few evaluations of initiatives have been completed, and that some initiatives are only at a needs analysis stage.

Recommendations arising from this report are:

1. That close consultation about the development of mental health services and initiatives in primary care is a priority in the relationships between DHBs and PHOs;

2. That PHOs are supported to develop models of mental health service delivery that meet the needs of their populations;

3. That there is continuing emphasis on developing workforce capacity, and addressing issues of stigma where it is a barrier to service development and delivery;

4. That the sector works together to enable people with severe mental illness, with support from secondary services, to receive all their healthcare in the primary care sector;

5. Further research could examine provision of mental health care at a practice level through file audit, interviews with practitioners, and analysis of data on numbers of patients treated for mental health issues using mechanisms such as SIA and Care Plus.

Specific recommendations for District Health Boards are that DHBs:

6. Actively liaise with the primary health care sector to support primary care practitioners in developing skills in the assessment and management of people with mental disorders;

7. Work with the primary care sector to develop sustainable models of mental health in primary care;

8. Work with PHOs to monitor their implementation of the MOH toolkit for mental health;

Specific recommendations for Primary Health Organisations are that PHOs:

9. Systematically collect data on their mental health capacity and training needs;

10. Prioritise mental health as an area of service delivery, and explore existing and new funding streams where these will assist in providing mental health care;

11. Continue to work towards implementing the MOH toolkit for mental health.

An additional recommendation relates to the variety of mental health services currently in place. While some information about those initiatives is contained in this report, the NDSA could consider ways of communicating information about successful initiatives within the
sector. This would enable both DHBs and PHOs to learn from each other’s experience, and to consider initiatives that have already been trialled.
References


Northern Regional Mental Health Funding Team and the Northern Regional Mental Health Network. (2003). *Northern Regional Mental Health and Addictions Plan 2003-2004*: Northern DHB Support Agency.


## Glossary of Terms

**Access funding**  
Funding provided to those PHOs classified by the MOH as having populations with high needs. Access funding is initially targeted at PHOs with high needs populations; this level of funding is to be extended to all PHO enrollees in the future. To qualify, a PHO must have 50% Maori, Pacific, or living in Decile 9 areas. Some scope for extension of this formula to other PHOs. For Access funding co-payments must be low, and agreed with DHB in service agreements.

**Care Plus**  
Care Plus is a service provided through Primary Health Organisations from 1 July 2004. It's aimed at people who need to visit their family GP or nurse often because of significant chronic illnesses such as diabetes or heart disease, have acute medical or mental health needs, or a terminal illness.

**Co-payments**  
Proportion of fee for primary health care service paid by patients. Co-payments vary widely, and are influenced by whether the practice is part of an Access funded PHO. Remainder of fee is from GMS. Individual doctors set their own co-payments regardless of level of GMS.

**Interim funding**  
Modified version of Access Funding; based on same factors, but retains CSC. Targets individual patients within a PHO, rather than all patients. Additional funding to PHOs specifically for patients aged 65 or over that will allow them to reduce their fees. For Interim funding co-payments must be low, and agreed with DHB in service agreements.

**IPAC**  
Independent Practitioner Association Council. An alliance of professionals (mainly doctors) working in primary care.

**FTE**  
Full time equivalent
Appendix One

<table>
<thead>
<tr>
<th>PHO Interview Recording Sheet</th>
<th>1a Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1b Interviewee name</td>
<td></td>
</tr>
<tr>
<td>1c Contact number</td>
<td></td>
</tr>
<tr>
<td>1d Email address</td>
<td></td>
</tr>
<tr>
<td>1e Name of organisation</td>
<td></td>
</tr>
<tr>
<td>1f DHB area (Circle)</td>
<td>CDHB</td>
</tr>
<tr>
<td></td>
<td>WDHB</td>
</tr>
<tr>
<td></td>
<td>ADHB</td>
</tr>
<tr>
<td></td>
<td>NDHB</td>
</tr>
<tr>
<td>1g What population group(s) does your PHO serve?</td>
<td>(i.e. one or more of adult, child and youth health, older health, Pacific health, Maori health, rural health, migrant or refugee groups)</td>
</tr>
<tr>
<td>1h Do you have any reports outlining the demographic profile of the population groups you serve?</td>
<td></td>
</tr>
<tr>
<td>1i How do you identify Maori and/or other ethnic group’s needs?</td>
<td></td>
</tr>
<tr>
<td>1j How do you address inequalities across different population groups?</td>
<td></td>
</tr>
<tr>
<td>1k In which region(s) do you provide services?</td>
<td></td>
</tr>
<tr>
<td>1l Which DHB do you hold contracts with?</td>
<td></td>
</tr>
</tbody>
</table>

2. PHO Current and Planned Mental Health Initiatives

In this section I would like to discuss with you any current and planned initiatives specifically focused on mental health care that your PHO is involved in providing. If we could first discuss any mental health initiatives that you are currently involved with and then move on to any planned initiatives for the future.
2a Does your PHO currently provide or have planned any specific MH initiatives? *(i.e. programmes or initiatives to meet common mental health and AoD needs, shared care, transfer of secondary to primary care, physical health needs, mental health promotion)*

<table>
<thead>
<tr>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

2b Do you have a mental health and addictions action plan?

<table>
<thead>
<tr>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

2c Number Initiative:

<table>
<thead>
<tr>
<th>2d: Current/planned (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

2e Start date:

<table>
<thead>
<tr>
<th>2f End date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

2g Contract/no contract (circle):

<table>
<thead>
<tr>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

2h Title of initiative

<table>
<thead>
<tr>
<th>2i Staff involved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

2j Funding

<table>
<thead>
<tr>
<th>2k Target group/s (age, ethnicity, health issue)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

2l Can you give me a description this initiative?

<table>
<thead>
<tr>
<th>2m What are the objectives of this initiative?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

2n What evaluations of this initiative are planned or completed?

<table>
<thead>
<tr>
<th>2o How successful was this initiative in meeting these objectives? (Current initiatives only)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

2p Do you have any printed or electronic information on this initiative? Yes/No (if yes, specify)

<table>
<thead>
<tr>
<th>2q</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

3. Are there any other initiatives currently underway or planned in your PHO that have a mental health component? *(i.e. Chronic Care Management, Adolescent Health)*

<table>
<thead>
<tr>
<th>Number initiative:</th>
<th>3b Current/planned (circle)</th>
<th>3c Start date:</th>
<th>3d End date:</th>
<th>3e Contract/no contract (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3f No of staff involved

<table>
<thead>
<tr>
<th>3g Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

3h Funding

<table>
<thead>
<tr>
<th>3i</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

3j Funder

<table>
<thead>
<tr>
<th>3k</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

3l Funder

<table>
<thead>
<tr>
<th>3m</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

56
3h Target group/s (age, ethnicity, health issue)

3i Can you give me a description this initiative?

3j What are the objectives of this initiative?

3k What evaluations of this initiative are planned or completed?

3l How successful was this initiative in terms of meeting these objectives?

3m Do you have any printed information on this initiative? Yes/No (if yes, specify)

4. Workforce Profile (Interviewer to provide introductory explanation of this part of the interview)

For the following employees, what proportion of their time is allocated specifically to MH care?

<table>
<thead>
<tr>
<th>Staff category</th>
<th>Full time MH</th>
<th>Some allocated mental health time (specify)</th>
<th>No specific allocated MH time</th>
<th>No specific allocated MH time but do provide some MH care within their role (estimate how much time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4a Primary Care Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4b Mental Health Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4c Enrolled nurse RHCA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4d General Practitioner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4e Registered Midwife</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4f Support worker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4g Social worker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4h Counsellor/therapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>4i Nutritionist/dietician</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4j Occupational therapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4k Physiotherapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4l Psychologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4m Language therapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4n Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 5. Workforce Development

#### 5a Does your PHO have a workforce development plan?
- Yes/No

#### 5b Have staff received education and training in mental health care as part of their employment in your PHO?
- Yes/No

In this section I would like to discuss the details with you of any current and planned education, staff development and support your staff working in MH may have received. For each staff member, can you describe firstly the current education, staff development and support they have received. Then we will discuss any education, staff development or support that has been planned for each staff member working in MH.

#### 5c Current/planned

#### 5d Staff category i.e. nurse

- **Type of training**
  - 5e As part of their education programme for registration
    - Yes/No
  - 5f Post registration staff development in mental health in the past 5yrs
    - Yes/No
  - 5g Post graduate education in mental health care (certificate/ diploma)
    - Yes/No
<table>
<thead>
<tr>
<th>5h Other (specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5i Description <em>i.e.</em> funding, length, objectives, content</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

6 What staff development or support has been provided or planned for staff involved in mental health care?

6a Current/planned

6b Staff category *i.e.* nurse

<table>
<thead>
<tr>
<th>Type of support</th>
<th>6c Study leave</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>6d In house staff development programmes</td>
<td>Yes/No</td>
<td></td>
</tr>
<tr>
<td>6e Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7 What are some of the further mental health training needs for your staff?

8 What are the issues or priorities for workforce development for your staff members involved in MH care?

9 Have you experienced any barriers to workforce development for your staff? *i.e.* support and resource requirements, funding, lack or courses/ expertise

10 How do you support your staff to provide culturally responsive services?
1. Current and Planned Mental Health Initiatives

*In this section I would like to discuss with you any current and planned initiatives specifically focused on mental health care that your DHB is currently funding through contracts with PHOs. If we could first discuss any mental health initiatives that you are currently involved with and then move on to any planned initiatives for the future.*

<table>
<thead>
<tr>
<th>1a Does your DHB currently provide or have planned any specific primary MH initiatives?</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a Number Initiative:</td>
<td>1b Current/Planned (circle)</td>
</tr>
<tr>
<td>1d PHO or other provider involved e.g. NGO</td>
<td></td>
</tr>
<tr>
<td>1e Title of initiative</td>
<td></td>
</tr>
<tr>
<td>1f Target group/s i.e. age, ethnicity, health issue</td>
<td></td>
</tr>
<tr>
<td>1h Can you give me a description this initiative?</td>
<td></td>
</tr>
<tr>
<td>1i What are the objectives of this initiative?</td>
<td></td>
</tr>
<tr>
<td>1j What evaluations of this initiative are planned or completed?</td>
<td></td>
</tr>
<tr>
<td>1k How successful was this initiative in meeting these objectives? (Current initiatives only)</td>
<td></td>
</tr>
<tr>
<td>1l Do you have any printed or electronic information on this initiative?</td>
<td>Yes/No (if yes, specify)</td>
</tr>
</tbody>
</table>
Appendix Two

This appendix lists all the initiatives identified by the PHOs and DHBs. A range of information on each initiative is provided (within the limits of data gathered through interviews, documents and other sources).

### Northland Region

<table>
<thead>
<tr>
<th>Initiative Title</th>
<th>DHB/PHOs</th>
<th>Current/Planned</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northland Integrated Regional Model</td>
<td>Northland DHB Whangaroa Health Te Tai Tokerau PHO Tihewa Mauriora Manaia Health Kaipara Care Hokianga Health</td>
<td>Current</td>
<td>An integrated project involving the DHB/PHOs providing a range of mental health services and initiatives. Sufficient flexibility exists within the project for each PHO to adopt a model suitable to their particular needs and population – see below for the PHO level variations in nature and progress.</td>
</tr>
<tr>
<td>Primary Mental Health Coordinator</td>
<td>Whangaroa PHO</td>
<td>Current</td>
<td>0.5 FTE primary mental health coordinator.</td>
</tr>
<tr>
<td>Adolescent Health Services</td>
<td>Whangaroa PHO</td>
<td>Planned</td>
<td>Primary mental health coordinator plans to work with young persons at local schools.</td>
</tr>
<tr>
<td>Service Type</td>
<td>Location</td>
<td>Funding Source</td>
<td>Status</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>----------------</td>
<td>-------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Primary mental health Coordinator &amp; Recreational Therapy</td>
<td>Hauora Hokianga</td>
<td>Part of Ministry of Health funded initiative</td>
<td>Current</td>
</tr>
<tr>
<td>Community Mental Health Services</td>
<td>Hauora Hokianga</td>
<td>Hokianga Health funded</td>
<td>Current</td>
</tr>
<tr>
<td>Community Development Team</td>
<td>Hauora Hokianga</td>
<td>Hokianga Health funded</td>
<td>Current</td>
</tr>
<tr>
<td>Primary Mental Health Coordinators &amp; Relapse Prevention</td>
<td>Te Tai Tokerau</td>
<td>Part of Ministry of Health funded initiative</td>
<td>Current</td>
</tr>
<tr>
<td>Adolescent Health Service</td>
<td>Te Tai Tokerau</td>
<td>SIA funded</td>
<td>Current</td>
</tr>
</tbody>
</table>
| Ministry of Health Funded Initiative | Manaia Health | Current | Five parts:  
1. Two FTE primary mental health coordinators.  
2. Subsidised counselling sessions  
3. Relapse prevention.  
4. IT component.  
5. Workforce development. |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal Methadone Programme</td>
<td>Manaia Health</td>
<td>Current</td>
<td>GPs prescribe a minimal amount of methadone while clients are on waiting list for the methadone maintenance treatment programme.</td>
</tr>
<tr>
<td>SIA funded</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Ministry of Health Funded Initiative | Kaipara Care | Current | Three parts:  
1. One 0.5 FTE primary mental health coordinator.  
2. Subsidised counselling sessions.  
3. IT component. |
| Ministry of Health Funded Initiative | Tihewa Mauriora | Current | Three parts:  
1. Referral and liaison.  
2. Workforce development.  
3. Health promotion. |
| Traditional Maori Healing funded | Tihewa Mauriora | Current | The PHO works with local groups supporting traditional Maori healing and health promotion activities. |
### Waitemata Region

<table>
<thead>
<tr>
<th>Initiative Title</th>
<th>DHB/PHOs</th>
<th>Current/Planned</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Ministry of Health Regional Initiative</td>
<td>Coast to Coast Harbour PHO HealthWEST ProCare North Te Puna Waiora</td>
<td>Planned</td>
<td>Primary options for clients with mild to moderate mental illness. ProCare lead. Currently working on service specifications.</td>
</tr>
<tr>
<td>West Auckland Primary Partnerships</td>
<td>HealthWest</td>
<td>Current</td>
<td>Project to improve the transition of clients from secondary services to primary care. Physical health care of moderate to severe mental health clients.</td>
</tr>
<tr>
<td>School Based Youth Clinics</td>
<td>HealthWest</td>
<td>Current</td>
<td>GP clinic in five low decile schools. Provides personal health and health promotion programmes (including mental health).</td>
</tr>
<tr>
<td>Iwi Support Programme</td>
<td>Te Puna PHO</td>
<td>Current</td>
<td>Programme of iwi support for secondary mental health clients.</td>
</tr>
<tr>
<td>Children, Young Persons and Families Initiative</td>
<td>Te Puna PHO</td>
<td>Current</td>
<td>CYPFS provide services Maori and Asian populations for low socio-economic status.</td>
</tr>
<tr>
<td>ProCare Psychological Services (PPS)</td>
<td>ProCare Network North, Auckland and South</td>
<td>Current</td>
<td>A variety of services providing psychological assistance to individuals, couples and families experiencing difficulties.</td>
</tr>
<tr>
<td>Community Health Services</td>
<td>ProCare Network North, Auckland and South</td>
<td>Current</td>
<td>Help facilitate all initiatives. Includes Maori Programme Service Coordinator and CHS coordinators.</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------------------------------------</td>
<td>---------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>ProCare Network North, Auckland and South</td>
<td>Current</td>
<td>‘Pulse’ publication and marketing team aim to improve health promotion.</td>
</tr>
<tr>
<td>ProCare funded</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘Engage Project’</td>
<td>ProCare Network North, Auckland and South</td>
<td>Current</td>
<td>A package of interventions to improve access and quality of mental health services for high needs groups.</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIA funded</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-Natal Depression</td>
<td>ProCare Network North, Auckland and South</td>
<td>Current</td>
<td>Screening programme targeted at new mothers to identify undetected post-natal depression.</td>
</tr>
<tr>
<td>Screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ProCare funded</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Auckland Region

<table>
<thead>
<tr>
<th>Initiative Title</th>
<th>DHB/PHOs</th>
<th>Current/Planned</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Liaison Service (Strategic Direction)</strong></td>
<td>Auckland DHB</td>
<td>Current</td>
<td>Addresses issues related to the interface between primary health care and specialist mental health care services.</td>
</tr>
<tr>
<td><strong>Project Manager</strong></td>
<td>Tamaki Healthcare</td>
<td>Current</td>
<td>1 FTE project manager will conduct scoping exercise with secondary services and GPs to provide recommendations on the way forward for the PHO.</td>
</tr>
<tr>
<td><strong>Ministry of Health Funded</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Psychological Services</strong></td>
<td>Tamaki Healthcare</td>
<td>Current</td>
<td>1 FTE psychologist provides mental health services to PHO catchment.</td>
</tr>
<tr>
<td><strong>Tamaki funded</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Refugee Service</strong></td>
<td>Tamaki Healthcare</td>
<td>Current</td>
<td>1 FTE social worker provides a range of services to refugee population in PHO area.</td>
</tr>
<tr>
<td><strong>SIA funded</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Training Initiative in Mental Health</strong></td>
<td>Tamaki Healthcare</td>
<td>Current</td>
<td>PHO in conjunction with Manaaki House provide training in mental health for GPs and practice nurses.</td>
</tr>
<tr>
<td><strong>Tamaki/Manaaki House funded</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pilot Early Intervention Scheme</strong></td>
<td>Tikapa Moana</td>
<td>Planned</td>
<td>Psychiatric nurse will be employed for pilot early intervention programme with service users focusing on education. Community awareness also involved.</td>
</tr>
<tr>
<td><strong>ADHB funded</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Alcohol and Drug Service</strong></td>
<td>Tikapa Moana</td>
<td>Current</td>
<td>1 FTE counsellor, 0.2 medical officer, 1 FTE detox nurse, 0.5 dual diagnosis nurse worker provide and detox &amp; dual diagnosis services.</td>
</tr>
<tr>
<td><strong>ADHB funded</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program</td>
<td>Funding Body</td>
<td>Health Provider</td>
<td>Status</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Domestic Violence Service</td>
<td>Tikapa Moana funded</td>
<td>Tikapa Moana</td>
<td>Current</td>
</tr>
<tr>
<td>Extension of SIA ‘Engage Project’ – Mental Health Services</td>
<td>ProCare Network Auckland</td>
<td>ProCare Network Auckland</td>
<td>Current</td>
</tr>
<tr>
<td>‘Back to Action’ Pilot</td>
<td>ProCare Network Auckland</td>
<td>ProCare Network Auckland</td>
<td>Current</td>
</tr>
<tr>
<td>Pacific PHO Co-ordinating Group</td>
<td>Ta Pasefika Tongan Health Society</td>
<td>Ta Pasefika Tongan Health Society</td>
<td>Current – in development</td>
</tr>
<tr>
<td>Co-Location Initiative</td>
<td>Tongan Health Society</td>
<td>Tongan Health Society</td>
<td>Planned</td>
</tr>
<tr>
<td>CCM – Depression module</td>
<td>Tongan Health Society</td>
<td>Tongan Health Society</td>
<td>Planned</td>
</tr>
</tbody>
</table>
### Counties Manukau Region

<table>
<thead>
<tr>
<th>Initiative Title</th>
<th>DHBs/PHOs</th>
<th>Current/Planned</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental Health Services Referral Project</td>
<td>Counties Manukau DHB (and all primary care providers)</td>
<td>Current</td>
<td>Initiative aimed at improving the interface between primary health practices and secondary services</td>
</tr>
<tr>
<td>Planned Physical Health Project</td>
<td>Counties Manukau DHB (and all primary care and NGO providers)</td>
<td>Planned</td>
<td>Will aim to meet the physical needs of people with moderate to severe mental illness.</td>
</tr>
<tr>
<td>Providing Access to Health Solutions</td>
<td>CMDHB</td>
<td>Current</td>
<td>Aims to assist people who receive the Sickness and Invalids Benefit to return to the workforce.</td>
</tr>
<tr>
<td>Mental Health Co-ordinator &amp; Organisational Structures</td>
<td>East Health Services</td>
<td>Current</td>
<td>Two parts: 1. Organisation structure development. 2. 1 FTE mental health coordinator.</td>
</tr>
<tr>
<td>Care Plus</td>
<td>East Health Services</td>
<td></td>
<td>GPs can provide clients with up to 4 subsidised visits under certain criteria - one of which relates to depression</td>
</tr>
<tr>
<td>Depression and the Elderly</td>
<td>East Health Services</td>
<td>Planned</td>
<td>A proposed pilot project to look at how to better care for this age group around depression. At needs analysis stage.</td>
</tr>
<tr>
<td>Initiative</td>
<td>Organization</td>
<td>Stage</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
<td>-------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Child &amp; Adolescent Binge Drinking Initiative</td>
<td>East Health Services</td>
<td>Planned</td>
<td>Project to build better relationships with Police around binge drinking and young people. At needs analysis stage.</td>
</tr>
<tr>
<td>Chronic Care Management – Depression Model</td>
<td>ProCare Network South Te Kupenga o Hoturoa Ta Pasefika</td>
<td>Current</td>
<td>Pilot programme to improve outcomes for people with moderate to severe depression through better and extended management and care, targeted staff training and specialised systems.</td>
</tr>
<tr>
<td>Sickness Benefit and Invalid’s Benefit Programme</td>
<td>ProCare Network South</td>
<td>Current</td>
<td>Programme to assist sickness beneficiaries who are keen to return to paid employment</td>
</tr>
<tr>
<td>Pacific PHO Co-ordinating Group</td>
<td>Ta Pasefika Tongan Health Society AuckPAC Health Trust</td>
<td>Current – in developmental stage</td>
<td>1 FTE project manager. Two parts to the initiative: 1. Train and develop capacity and capability of Pacific primary care workforce. 2. Treat patients for mental health within primary care.</td>
</tr>
<tr>
<td>Alcohol and other Drugs Service</td>
<td>Ta Pasefika</td>
<td>Current</td>
<td>Alcohol and other drug services.</td>
</tr>
<tr>
<td>School Clinics</td>
<td>Ta Pasefika</td>
<td>Current</td>
<td>Utilise school clinics to promote awareness of alcohol and drug issues.</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>Ta Pasefika</td>
<td>Current</td>
<td>Providers are currently using a Pacific version of GHQ (GHQ-9) for depression screening.</td>
</tr>
<tr>
<td>Family Support</td>
<td>Ta Pasefika</td>
<td>Current</td>
<td>Programme that is provided in collaboration with Plunket and has mental health component.</td>
</tr>
<tr>
<td>Mental Health Project Worker</td>
<td>People's Health Care Trust</td>
<td>Current</td>
<td>Project to employ project manager to carry out a range of training, support and relationship initiatives.</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------</td>
<td>--------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>Detoxification Service</td>
<td>People’s Health Care Trust</td>
<td>Current</td>
<td>PHO in collaboration with Auckland City Mission provide detoxification service for alcohol and other drug clients.</td>
</tr>
</tbody>
</table>