NgOIT

Towards Integration

Building an integrated primary mental health and addiction service

NgOIT

NgOIT is the brand used to identify information collection projects that are commission by Platform Trust on behalf of the community non government organisations (NGOs) providing mental health and addiction services in New Zealand. The information collected is shared and used in ways that increase understanding about the critical role community organisations take in the health and wellbeing of our nation.

NgOIT Projects to date

The initial **NgOIT2005 Landscape Survey** represented a national collection of data that provided a snapshot in time about the community organisations contracted by the Crown to provide mental health and addiction services.

The **NgOIT2007 Workforce Survey** further developed the information provided in the Landscape survey and concentrated on the workforce. It described qualifications, age, gender and the types of work people did within their organisations.

The **NgOIT 2008 NGO-DHB Contracting Environment** was produced at the request of community mental health and addiction service providers to draw attention to the contracting environment in New Zealand that stifles innovation.

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Executive summary

Health Workforce New Zealand has released a report that recommends the focus of mental health shift towards primary and integrated care and preventive interventions at both ends of the life-cycle, from children and adolescents through to the elderly. This change should take place within a wider context that includes the adoption of a whole of system, person centric view and family/whānau centred approach to self-care and positive mental well being. The aim is to reach towards the 7- 9% of our population with the highest mental health and addiction needs. The report, Towards the Next Wave of Mental Health and Addiction Services and Capability (2011) also recognises a need to create a supportive environment for a wider population and to improve access to organised mental health and addiction responses.

The direction towards primary mental health care is not new. It is built on a solid base of evidence that tells us that unmet mental health needs are the single greatest contributor to poor health and social outcomes. By providing a mix of supported self care, medication, brief interventions, and navigation to other services, peoples' needs can be met in the least intrusive and non stigmatising settings. These qualities can both increase and improve access to supports and extend the reach of mental health services towards unmet needs.

Non government organisations (NGOs) deliver flexible and cost effective community services. Our strength lies in a deep understanding of the context in which people live their lives and the problems they experience. NGOs are skilled in supporting people to live the best possible life. This means responding to people across their lifespan and collaborating with primary and secondary services and a wide range of social, housing, education and justice agencies.

In 2010 Platform met with leaders from NGO and primary care providers in Auckland, Wellington and Christchurch to talk about the current state of collaboration between primary care and NGOs and how this could be further developed. We discovered that, while there is strong interest in collaboration, in reality our experience is at an early stage. More often than not NGOs have little contact with primary care but they see an opportunity to extend their services to reach people at an earlier stage in their illness. We also found that, while some primary health organisations (PHOs) are interested in developing a relationship with NGOs, they are unsure of how it could work and what could be achieved. Others could not see the advantages of working with NGOs over employing their own primary mental health staff or sub-contracting services on an individual basis. If we are going to achieve a vision of seamless services across life stages significant shifts in the perceptions of key players are required.

We believe that by building on each other's strengths the capacity of NGOs and primary care can be extended leading to improved outcomes for the people living in our communities. This report outlines six key directions that will enable us to progress towards this goal. The directions are to:

1. Change our language and concepts of need
2. Address the barriers to collaboration
3. Focus on navigation and coordination
4. Explore community service options
5. Explore brief intervention options
6. Focus on workforce development

While NGOs and primary care providers can make some progress towards these directions, we can only fully achieve our vision with the support and collaboration of key partners including Health Workforce New Zealand, District Health Boards and the workforce agencies.
We have given some thought to the organisation best placed to lead each of the directions, and look forward to discussing these ideas with our partners in the near future.

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1 Introduction

1.1 Mental health and addictions workforce review

In 2011 Health Workforce New Zealand sponsored a workforce review. This was undertaken by a working group charged with identifying the service configurations, models of care and health workforce requirements through to 2020. Core assumptions behind the review are that by 2020 demand for services will have doubled with only a 40% increase in funding from 2010 levels.

The review recommends a shift towards primary and integrated care and preventive interventions at both ends of the life-cycle. There is a focus on:

- intervening earlier in the life course with at risk families, children and adolescents
- integration across primary and secondary services using stepped care approaches
- working with Child, Youth and Family, Education and Justice to reduce system wide costs
- proactively managing the impact of mental health conditions on older people.

Meeting the challenges will require transformational changes to models of care and a move towards an integrated primary and community based response that leverages off the limited capacity of specialist services (Health Workforce New Zealand 2011). This requires all services to examine their position and to think about where they should be by 2020.

1.2 Community services

Mental health and addiction NGOs support people to live the best possible life in their community of choice. This means responding to people across their lifespan and at different stages in their illness and recovery. It includes collaborating with and working alongside primary and secondary services and a wide range of social, housing, education and justice agencies. It also includes providing (or finding) accommodation, and supporting people to find employment, and to access education and a wide range of community resources (Peters 2010).

NGOs account for one-third of the national mental health and addiction service expenditure (Te Pou o Te Whakaaro Nui 2006). The workforce includes 'expert' peer workers, who are people with lived experience of mental health and addictions. Other workforce groups include support workers, Māori and Pacific cultural workers, navigators/ coordinators and health professionals.

Many NGOs developed alongside the closure of institutions and as result they are aligned with secondary services. Currently access to community services is usually mediated by service coordinators employed by secondary services. This means that the resources held by NGOs are only available to those people with serious mental illnesses engaged with secondary services. NGOs provide invaluable services to this group of people and we need to preserve the gains made in this area. However there is a significant opportunity to make better use of the capacity and capability of community services to support the delivery of primary care interventions and access to a wide range of community resources. This requires primary care to have direct access to community services. It also requires the relationship between community services and the emerging Integrated Family Health Services to be nurtured and developed.

1.3 Better sooner, more convenient care

PHOs support the delivery of essential services to their enrolled population. They bring together doctors, nurses and other health professionals to serve the health needs of their enrolled populations and communities. They vary widely in size and structure, are not-for-profit and provide services either directly by employing staff or through other means such as subcontracting with other providers.

Further development of primary mental health care is part of the Government's policy direction to provide better, sooner and more convenient care, and this is aimed at providing more services closer to home and delivering personalised and service user-centred care. The goal is to reduce the burden of mental health and substance abuse disorders and related physical illnesses on the population (Ministry of Health 2009).

Mental health issues are more common than is generally recognised. Te Rau Hinengaro: the New Zealand Mental Health Survey (Oakley Browne, Wells & Scott 2006) indicates that 47 percent of the New Zealand population will meet the criteria for a mental disorder at some time in their lives, with 39.5 percent having already done so and 20.7 percent having a disorder in the past 12 months.

2 International developments in integrating mental health into primary care

In 2008, the World Health Organization (WHO) and the World Organization for Family Doctors (Wonca) jointly released a report called Integrating mental health into primary care: A global perspective. This report highlights the prevalence of mental disorders and the advantages that access to mental health services bring, and outlines the justification for providing mental health services in primary care.

In addition, many people with mental illness will have other issues that impact on their health and quality of life, such as substance abuse problems, chronic physical illness, long-term unemployment and other forms of social disadvantage. The suffering, disability and economic losses incurred when mental disorders are left untreated are substantial, yet despite the potential for successful treatment of mental disorders, only a small minority of those in need receive even the most basic treatment (WHO and Wonca 2008). WHO and Wonca conclude that:

Integrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental health they need. Primary care for mental health is affordable, and investments can bring important benefits. (WHO and Wonca 2008)

WHO and Wonca take the view that primary mental health works best when it is integrated with and supported by other levels of care. This includes educational, social, housing, employment and other sectors, as these can support people's recovery and full social inclusion and decrease the need for hospitalisation.

3 Coordination, collaboration and integration

3.1 Primary mental health models of care

At present there is no single model of primary mental health care that can be universally applied to services. Instead, effective models for collaboration will comprise tailor-made combinations of structures, processes and techniques to address service user needs and systemic and community circumstances (Kodner 2009).

WHO and Wonca take the position that successful models will be developed through the sensible application of a set of 10 common principles:

1) Policy and plans need to incorporate primary care for mental health.
2) Advocacy is required to shift attitudes and barriers.
3) Adequate training must be provided for primary care workers.
4) Primary care tasks must be limited and doable.
5) Specialist mental health professionals and facilities must provide support to primary care.
6) Patients must have access to essential psychotropic medication in primary care.
7) Integration is a process, not an event.
8) A mental health service coordinator is crucial.
9) Collaboration with other government non-health sectors, non-government organisations, community health workers and volunteers is essential.
10) Financial and human resources are needed. (WHO and Wonca 2008)

To date, primary mental health care developments have largely focused on mental health skill development within primary care and building vertical collaboration between primary care and secondary mental health and addiction services. This appears to reflect a hierarchy of development needs that is seen both nationally and internationally: building links between primary and secondary services takes priority over building links between primary and community services.

3.2 The transition from linking to integrating

'Linkage', 'coordination', 'collaboration' and 'integration' are commonly used terms yet the meanings can vary. The key term used in this paper is 'collaboration', as this encompasses a range of models. Before we examine the various service models it is important to understand the differences. The distinctions used in this paper are based on those developed by Collins, Hewson, Munger & Wade (2010) and Leutz (cited in Kodner 2009).

Linkage is the least-change approach. It entails providers working together on an ad hoc basis within major system constraints (Leutz cited in Kodner 2009). In a New Zealand context, it is centred on primary care having a referral and liaison relationship with secondary mental health and addiction services, with a limited relationship with NGOs and other social care agencies. NGO services are accessed through secondary services for people with moderate to severe mental illnesses. This is the way most of our services are organised now.

Coordination is a structured, inter-organisational response involving defined mechanisms to facilitate communication, information-sharing and collaboration while retaining separate eligibility criteria and service responsibilities (Leutz cited in Kodner, 2009). It occurs when primary care commits to a strategy aimed at improving access and meeting the mental health, addiction and related needs of their community. The primary care team will usually include a coordination function and professionals with mental health knowledge and experience. Functions include providing information, developing funded packages of care and supporting people to access community supports and services including NGOs.

Various functional activities may be integrated, for example, system and management activities. It involves mental health and addiction services working within and as part of the primary care team in the delivery of personalised services through a single care and support plan.

Table 1 below broadly illustrates the differences between linkage, coordination/ collaboration and integration.

Table 1: Categories of collaboration between primary care, secondary care and NGOs

Linkage	Coordination and collaboration	Integration
Referral and liaison relationship with secondary services, with a focus on those with the most severe needs (the 3% defined in the Mental Health Blueprint). Limited knowledge and relationship with NGOs and other social care agencies, but referrals made as opportunity arises. Separate care and support plans. Separate contractual and financial responsibilities.	Focus on people with mental health and addiction problems (the 20% of the population defined in the Blueprint). Primary care team includes a coordinator (or similar function) knowledgeable about secondary services, NGOs and other social care agencies. Packages of care used to provide support services and brief interventions. Separate but aligned care and support plans.	Focus on people with mental health and addiction problems and may extend to a wellbeing approach. Relationship between primary care and NGO is formalised to some degree through, for example, a memorandum of understanding, subcontract or joint contract. A team working together to deliver services – either a virtual team or NGO staff – may be co located within primary care. Single care and support plans.

3.3 Definitions and approaches to integration

Integration is a word used to describe a variety of ways services can work together or collaborate. The Ministry of Health describes this as creating connectivity and alignment within and between services, providers, organisations and sectors and working towards single system, personalised care. From a service user's perspective, integrated care means a seamless experience across the continuum of mental health and addiction services and across both health and social care providers. From a service provision perspective, integration may be about working jointly with other providers to streamline care and improve system efficiency. Both perspectives are important but the key driver for integration should be to improve outcomes from a service user perspective, and this means enhancing a person's wellbeing and health and social outcomes (Hutschemaekers et al 2007).

Horizontal and vertical integration are terms used to describe two different approaches.
The bringing together of professions, services and organisations that operate at similar levels in the care hierarchy is known as horizontal integration. Collaborative working arrangements between primary health care and social services are an example of horizontal integration in direct care delivery. Vertical integration refers to the bringing together of different levels in the hierarchy of care. Both horizontal and vertical integration can achieve person-centred outcomes.

3.4 Applying an integration continuum

A helpful way to consider service models is to look at degrees of integration along a continuum and the mechanisms used at each level. The Ministry of Health has described five levels of integration, and this is based on levels developed by Doherty (cited in Collins et al. 2010). Further adaptations have been made to reflect the relationship between primary care and NGOs. The five levels are as follows:

1. **Minimal collaboration.** Primary health care and mental health, addiction, NGO and other social care providers' work in separate facilities, have separate systems and communicate sporadically. The relationship between primary care and NGOs is through secondary services and is limited to those with severe needs.

2. **Basic collaboration at a distance.** Providers have separate systems at separate sites, but engage in periodic communication about shared service

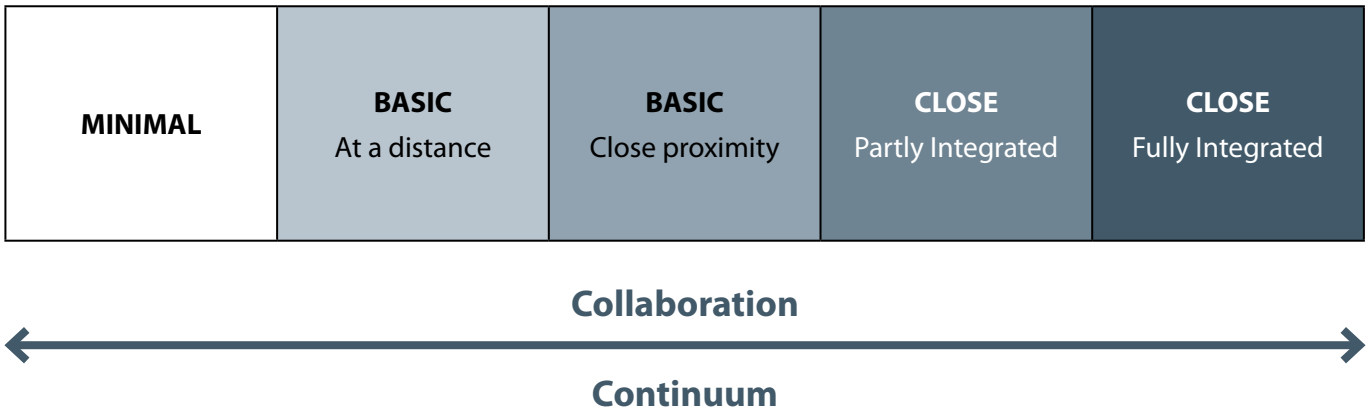
users. Communication is typically driven by specific service user issues. Mental health and other health professionals view each other as resources, but they operate in their own worlds with little sharing of responsibility or understanding of each other's cultures. NGOs have regular communication with primary care, but this is usually limited to people with severe needs.

3. **Basic collaboration at close proximity.** Providers have separate systems but often share the same facility. Proximity allows for more face-to-face communication, but each provider remains in its own professional culture. A designated role such as a primary mental health coordinator may be in place and make referrals to secondary services and NGOs, and funding is available for packages of care for those with mild to moderate needs.

4. **Close collaboration in a partly integrated system.** Providers have some systems in common, such as for scheduling appointments or sharing medical records. There may be regular face-to-face interactions about service users, mutual consultation and a basic understanding and appreciation for each other's roles and cultures. A designated role such as a primary mental health coordinator is probably in place and funding is available for packages of care. The relationship between the primary care and the NGO is formalised into an agreement of some kind. There is a sense of being part of a larger team in which members work together to meet a wider range of service users' needs.

5. **Close collaboration in a fully integrated system.** Providers are part of the same team, sharing the same vision and systems in a seamless web of biopsychosocial services. No special paperwork or processes are required to see the mental health provider. Professionals have developed an in-depth understanding of each other's roles and cultures. Regular collaborative team meetings are held to discuss both service user issues and team collaboration issues. There is sharing of power and responsibility.

The following diagram illustrates the continuum, and it is used in the following sections to show where developments fit on the continuum.



4 Review of New Zealand developments

Over the last 15 years, the development of mental health and addiction services in New Zealand have been guided by various Ministry of Health strategies and the Mental Health Commission's Blueprint for mental health services (1998). Developments have occurred in phases, and this section outlines the progress made through the key phases.

4.1 Looking Forward and the Blueprint

Looking Forward, New Zealand's first coordinated mental health policy, was developed in 1994 (Ministry of Health 1994). It emphasised the need for more services while also signalling a commitment to developing community-based services. Three years later, Moving Forward, the first mental health plan (Ministry of Health 1997), emphasised the need for better services. This was followed in 1998 by the Blueprint, which detailed the service developments required for putting Moving Forward into action.

The Blueprint focused on meeting the needs of people affected most severely by mental illness, while also recognising that a further 20 percent of the population have a diagnosable mental illness or substance related disorder at any one time. The 3 percent of people with serious illnesses, identified by the Blueprint require treatment from specialist mental health or alcohol and drug services, with NGOs now on the continuum of services, particularly for people with ongoing and severe problems and disability support needs.

The Blueprint describes the relationship between primary and secondary services from both a continuum and pathway perspective, with service users accessing the level of service that best matches their level of need. Secondary services are described as having a consultation and liaison role aimed at supporting primary care to deliver on its responsibilities (Mental Health Commission 1998).

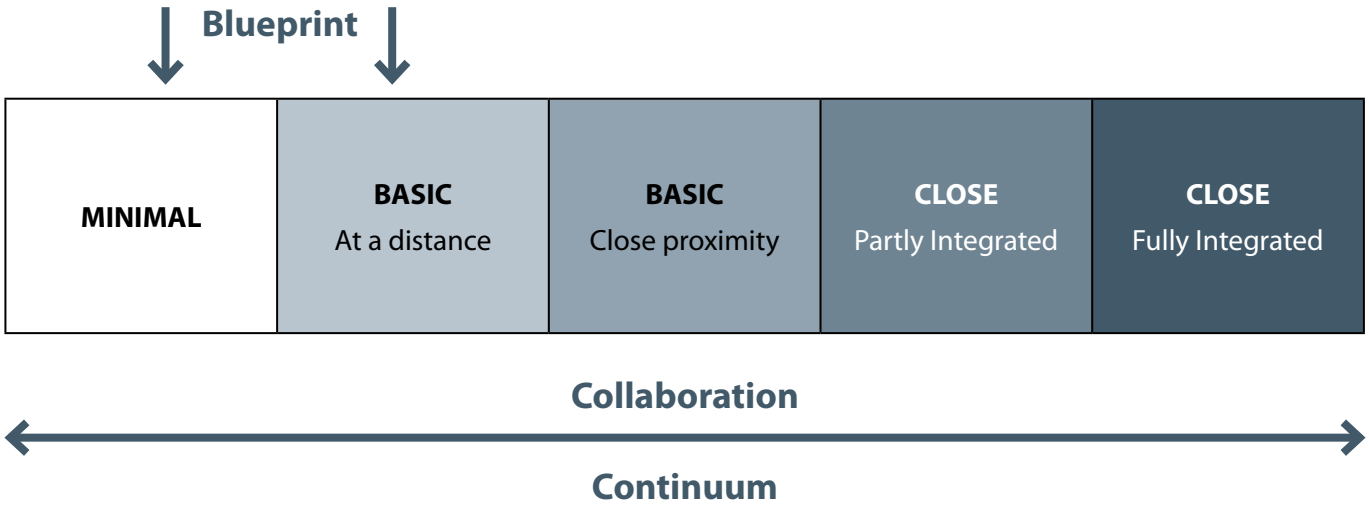
While the Blueprint recognised the need for primary and secondary services to work together, the level of direction was limited, as the Blueprint's main focus was on secondary services. Also, no dedicated funding stream was identified. Pilot projects aimed at building linkages between primary and secondary services were initiated. The focus was on building capacity within primary care to support people with serious mental illnesses and not on shared service delivery. The relationship between primary and secondary services was noted as an area for further development.

4.2 Te Tāhuhu and the Primary Care Strategy

Te Tāhuhu is the second and current mental health plan (Minister of Health 2005). It extends the Government's interest in mental health and addictions to all New Zealanders, with the expectation that all government departments and entities will pursue the objectives.

Te Tāhuhu recognises that the primary health care strategy (Minister of Health 2001) brought about changes in the primary health care sector and that there are opportunities to improve responsiveness to mental health and addiction needs as an integral part of PHOs and to promote wellbeing in every aspect of health care. The immediate emphasis for action is on:

- building the capability of primary health care practitioners to assess the mental health and addiction



needs of people and to meet these when they can best be met within primary health care settings
- building linkages between PHOs and other providers of mental health and addiction services to ensure integration occurs to meet the needs of all people with mental illness and addiction
- strengthening the role of PHOs in communities to promote mental health and wellbeing and prevent mental ill health.

4.3 Primary mental health and NGO initiatives

All PHOs have received funding to establish primary mental health services, which have been targeted at people with mild to moderate mental health and/or substance use disorders. The first group of initiatives received funding from the Ministry of Health and were evaluated by the University of Otago. Information on the second and broader group of initiatives has been gleaned from the primary health care website. These initiatives have been funded either by the Ministry of Health or by District Health Boards.

Primary mental health initiatives

The University of Otago evaluated initiatives developed by PHOs for people with mild to moderate mental health problems. Selected PHOs received funding to establish primary mental health initiatives (PMHI) for those with mild to moderate mental illness, with a focus on Māori, Pacific and low-income populations. In total, 26 programmes were evaluated by the University of Otago, and these were clustered into groups as outlined below, with models 1–4 being most commonly used:

- Model 1 – packages of care with contracted psychological therapies and clinical coordinators with or without social supports or extended GP consults.
- Model 2 – packages of care with contracted psychological therapy providers, non-clinical coordinators and extended GP consults.
- Model 3 – a primary mental health clinician services one or a small number of practices.
- Model 4 – employed talking therapist(s) and GP liaison position.
- Model 5 – multidisciplinary primary mental health team.
- Model 6 – youth mental health/addiction service.
- Model 7 – chronic care management model for depression.
- Model 8 – use of psychiatrist/clinical nurse specialist and screening.
- Model 9 – GP liaison role without a caseload.

Seventeen programmes had either a clinical or a non-clinical coordinator (models 1, 2 and 3) and incorporated, to some degree, a wider and more holistic view of needs, either through referral to community supports and services or with packages of care that may have included social supports such as transport, child care or household maintenance (Dowell et al. 2009). Four programmes had direct relationships with NGOs. These initiatives advanced the level of collaboration between primary care and secondary and NGOs and other social agencies to varying degrees with a focus primarily on referral and coordination rather than shared systems and service delivery.

The evaluation found that the size of improvements for service users did not differ significantly among the models and none "offered an inherently superior value for money or more cost-effective service compared to others" (Dowell et al. 2009). A key finding of the evaluation was that there was a substantial impact on measured outcomes, almost irrespective of type of model or intervention length.

Other NGO and primary care initiatives
The primary mental health care website (http://www.primarymentalhealth.org.nz) provides information about the services available in New Zealand. It has a database of activities and initiatives under development. In 2010, there were 94 initiatives involving approximately 60 PHOs – some of which pre-date the primary mental health initiatives evaluated by the University of Otago.

A search of the database found 18 initiatives of primary care services that involve NGOs to some degree. In most cases, the PHO has a coordinator or other worker with mental health skills and knowledge who makes referrals to NGO services and other supports – akin to models 1, 2 and 3. In 10 of the initiatives PHOs and NGOs have joint responsibility for service delivery to some degree, and in some cases this has been formalised into a contractual and funding relationship.

The information provided by the PHOs on their primary mental health activity was not sufficient on its own to allow an assessment of the degree of the collaboration actually occurring between PHOs and NGOs.

A brief description of these initiatives is outlined in Appendix 1. The list is not exhaustive, as pockets of developments are occurring in various parts of the country.

5 Collaboration at work

This section outlines two case studies that demonstrate different models of collaboration between PHOs and NGOs. They were put together by the agencies responsible for the services.

The case studies are followed by a discussion on the features of integration demonstrated by the case studies.

5.1 Your Choice – HealthWEST Te Puna Manawa

Background

The Your Choice Project was established by HealthWEST PHO in October 2008 with the aims of improving the health and wellbeing for young people (10–24 years of age) with mild to moderate mental health issues, removing barriers and improving access to services. After the PHO configurations, HealthWEST has remained as a primary care community provider and is contracted by Waitemata DHB to provide 459 packages of care per annum.

The programme goal is to provide early intervention services that

- upskill young people to better manage their immediate problems
- increase young people's ability to manage similar problems that may arise in the future
- reduce the chance of problems escalating to more serious levels
- avoid young people being prescribed medication only, by providing therapeutic and youth development interventions.

Most referrals relate to personal and relationship issues, family stressors and low mood or depression. The model of care is for collaborative practice between young people, their family or whānau, schools, GPs, secondary services and NGOs.

Target group and referrals

The contract specifies that the project should aim to reach 30 percent Māori, 15 percent Pacific Island and 55 per cent Pākehā European. From October 2008 to March 2010, of the young people that had completed a care package 35 percent were Māori, 14 percent Pacific Island and 51 percent Pākehā.

Referrals come from a wide range of sources. From October 2008 to March 2010, 46 percent of referrals were from schools, 15 percent were from GPs, 10 percent were from alternative education providers, 10 percent were from Marinoto (the DHB Child and Youth Mental Health Services), 8.5 percent were self-referrals and 10.5 percent were from a mixture of NGOs and other government organisations.

Programme delivery

The Your Choice Project is embedded in the Waitākere Youth Health Clinic, which is a multiagency and multidisciplinary team made up of clinicians from HealthWEST and three secondary DHB services: Child and Family Service, Marinoto and Altered High. Referrals are triaged at the clinic, and once a young person has completed a care package, they are discharged through the clinic.

HealthWEST contracts with various providers experienced in working with youth. The providers are a mixture of psychologists, psychotherapists and counsellors who either work independently or as part of a collective. The contractual agreement clearly outlines the intervention process and states that HealthWEST and providers work together to support the best outcomes for young people receiving the service.

The service ethos is for young people to be centrally involved in decisions about their lives, so they are given choices of providers and package of care options. Once a decision is made, the Your Choice coordinator emails a referral form to the provider, who then contacts the young person directly. The provider and the Your Choice coordinator maintain regular contact via email and phone calls. Where there are concerns, for example the young person's mental health deteriorates and a referral to a secondary service is required or the young person fails to attend appointments, the provider will contact the coordinator for follow-up.

The Your Choice Project has a provider information evening once a year and sends regular emails to all providers with an update on the project.

Evaluation
Young people complete a strengths and difficulties questionnaire (SDQ) on entry to the project and on discharge. Providers complete a global assessment scale on entry and on discharge. Young people also have the opportunity to complete a client survey form at the completion of their care package. Providers complete a discharge summary, which is reported back to the Waitākere Youth Health Clinic triage meeting.

Limitations
A process to manage demand needs to be implemented within the wider sector. There are high numbers of young people requiring support and not enough funded packages. The project's original purpose was to increase access to early intervention and this goal has been successfully achieved.

5.2 HELP 4 U – Waikato Primary Health and Pathways

Background
The HELP 4 U initiative was originally created from the Waikato PHO mental health and addiction plan 2005–2008. The four key goals of the plan are to:

- improve community management and early detection of mental illness and addiction
- address physical health needs
- improve access to primary, community and self-support services
- improve collaboration and communication between health care service providers.

The expected outcomes of addressing the physical needs of those with mental illness or addictions are:

- reduced physical adverse effects of medication for people on psychotropic medication for more than 2 years
- reduced obesity and smoking rates and increased physical activity for those people on psychotropic medication for more than 2 years
- improved oral health for those people on psychotropic medication for more than 2 years.

The programme is funded by Waikato DHB and has the goal of improving access to primary services for high-need populations.

The project is delivered through collaboration between Waikato Primary Health and Pathways Health Ltd, and there is a formal agreement and contract between the two organisations.

Programme description
HELP 4 U is a healthy education and lifestyle programme established in 2006. It is a 20 week programme that includes but is not limited to:

- choices from a menu of healthy lifestyle activities/ educational sessions
- nutrition education
- physical activity options
- social options that lead to healthy lifestyles
- cessation of smoking options
- self-esteem components
- budgeting/shopping education
- motivational counselling
- oral health planning.

Health screening is completed prior to and after the programme, and increasingly, co morbidities are being reported.

Target group and referrals
The target group for the programme is:

- people enrolled with a Hamilton City (Pinnacle) Medical Centre and who have mild to moderate mental illness, or
- people that have been on psychotropic medication for over 2 years.

The contract anticipates that the majority of participants are Māori and Pacific people or people of low socioeconomic status.

Referrals come from a wide range of sources including Hamilton City (Pinnacle) Medical Centres, DHB services, Sport Waikato, self-referrals, NGOs, peer-support services and pharmacies.

Programme delivery
Pathways employ a healthy lifestyle coordinator who oversees the programme. She is supported by the wider

Pathways team and has access to registered health professionals, service and team leaders. In addition, Pathways subcontracts with a dietician who provides nutritional advice, a supermarket tutorial and recipe/cooking advice and a fitness instructor who gives classes such as aqua-jogging. The healthy lifestyle coordinator is also a smoking cessation practitioner.

The healthy lifestyle coordinator's role includes:

- ensuring health screening takes place before and after the programme
- working with individuals and their personal lifestyle plans
- ensuring people can get to programme activities
- liaising with a range of other physical activity providers, Work and Income, dental services, budget advisors, community groups/organisations and smoking cessation providers
- ensuring outcomes are evaluated and reporting is completed.

The programme is designed to provide person-centric services – no two programmes will be the same. Each person is supplied with a personal reflective journal that they work though with the coordinator. Personal lifestyle planning is discussed. The goal is to support the person in finding activities in their own community that they are interested in participating in, and to have specific, measurable, and achievable goals with timeframes. This also ensures that the person's goals can be clearly communicated to the primary care team.

Evaluation

The Camberwell assessment of need and the Rosenberg self-esteem scale are used to measure outcomes. These scales allow the coordinator to assist each individual with their personal lifestyle plans and to assess the positive effect of the programme. An individual's lifestyle goals are recorded at pre-screening, and achievements are reported on at the end of the programme. In addition to this, the HELP 4 U programme has a satisfaction survey that is offered to all participants.

Limitations

The capacity of the programme is limited in the number of participants it can accommodate. To date, resource levels have been adequate, but as interest in the programme has grown, the service now has a waiting list.

All effort is made to introduce participants to local activities, but where activities are further away from a person's home, public transport can be an access barrier and staff at times need to provide some transport.

5.3 Discussion

Both case studies aim to meet the early intervention and the wider wellbeing needs of the service users. A range of systems and methods are used to create connectivity between primary care and NGOs to achieve the delivery of personalised services. Both programmes have a coordination role. With Your Choice the coordinator is part of the primary care team and there is a focus on clinical outcomes and seamless service delivery. With Help 2 U the coordinator is part of an NGO and the focus is on lifestyle planning and supporting service users to access a wide range of community services and achieve sustainable self-care.

Your Choice is an example of vertical integration. The model involves primary, secondary and specialist services working together to provide personalised care, and these services are at different levels in the care hierarchy.

Your Choice has the explicit aim of avoiding young people falling through the cracks between services. The Your Choice team and Waitemata DHB's child and youth services jointly triage referrals and monitor progress and outcomes. This allows young people to move seamlessly between primary and secondary care – reducing fragmentation is a key aim of integrated service delivery.

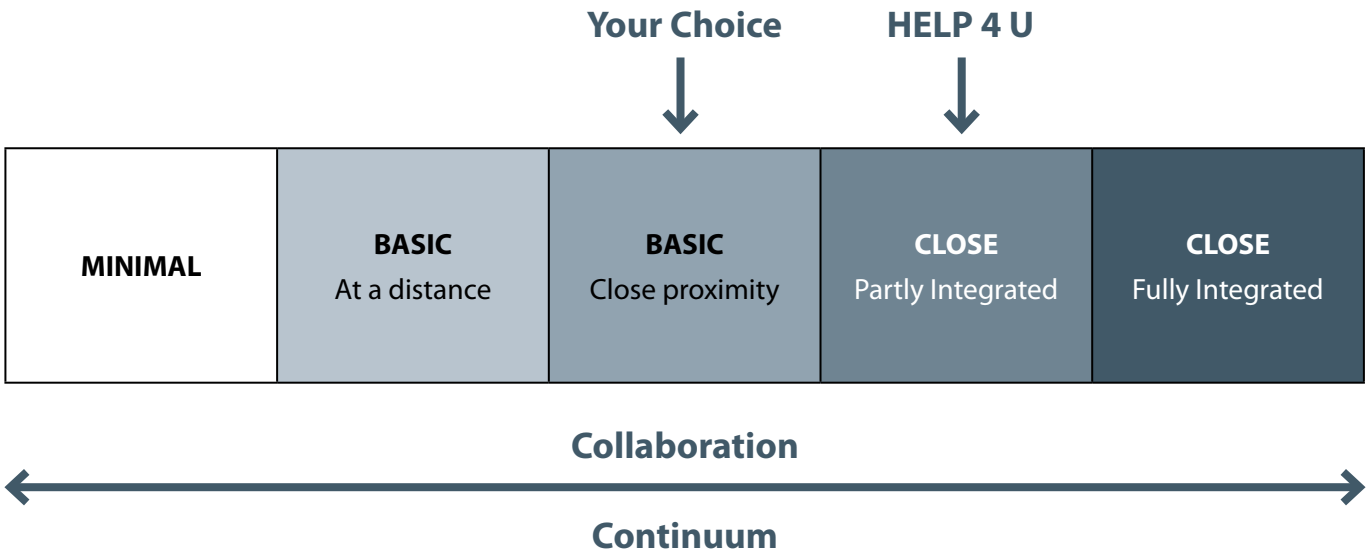
HealthWEST employs clinical staff with mental health experience into the Your Choice team, and they are responsible for assessing needs, developing care plans, and liaison and coordination.

HealthWEST also contracts with a range of providers to deliver components of packages of care on a referral basis. The providers are not required to adapt their services, although they are selected because of their experience in working with youth, and they are specialists to some degree. The providers are not privy to care plans but deliver services as specified by the Your Choice team. The actual relationship between HealthWEST and the providers is limited and the key integration tools are the referral process and contractual relationships.

Waikato Primary Health contracts with Pathways to deliver a healthy education and lifestyle service on its behalf. In this case Pathways is an extension of a primary care service so the model is an example of horizontal integration. Generally the service users are not engaged with secondary services, and the programme aims to prevent the onset of serious mental illnesses and other health problems. As a brief intervention programme the focus is on wellbeing and promoting self-care with support from primary care.

HELP 4 U includes a new role for Pathways. The healthy lifestyles coordinator's skill set is orientated towards primary care and includes smoking cessation, goal setting with a focus on wellbeing, and linking with a wide range of community services. To ensure flexibility and responsiveness to personal needs, Pathways also sub-contracts with a range of other health and wellbeing providers.

The following diagram gives an indication of where Your Choice and HELP 4 U sit on the collaboration continuum. With Your Choice the services are not co-located but a proximity effect is achieved through joint meetings and integrated systems.



6 Key directions for shifting the balance and building integration

In 2010 Platform met with leaders from NGO and primary care providers in Auckland, Wellington and Christchurch. In Wellington and Auckland links were made with existing network meetings to ensure that a cross-section of groups could attend. In Christchurch, Pegasus Health hosted a workshop specifically for this project. In total, 46 people participated in the workshops. The list of participants is in appendix 2.

The purpose of the workshops was to talk about the current state of collaboration between primary care and NGOs and how this could be further developed. The key directions are based on the themes identified at the workshops. They provide direction on how we can shift the balance to further develop a mental health and wellbeing approach to primary and community services. Where possible, the group or groups most able to lead developments are identified.

6.1 Change our language and concepts of need

There are issues with the language we use to describe the population that would benefit from mental health and addiction interventions. References to the wider sector incorporate the terms 'mental health' and 'addiction' separately and fail to acknowledge the large number of people with co-existing problems . Currently, service users are grouped into those with mild, moderate and severe needs. Such terminology perpetuates the silo between primary and secondary services – usually people with mild needs are expected to be treated by primary care and those with more serious needs treated by secondary services. Generally, and by association with current service models, the terms we use to describe needs are exclusionary and work against the delivery of personalised and integrated responses to needs.

Health Workforce New Zealand, WHO and Wonca, and the Mental Health Commission have all recognised the links between mental health and a wide range of education, social, housing, employment and other needs. These needs can contribute to or increase a person's vulnerability to poor mental health. Our future focus should be on concepts of mental health and wellbeing that are relevant to everyone. This should be reflected in plans developed by the Ministry of Health and the Mental Health Commission. For their part, NGOs can form partnerships and alliances with primary care and a range of other social agencies.

6.2 Address the barriers to collaboration

As already noted, the development of many NGOs in New Zealand is linked to the closure of large institutions. Many NGOs are aligned with secondary services and this is reflected in contracts and service specifications where the eligibility criteria and structures that support the service silos are enforced. Access to community services is usually mediated by DHB service coordinators and typically a person with the mental illness must have a 'care manager'. Once the person is discharged from secondary services they will lose access to community services. Equally, once they are in the community they do not have easy access back to the secondary services they may need on an intermittent basis. This means that the resources held by NGOs are only available to those people with serious mental illnesses engaged with secondary services.

The development of primary mental health requires the Ministry of Health and District Health Boards to take the lead and examine current contractual requirements and systems. This is necessary to enable some of the resources and skills within NGOs to be 'liberated' from a secondary service context and made available through primary care. This may not involve increasing the investment into NGO services in the initial stages as the focus is on leveraging existing capacity and value for money gains.

6.3 Focus on navigation and coordination

Regardless of which service a person experiencing a mental illness approaches, they should be able to find their way to the service most appropriate to their needs. We believe that any door should be the right door and coordination has an important role in achieving this. It is also pivotal to the delivery of personalised care.

Key coordination roles relate to facilitating

communication, information-sharing and collaboration between services and developing funded packages of care. The Primary Mental Health Initiative programmes recognised the importance of coordination and 17 of these programmes had either a clinical or a non-clinical coordinator, with the majority employed by PHOs.

NGOs work alongside people to navigate and coordinate their access to a wide range of community resources as well as a wide range of social, income support, housing, education and employment agencies. This is a core competency for a community service and the role is complementary to both primary and secondary care services.

Clarify coordination and navigation roles

Currently there are different types of coordination and this can be confusing. The ongoing scope and relationship between these roles requires consideration. Across PHOs there are a number of clinical and non-clinical coordination roles. There is a close relationship between non-clinical coordination and the navigation services provided by NGOs. For the future PHOs may be best placed to provide clinical coordination while NGOs focus on supporting and navigating access to community resources and services.

DHBs also provide needs assessment and service coordination (NASC). Referrals to NASC are made by secondary community mental health services and inpatient mental health and addiction services. The aim is to facilitate access to a range of community-based supports and services. Referrals are triaged to enable access to respite and other community options and assist with timely discharges from acute inpatient services. However a disadvantage of service coordination being part of a DHB is that it supports a focus on secondary services. The development of primary mental health raises questions about the future role of NASC services as they are currently configured.

Take a streamlined and collaborative approach to development

More thought on the purpose of and relationship between coordination and navigation services is required. Without this there is risk that these functions are duplicated across primary, secondary and community services. There is also a risk that the workforce investment is duplicated and not cost-effective. With so many 'fingers in the pie' the need for a streamlined and collaborative approach to planning and development is apparent. In our view, Health Workforce New Zealand is in the best position to lead this work as it has the umbrella view. It is also well-placed to identify the linkages with other sectors, including aged care and disability services. This work should be done in collaboration with the key groups involved in coordination and these are NGOs, DHBs and primary care.

6.4 Explore community service options

NGOs are exploring what types of services are suitable for delivery through and alongside primary care. The focus has been on the 'non-health' elements of well-being and recovery such as having a secure home, a job, a sense of hope and a plan for self care. To date the types of services delivered by NGOs include:

- navigation
- healthy lifestyle and wellbeing services
- education programmes,
- peer support programmes and
- housing, access and support
- employment support

Contracts between PHOs and NGOs are in place and services are usually funded on a fee-for-service basis as part of packages of care. This type of arrangement is useful during the early stages of service development as it allows models to be tested and adjusted. It does, however, have its limitations including preventing community services from addressing all of the 'non-health' elements of mental well-being. More research on successful community service models and outcomes is required. This should examine the current service models as well and take a fresh look at how community services can complement primary care. Such research will also usefully inform further workforce planning and development.

6.5 Explore brief intervention options

NGOs can work in collaboration with PHOs to co-ordinate access to clinical services and packages of care as illustrated in the Auckland based Your Choice programme profiled in this report. A brief series of talking therapies are a common component of packages of care in primary care which NGOs could provide or contract providers to deliver. Te Pou has developed a suite of talking therapy resources focused on developing the therapeutic relationship with service users from a range of different cultural backgrounds that will be useful for people working in NGOs.

6.6 Focus on workforce development

While NGOs have a very skilled workforce, some of the skills required for primary mental health are different from those required for traditional secondary-care orientated services. There is also a recognised need to develop the highly valued peer support workforce.

Platform has partnered with Careerforce to develop skill strategies for the mental health and addiction support workforce through to 2015. The strategies recommend:

- developing primary care skills
- developing the peer support workforce
- developing skills for working with people with co-existing (mental health and addictions) disorders across the support workforce
- developing skills for working with older people with mental health needs across the support workforce
- developing skills for working with children and young people and their families

There is a growing need for strategies that will develop additional skills within NGOs. These skills may also be applicable to parts of the primary care and secondary service workforces. The skills include:

- navigation and coordination
- brief interventions

Te Pou works to support and develop the mental health, addiction and disability workforces in New Zealand. Resources such as the Knowing the People Planning tool can assist NGO's effectiveness when working in primary settings by providing a mechanism to develop individualised treatment/recovery plans that could identify employment and housing issues.

[3]Careerforce is the Industry Training Organisation for the mental health and addictions support workforce. Careerforce administers the National Mental Health Support Workers Grant on behalf of the Ministry of Health. This grant is available for either the National Certificate in Mental Health and Addiction Support (level 4) or National Diploma in Mental Health Support Work (level 6).

Appendix 1: Joint PHO and NGO initiatives

Initiative	PMHI model (where relevant)[4]	Brief description
Eastern Bay of Plenty PHO and Pou Whakaaro (NGO)	Not applicable	Available to youth (aged 13–24) with mild to moderate mental health issues. Pou Whakaaro provides youth services in both Whakatāne and Kawerau, and these include brief interventions to support the development of young people with stress, anxiety or drug- or alcohol-related health concerns. Complements Voyagers, a secondary service for youth with severe needs.
Health Rotorua PHO and Te Rūnanga o Ngāti Pikiao Trust (NGO)	Model 1	Available to all age groups and those with a mild to moderate mental health condition experiencing significant emotional distress that impairs their normal functioning. The PHO has a mental health coordinator and clinical leader and subcontracts with Te Rūnanga o Ngāti Pikiao Trust, an iwi-based NGO that provides a range of health, education and social services in the Rotorua district.
HealthWEST Lifestyle Option and Your Choice programme and range of NGOs	Model 2	Available to adults 18 years and over with mild to moderate mental health needs. Focus on early intervention with mental health and addictions and lifestyle issues including exercise, smoking, alcohol, drugs, gambling, depression, anxiety, abuse, anger and, sleep. Funding and agreements with NGOs to provide services on request.
Pinnacle Incorporated (Peak Health PHO) and Manaaki Oranga (NGO)	Model 1	Available to adults 18 years and over with mild to moderate mental health needs. Service is provided across three PHOs with Manaaki Oranga responsible for supporting both service users and the general practices. Coordinators are based at Manaaki Oranga.
Aoraki PHO and South Link Health	Not applicable	Available to adults 18 years and over with mild to moderate mental health needs. This is a brief intervention service delivered by South Link Health, an IPA. The South Link Health team works closely with general practice teams and are seen as an extension of the general practice – the mental health specialists within the practice.
Tararua PHO Inner Strength programme and Tararua Community Youth Service (NGO)	Not applicable	Available to youth and adults with addiction and mild to moderate mental health issues. Tararua Community Youth Service provides a worker.

[4]Where the initiative was evaluated by the University of Otago, the type of model used for service delivery (as outlined in section 4.3.1) is indicated.

Initiative	PMHI model (where relevant)[4]	Brief description
Total Healthcare Ōtara (PHO) CCM depression and Connect programmes with Ōtara Health Inc (NGO)	Model 7	Available to adults who meet the depression-related criteria. Packages of care and social supports are provided. Ōtara Health Inc is a not-for-profit organisation delivering health promotion, community development and health education programmes Other partners are ProCare Psychological Service and East Tāmaki Healthcare Ltd.
Waikato Primary Health Help4U (PHO) and Pathways (NGO)	Not applicable	Available to adults with mild to moderate mental health needs or people who have been on psychotropic medication for 2 years or more. Pathways is contracted to deliver this service. Each participant completes a healthy lifestyle programme that includes healthy eating education, physical activity options, smoking cessation, oral health, budget management and motivational counselling. In addition, clients are encouraged to undertake the usual health interventions available from their general practice.
Waikato Primary Health (PHO) Te Hikoi o Nga Tane and Pai Ake (NGO)	Not applicable	Available to men aged 18 years and over with mental health and addiction needs. The aim is to influence health outcomes for Māori men and rangatahi, particularly in the area of healthy lifestyles. The focus is on enhancing total wellbeing within the context of whānau ora. Pai Ake delivers Te Hikoi o Nga Tane, a 15-week programme that includes education, skill development and peer support.
Waikato Primary Health (PHO) Whanake and Pai Ake (NGO)	Not applicable	Available to youth aged 12–17 years with mental health and addiction needs. Pai Ake delivers Whanake, a 10-week group-based programme that focuses on physical, mental and social wellbeing. It is a flexible strength-based programme promoting whanaungatanga as a model of wellbeing.

Appendix 2: Participants

The following is a list of people who participated in the workshops:

Michelle Clayton – WATCS
Lesley Gamlen – TRANX
Marica Read – Phobic Trust
Robert Coats – Arataki Ministries
Lorna Murray – Connect SR
Rodger Jack – Mind and Body Consultants
Naomi Cowan – EQUIP
Bernadette Brewer – Toi Ora Live Arts Trust
Gary Sutcliffe – Auckland Regional Consumer Network
Erwin van Asbeck – Toi Ora Live Arts Trust
Denise Whitfield – Te Pou
Clive Plucknett – Challenge
Cynthia Orme – Problem Gambling Foundation
David Basham – WISH Trust
Sally Pitts-Brown – Blueprint for Learning
Taone O'Regan – Atareira
Barbara Symonds – M.A.S.H Inc
Lynnette Knox – Care NZ
Berni Marra – Capital PHO
Murray Trenberth – WellTrust
Tina Bennett – Inner City Project
Peter Barnett – Newtown Union Health Service
Michelle Glenny – Pathways
Carol Searle – MASH Trust
Jane Watt – MASH Trust
Merryn Kitto – MASH Trust
Sarah Dwyer – Ministry of Health
Sarah Eames – Valley PHO
Rachel Cooper – Wellink Trust
Angela Crawford – Q-nique Ltd
Alan MacDonald – Sir Charles Burns Trust
Gary Platz – Wellink Trust
Jeff Thomas – Wellington Refugees as Survivors
Wendy Risdon – Canterbury University
Helen Telford – Richmond New Zealand
Robyn Craw – Pathways
Sandy McLean – Canterbury DHB
Kay Fletcher – Comcare
David Kerr – Pegasus Health
Cerina Altenburg – Pegasus Health
Paul Rout – ADANZ
Glen Dodson – Stepping Stone
Jane Cartwright – Partnership Health
Stephen Lavery – Pegasus Health
Helen Johnson – Christchurch PHO
Paul Wynands – Rural Canterbury PHO

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