

TOOLKIT FOR PRIMARY MENTAL HEALTH CARE DEVELOPMENT

03/0201/2009

A TRANSLATIONAL RESEARCH PROJECT TO HELP SHAPE THE FUTURE OF PRIMARY MENTAL HEALTH

A DHBNZ/HRC research grant has been awarded to a partnership of the University of Otago Wellington and Synergia for an 18 month research programme to develop and translate existing evidence based practice into a sustainable framework for primary mental health care. This will build on, and strengthen, existing capacities and capabilities.

The overall aim is to support Primary Mental Health Care implementation in a range of New Zealand settings by producing a series of best practice toolkits to facilitate service design, clinical practice and supporting infrastructure.

To achieve this, the research is built around active partnership between DHBs, PHOs, practices and community organisations across four districts.

The research has a strong emphasis on knowledge development and knowledge transfer, with an explicit goal to develop frameworks in collaboration with DHBs, PHOs and community organisations in order to ensure that the research outcomes are useful at both national and regional levels.

WHO IS DOING THE RESEARCH?

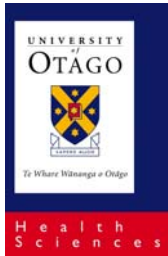
The research is being undertaken by a partnership that combines the University of Otago's knowledge and research capability in primary mental health with Synergia's sector experience in primary health service design and implementation.

Dr Sunny Collings and Professor Tony Dowell are leading the programme from the University Of Otago Wellington. Familiar to many in the sector through the MaGPIe research group and more recently in the evaluation of the primary mental health pilots, Sunny and Tony bring a wealth of clinical and service knowledge to the research.

Philip Gandar and David Rees are leading Synergia's contribution to the research, employing their innovative use of systems based approaches to the design and development of health services with the Ministry, DHBs and PHOs.

WHAT DO WE NEED FROM COLLABORATIVE RESEARCH PARTNERS?

The main expectation from the research team is that each partner in the research is committed to an active collaborative process of review, design and planning for primary mental health services from family and community support through to primary and specialist services.



It is also essential that each partner builds on its own existing primary mental health networks, embracing the research as an opportunity to develop its own capability.

We anticipate that collaboration partners would desire and seek an active role within an Expert Advisory Group through the nomination of a person who could both represent the interests of the locality as well as contribute specialist expertise to the overall development of the research programme.

We also anticipate that for each contributing research partner a multidisciplinary, cross-organisation project team would be formed at the local level, and that this team would contribute their knowledge, relationships, data and insights into the system modelling and framework development.

BENEFITS OF PARTICIPATION

We anticipate the following benefits from participation:

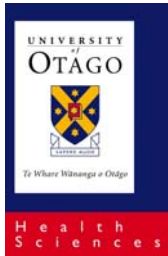
- The opportunity to develop a systemic approach to primary mental health care in each locality, drawing on evidence, experience and practice. The modelling approach that underpins this research would enable each district to use their population data, service and resource patterns to test alternative models of care and support configurations and understand the impact of these different models on the health outcomes for their population.
- Enhanced communication between local stakeholders across the continuum of care, including community, NGO services, specialist primary providers, primary and secondary care. Our experience with this approach is that this dialogue is key to the adoption and implementation of any significant change within any complex system.
- The opportunity to accelerate learning from participation in the research process, through the engagement with the interim research findings and analysis.
- The generation of insights, methods and tools that are transferable from this programme to other domains or to more detailed service design.
- Capability development for key people involved in each local project.

FIRST STEPS

Our aim is to involve partners as early as possible in the design and direction of the research with a workshop to be held in late February 2009.

The workshop would:

- Build a common understanding of what we mean by integration of mental health care within a primary health care setting
- Introduce the systems modelling method
- Refine the purpose and focus of the research using local partners' contributions to define the important issues, opportunities and constraints
- Create a working draft model of the attributes and functions of an effective and sustainable primary mental health system



To make this work, we expect that each local partner will have a process of engagement within their existing primary mental health networks in order to establish commitment, support and understanding of the process.

Please let the research team know what support you may need to make this process work for you.

WANT TO KNOW MORE?

A summary of the preliminary research design is attached as an appendix to this document or please contact the research leaders below.

CONTACT DETAILS

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APPENDIX 1: PRELIMINARY RESEARCH DESIGN

The research design involves three phases of activity over 18 months commencing at the beginning of 2009.

The diagram below illustrates the key elements and processes in plan.

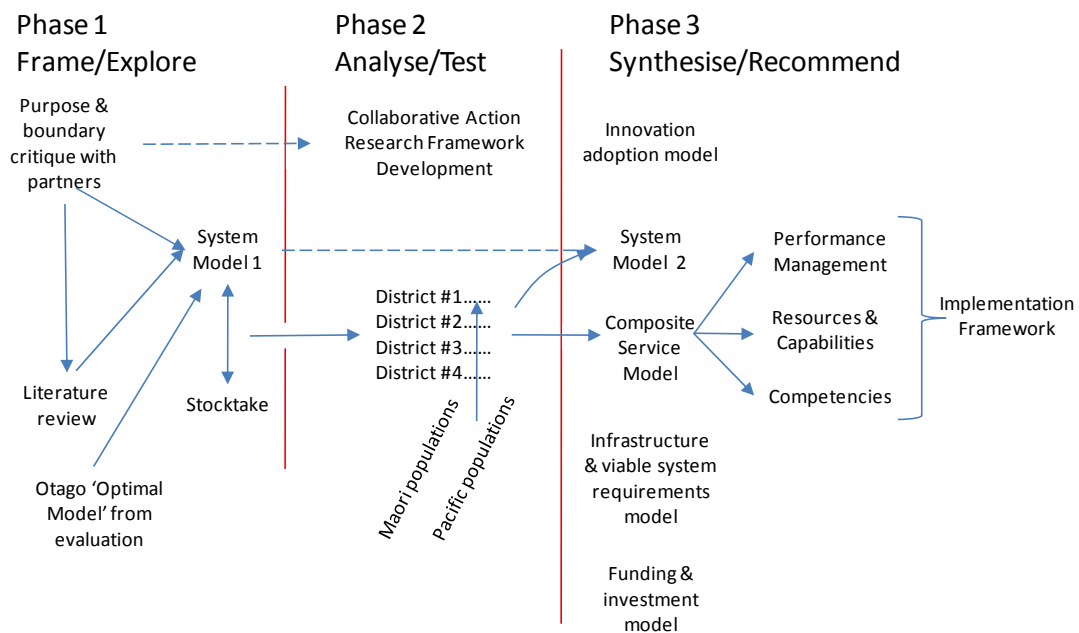


Figure 1: Project plan

The important features of **Phase 1** are:

1. the early engagement of partners from districts in a process of exploration of the initial research questions, issues and assumptions through a process of purpose and boundary critique
2. the close involvement of partners in production of a 'working system model' (System Model 1a), via their reflection on and critique of existing information (stocktake, Otago optimal model¹, relevant literature)
3. a review of existing primary mental health services against the 'System Model 1a' structure
4. the synthesis of information from all these sources into progressive iterations of Systems Model 1a to address implementation and sustainability issues in different contexts
5. translation of the resulting concept models into an exploratory computer simulation model(s)² elaborating the theories behind key interventions, expected service requirements and likely impact on

¹ At present the final report which contains this model is under consideration by the Ministry Health. The Otago Optimal Model will be used as the first prototype model for this project.

² A computable simulation model using the Systems Dynamics method facilitates the translation of the service and clinical model into a visual representation of implied effects on population flows, service utilisation and

the mental health needs of NZ population. This will allow testing and validation of key assumptions of service design and effectiveness, highlighting particular issues to be tested in phase 2

6. further testing of this model, subjecting it to detailed comparison with the actual structures and processes (both organisational and clinical) in a small number purposefully selected 'archetypal' examples selected from PHOs, Maori providers and NGOs
7. a refined and more robust (i.e. transferable) version of System Model 1 that can be tested in Phase 2

Phase 2 represents the major Participative Action Research (PAR) component of the project based on partnerships with four geographical districts that reflect the diversity of New Zealand's PMH context. Each partner district will participate in the following PAR process:

1. Within each district we will utilise existing clinical and service networks as the nucleus of 'coalition' representing key actors in the system including DHBs, PHOs, primary care practices, PMH support services, Maori providers and community organisations.
2. Understanding the context of each area will be important to informing a collective view of the way each area has developed its approach to PMH as well as its capacity to support adoption and diffusion of learning. Processes to support the development of this understanding include collection of 'hard' data on population and service levels drawn from local and national information sources as well as 'softer' information based on collective narrative views on how PMH has evolved in an area. This is the 'diagnostic' step of Phase 2.
3. The next step in this phase is 'theory building'. This is a method of systematic enquiry to develop partners' understanding of their area's existing characteristics and context compared to 'System Model 1'. This will inform the 'content' of the model, for example, the clinical and service elements and the 'system infrastructure'. This step will utilize frameworks from the field of organizational design, including systems theory,⁴ innovation assessment frameworks, and other work focused on the adoption of innovations in health care systems.
4. The 'test' component of this phase will be facilitated through use of Model 1 adapted to incorporate districts' self-generated theories and data on local population, services and resources, and the detailed content knowledge of PMH generated from Collins and Dowell's previous research in PMH. Using system simulation software, district partners will be able to explore reconfiguring their system through an iterative process of reflection, theory building and testing against Model 1 descriptions of system functions. This will aim to accelerate learning about what to implement and how, by allowing district partners to simulate and test many more plans and alternatives than would be achievable in reality or the time available. A smaller number of identified critical changes can thus be identified and tested in practice.
5. For each partner's district, selected real world tests of specific changes and the challenges in developing and implementing 'Model 1' will be cycled back through the diagnostic and theory building stages delineated above, in an effort to catalyse practical learning cycles.
6. Transmission of learning across area partners will be facilitated in order to accelerate development of practical tools, resources and capabilities, so that each partner can fully internalize benefits from the collective experience.

expected benefits. The model can incorporate clinical evidence as parameters. It enables scenario analysis of different models of care, levels of impact, service configurations and capacity investments.

7. The final products of Phase 2 are (i) a case-based description of the results of each partner's learning, (ii) a synthesis of the implications of 'Model 1's teaching and (iii) a collection of models, tools, resources, practice and service guides that will serve as input to Phase 3.

Phase 3 is the stage of synthesis and formulation of recommendations attuned to the wider range of national, regional and local contexts. Figure 1 on page 6 covers five components:

1. An innovation adoption model. This will contribute to the wider body of knowledge about how to support building awareness, trial, adoption and adaptation of innovations in health systems. It will be a contribution to national level policy and support system thinking and create the larger context for the PMH implementation Framework.
2. The framework itself will be constructed around 'System Model 2' – the refined and distilled version of Model 1 that incorporates lessons from each district partner together with insights developed in the research team and in consultation with wider stakeholders. It would represent the third stage of update of the 'Otago Optimal Model' that is contained in the current report together with the systems based modelling developed in this project.
3. The 'composite service model' – a service oriented translation of the system model, representing the practical clinical and service tools, guides and descriptions that support the implementation of 'System Model 2' in a variety of different organisational contexts. This 'tool-kit' would form the external face of the implementation framework for providers and practitioners.
4. Infrastructure and viable system requirements model – this describes the organisational and inter-organisational 'service network' infrastructure and support systems required for the PMH model to be effective and sustainable. This is targeted towards primarily towards PHOs and DHBs although it is also likely to have regional and national implications.
5. A funding and investment model – specifically directed towards DHB Funding and Planning. This is built off the population/clinical 'System Model 2' described above that includes population level demand modelling, options for service response planning, service utilisation scenarios and implications for programme funding and infrastructure requirements. The final product of Phase 3 includes deliverables and peer-reviewed publications from each of the above components together with an active communication/dissemination process.