Mental Health Brief Intervention: Does It Work?

An Evaluation of Practice

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Abstract

Research tells us 20% of the population has a mental disorder at any one time. Of these people 3% are seen in the publically funded mental health services leaving 17% in Primary Health. Services are now being established in New Zealand to meet the needs of those with a mild to moderate mental disorder.

The South Canterbury Mental Health Brief Intervention Service (MHBIS) is a South Canterbury District Health Board initiative contracted to South Link Health to provide a service to General Practices to assist them manage the mental health needs of patients. MHBIS started in 2005 and provides up to four sessions for patients attending one of the 28 General Practices in the South Canterbury region.

This study has two main hypotheses. Firstly, that Mental Health Brief Intervention does improve the mental health status of patients attending General Practitioners. Secondly, that the Mental Health Brief Intervention Service enhances the interface between Primary Care Health Services and Secondary Mental Health Services (SMHS).

The main aims of the study were to ascertain the General Practitioner (GP), Practice Nurse (PN) and MHBIS Clinician perspectives of the MHBIS in regard to outcomes for patients and to determine if there has been a reduction in the need to refer patients into Secondary Mental Health Services.

The study sought to determine the group of patients who benefited most from the MHBIS and those who benefited least. The study determines how decisions by GPs and PNs to refer to MHBIS are made and looks at the benefits of a General Practice team approach, with the General Practitioner being the initial point of contact.

A mixed methods approach using questionnaires and focus groups for GPs, PNs and MHBIS Clinicians was employed. Results from patient surveys and patient outcome Kessler scores were also included in the analysis.
The results of this study confirmed the general impression that by removing barriers to receiving care and by providing earlier treatment MHBIS does improve outcomes for patients suffering from depression. Attending MHBIS also appears to reduce both the need for medication and the need for General Practice referrals to SMHS.

The findings indicated that people with anxiety and depressive disorders, grief and relationship issues benefited most by attending MHBIS.
Preface

Depression and anxiety disorders impact not only on the individuals but also on their families/whanau, relationships and in the workplace. Studies show that these disorders often emerge in adolescence and many years can elapse before treatment is sought (Oakley- Brown et al, 2006).

Stressful life events can cause distress affecting a persons ability to function well and make good decisions. If stress is ongoing it can lead to depression. Thus early detection and treatment of psychological conditions can have a major impact on peoples’ lives. General Practitioners (GPs) are in a pivotal position to assess for mental disorders, or psychological distress and can assist people access appropriate treatment. Until recently access and cost have been barriers to getting help. GPs have often been reluctant to discuss mental health issues as there has been no easy pathway for referral for help. Furthermore, GPs are limited in time and resources to do more than prescribe medication and provide follow up appointments.

The South Canterbury Mental Health Brief Intervention Service (MHBIS) provides a free, accessible service of up to four sessions for people with a mild to moderate mental disorder, thus opening the door for earlier intervention and treatment. MHBIS has greatly assisted General Practices in the treatment of people with mild to moderate mental health disorders. The service also assists in reducing the amount of psychotropic medicine being prescribed by providing a pathway for people with social and other issues impacting on their mental health to be referred for alternative treatment. Thus, only where necessary, they are referred to Secondary Mental Health Services (SMHS). In this way the longer term impact of MHBIS may in time reduce the burden of mental illness not only on individuals but also on health services and the community.

I am employed as a Mental Health Clinician within the MHBIS. My professional background is as a Social Worker. I am aware that there has been some evaluation of the MHBIS involving feedback surveys from patients and outcome measurements. As a
Clinician and Researcher it is of interest to me as to how MHBIS has assisted General Practices and whether there has been a reduction in the need to refer to SMHS.
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Chapter One

Introduction

Mental disorders make up five of the leading causes of disability worldwide (World Health Organization, 2001). As understanding develops about the level of unmet need and impact of disability caused through mental disorders there is recognition of the ongoing need to find new ways of treating mental illness that allow for earlier identification and treatment. This study describes and evaluates a Primary Care Mental Health Service that provides assistance for people with a mild to moderate mental disorder. Although many may have sub-threshold symptoms in regard to meeting full diagnostic criteria they are at risk of further developing a major depressive disorder as defined under the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), (American Psychiatric Association, 1994 [APA]).

Over the past six years New Zealand research has enabled the extent of mental health problems and level of unmet need to be determined. The Mental Health and General Practice Investigators Group (MaGPIe) provided the first in depth research looking at doctors perceptions of recognition and treatment of mental illness in General Practice (MaGPIe Research Group, 2003). This study concluded that almost half of GP patients had experienced some type of psychological problems in the past year. Screening of patients found that one in three had a diagnosable mental disorder in the past 12 months.

Te Rau Hinengaro, The New Zealand Mental Health Survey (Oakley-Browne et al, 2006) provided the first comprehensive data on the extent of mental health issues in the country. This study identified gaps in services and the areas for further policy and research. The survey also identified high numbers of people who do not access treatment but from self report of mental health symptoms would meet the criteria for a DSM-1V (1994) diagnosis. This means there are often a number of years between developing symptoms of mental illness and seeking treatment.

Furthermore Secondary Mental Health Services (SMHS) are only funded to treat the estimated three percent of the population with severe problems. This means the majority (17%) of mental disorders are treated by GPs in the community.
During the 1990s New Zealand saw the emergence of Community Mental Health Teams. This model of care is now well established. These teams provide case management for people with a diagnosed mental illness that require ongoing care.

Policy in New Zealand is now moving to recognise and support General Practices in providing mental health services and acknowledges that this has been a huge burden for general practitioners without adequate resourcing and often training. The Primary Health Care Strategy (Ministry of Health, 2001) heralds the beginning of this move and outlines the role of primary health services for people to improve peoples’ health and provide ease of access to services and to co-ordinate peoples’ health care. The underlying principles of this strategy are the acknowledgment of the special relationship between Māori and the Crown under the Treaty of Waitangi; good health and wellbeing for all New Zealanders; the improvement of health status of those currently disadvantaged; collaborative health promotion and disease preventions by all sectors; timely and equitable access to a range of services regardless of ability to pay; a high performing system people have confidence in and active involvement of consumers and communities at all levels (Ministry of Health, 2001:2).

Additionally the Second Mental Health and Addiction Plan: Te Tahuhu (Ministry of Health, 2005) signalled a move towards increased mental health service provision in the Primary Sector. The emergence of Primary Health Organisations (PHOs) is viewed as the vehicle for more effective delivery of mental health care at primary level. This report acknowledges evidence that “people with mental illness have significant health problems that are often neglected” (Ministry of Health, 2005:14). Furthermore “people with physical illnesses often suffer depression or anxiety or have a substance use problem. Improved integration of these services will lead to earlier recognition of these disorders and again will lead to better outcomes” (Ministry of Health, 2005:14). These reports have outlined the future direction for Primary Mental Health care.

The Ministry of Health initiated funding for proposals from PHOs in 2005 to look at ways of delivering Primary Care interventions. An evaluation of 26 of these proposals was carried out by the Ministry of Health through the Department of Primary Health Care and General Practice, University of Otago. The resulting report (Dowell et al, 2009) has provided
information about a range of service delivery models, service outcomes and identified major themes emerging.

While there are different models for the delivery of mental health services there are three major models of therapy. These models are psychodynamic therapy, cognitive therapies and post modern therapies (Ivey et al, 2002:93).

Psychodynamic therapies were the first talking therapies to be developed and focus on the past being a prelude to the future. Change is perceived to be short lived unless a person has some sense of how their present actions relate to their past experience (Ivey, et al, 2002). Psychodynamic therapies often seek to help people change over a long period of time. Psychodynamic therapy has not been supported by the National Institute of Clinical Excellence (NICE) guidelines for the routine treatment of severe depression (Middleton, 2005).

Over time new models of therapy developed and briefer models emerged in a response to cost. However research has shown that brief models do make significant changes. Short term psychological therapies have been found to be more effective and acceptable to patients than either placebo or waiting list controls (New Zealand Guidelines Group, 2008a [NZGG]).

Cognitive therapies (CT) are orientated to change dysfunctional thoughts and to gain self mastery. Cognitive therapy uses a range of techniques which include cognitive behavioural therapy, schema modification, solution focused, problem solving and skills training. The focus of cognitive therapy is on a short term observable change with a view to the future that assists the client to maintain a long term behavioural change (Ivey et al, 2002).

Post modern therapies recognise the complexity of peoples’ lives and the multiple challenges that exist within this. Talking about their life helps clients to understand, to synthesize the past and to develop new stories to give a more integrated and meaningful future (Ivey et al, 2002). There are a range of post modern therapies including narrative therapy and interpersonal therapies. Postmodern approaches have tended to see the client in relation to family, cultural or social context issues and as such are a useful approach within a primary health setting.
Effective counsellors need to be familiar with skills, competencies and a knowledge base of multiple theories. Clients respond to different approaches. Some may need an individual approach while others may need a family orientation or multicultural approach (Ivey et al, 2002:8).

Some short term psychological therapies have been found to be of equivalent efficacy to other treatments such as usual GP care or antidepressants. Additionally they are often better tolerated (New Zealand Guidelines Group, 2008a:84).

The focus of this study is the South Canterbury Mental Health Brief Intervention Service.

The South Canterbury Mental Health Brief Intervention Service (MHBIS) was initiated by the South Canterbury District Health Board (SCDB) in 2003 and began operating in 2005. The service was contracted to South Link Health (an Independent Practitioners Association). The service started operating prior to the Ministry of Health Primary Mental Health Initiatives and thus was not included in the evaluation of these initiatives. The MHBIS was selected as a winner in the Primary Care category of the New Zealand Health Innovation Awards in 2007.

The MHBIS employs registered Nurses, Social Workers and an Occupational Therapist who work with General Practices to see patients who have a mild to moderate mental illness. The patients are seen at their own GP surgery and can access up to four free sessions with a Mental Health Clinician. The role of the Clinician is to provide assessment, education, and treatment and to link clients into community services where appropriate. Feedback is given to the person’s GP after the first appointment and again on discharge. All the General Practices in South Canterbury refer to the service.

There are two main hypotheses:

1) Mental Health Brief Intervention does improve the mental health status of patients attending General Practitioners.
2) Mental Health Brief Intervention Service enhances the interface between Primary Care Health Services and Secondary Mental Health Services.

The overall aim is to evaluate the service from a General Practitioner (GP), Practice Nurse (PN) and MHBIS Clinicians’ perspective and to examine the impact of a mental health brief intervention on patient outcomes. Thus the objectives are:

1) To ascertain a GP perspective in regard to outcomes for patients.

2) To ascertain a PN perspective in regard to outcomes for patients.

3) To ascertain MHBIS Clinicians perspective in regard to outcomes for patients.

4) To determine if there has been a reduction in need to refer patients into SMHS.

5) To determine the group of patients who benefit the most from MHBIS.

6) To determine the group of patients who benefit the least from MHBIS.

7) To determine how decision making for referral to MHBIS is made.

8) To ascertain the benefits of a General Practice team approach, with the General Practitioner as the initial point of contact.

The methodology employed was both qualitative and quantitative. Questionnaires were completed by the GPs, PNs and MHBIS Clinicians (Appendices 1-8). Focus groups were also undertaken with each of these staff groupings (Appendix 9). Statistics from the MHBIS database and a client survey (Appendix 10) are used to measure positive change between admission and discharge.

The thesis contains eight chapters. This chapter has discussed the rationale for research. In chapter two the literature and theory around provision of Primary Mental Health Services and models of service delivery are reviewed. Chapter three describes brief interventions within Primary Care and looks at the evidence for what works. Chapter four describes the background of the MHBIS and a description of the service. The model of care used is also explored and the objectives of the service are outlined and discussed in the context of government policy.
The methodology employed is described in chapter five and the results are presented in chapter six. Chapter seven discusses the results and revisits the question, “does it work?” Chapter eight concludes the thesis and offers recommendations in regard to future research.
Chapter Two

Review of Primary Mental Health Literature

This chapter first looks at the prevalence of mental illness in New Zealand and overseas. The development of Primary Mental Health Services and policy in this area is then discussed. The differences between mental health presentations seen in Primary and Secondary Care are explored, as are the needs of mental health users. A range of models of service delivery, and international and national literature is reviewed and considered in regard to the best models of practice for the New Zealand situation.

Demographics

Internationally, a number of large scale surveys point to a high prevalence of mental disorders in the community. The most recent survey in New Zealand took place between 2003 and 2004 in conjunction with the World Health Organisation. This national survey has provided a wealth of information about the level of mental illness, co-morbidity, access to services, suicidality, addiction and Maori and Pacific mental health status. The published report, Te Rau Hinengaro: The New Zealand Mental Health Survey (Oakley-Browne et al, 2006) presents the findings of a mental health survey of 12,992 people in New Zealand. The objectives of this survey were to describe one month, twelve month and lifetime prevalence of major mental disorders among those over the age of 16 years, to describe the barriers to health service use for people with a mental disorder and to describe the level of disability associated with mental illness.

Key findings from this study showed that mental disorder is common in New Zealand and 47% of the population is predicted to meet criteria for a disorder at some time in their life. Furthermore 20% had reported having a disorder in the past 12 months. A higher prevalence of disorder was seen amongst younger people in the past 12 months. Prevalence of anxiety disorder, major depressive disorder and eating disorders was higher among women than men, whereas men had higher levels of substance use disorders than women.
Prevalence for mental health disorders was higher among Maori and Pacific people in any period than the ‘Other’ composite ethnic group (29% for Maori, 24% Pacific peoples and 19% for ‘Other’-general population). The higher burden of mental health problems for Maori and Pacific people in part related to the youthfulness of these populations and their relative socioeconomic disadvantage.

The proportion of people making a visit to their GP for mental health reasons was low, with 58% reporting a serious disorder, 37% with a moderate disorder and 19% with a mild disorder.

Co-morbidity of mental disorders is common, with 37% indicating two or more disorders. People with mental disorders also had a higher incidence of chronic physical conditions compared to people of the same age without a mental disorder.

The Christchurch Psychiatric Epidemiological Survey (CPES), undertaken in 1986 in a Christchurch urban area, provided information about prevalence of mental disorder. This study did not include prevalence for Maori and Pacific populations. Instead it focused on an urban population, thus the results cannot be generalised to the national population. However results indicate that 15% had experienced a mood disorder at some time in their lives, 21% a substance disorder and 11% an anxiety disorder (Wells et al, 1989).

The Epidemiologic Catchment Areas (ECA) studies surveyed over 20,000 adults in five United States (US) communities between 1980 and 1984 (Khin, 2004). This was the first large scale study to assess prevalence of mental disorders and to estimate the use of services (Khin, 2004). A lifetime prevalence of 32% was found.

The Australian National Survey of Mental Health and Well-being was a national survey to detect and describe psychiatric morbidity, associated disability, service use and perceived need for care. The sample included 10,641 Australians aged 18 years and over (Meadows et al, 2000). While the survey captured disorders present in the 12 months prior to the survey it did not measure lifetime prevalence (Oakley-Browne et al, 2006). The findings indicated that 18% of Australian citizens had a mental disorder at some time during the 12 months prior to the survey; the most common disorders being anxiety, depression and substance disorders (Andrews et al, 1999).
The World Health Organisation Survey Consortium (WHO WMHSC) undertook research between 2001-2003 in 14 countries in the Americas, Europe, the Middle East, Africa and Asia. Face to face surveys were conducted with 60,463 adults in the community (WHO World Mental Health Survey Consortium, 2004). DSM-IV (1994) disorders, severity and treatment were assessed with the World Mental Health version of the WHO Composite International Diagnositic Interview, a fully structured lay administered psychiatric diagnostic interview. This same tool was used in the New Zealand Mental Health Survey. Results from the international survey showed a wide variance of prevalence for having a disorder in the prior year to the survey. With prevalence ratings ranging from 4% in Shanghai to 26% in the United States.

In the survey mild disorders reported in the previous 12 months ranged between 33% (Columbia) and 81% (Nigeria). Serious disorders were associated with substantial impairment of roles. In the 12 months prior to the survey high numbers of people had not received treatment, for example 35% to 50% of serious cases in developed countries and 76% to 85% in less developed countries. The report concluded that careful consideration needs to be given to the value of treating some mild cases, in particular, those at risk of progressing to more serious disorders (WHO World Mental Health Survey Consortium, 2004).

The findings from these international studies indicate that there are a large number of people who do not seek treatment for mental disorders. The majority of these people do visit their GP for other health reasons which presents an opportunity for these disorders to be recognised.

**The development of Primary Mental Health Services in New Zealand**

While Primary Mental Healthcare initiatives have been implemented in USA and England since the 1980s, in New Zealand they are still at an early stage of development. It was not until the 1990s that New Zealand began working towards a shift to Primary Care initiatives.

The Blueprint for Mental Health Services in New Zealand (Ministry of Health, 1998) sets out a vision for the future development of Mental Health Services. This includes a focus
on a recovery approach to service delivery. Innovation in services was encouraged to allow for service users to move more easily between services.

A number of programmes emerged in New Zealand in the 1990s providing shared care between Secondary and Primary Care. These programmes are evaluated in a report published by the Health Research Council of NZ (Nelson et al, 2003). This report aimed to assist in the development of shared care services by describing the present programmes, summarising existing evaluations, devising a brief process for evaluation and recommending a way forward. The focus of this report was on providing services and shared care for those people with a severe mental health disorder who met the criteria for Secondary Mental Health Services (SMHS) but were mostly managed by their GP. This highlighted the need for a closer relationship between secondary and primary sectors.

A guideline for the ‘identification of common mental disorders and management of depression in Primary Care’ was published in 2008 (New Zealand Guidelines Group, 2008a [NZGG]). This document uses evidence-based practice to help health care practitioners and consumers make decisions about health care in specific clinical situations. The guideline provides a summary of current New Zealand and overseas literature about the identification and management of common mental disorders in young people and adults in the Primary Care setting. This document focuses on depression rather than other mental health disorders that present in Primary Care.

**Models of Primary Health Care in New Zealand**

In 2004 in response to the Primary Health Strategy (Ministry of Health, 2001) the Ministry of Health began to look at ways of implementing mental health initiatives, requesting proposals for mental health initiatives and innovations. A request for proposals (RFT) was sent to Primary Health Organisations (PHOs) to develop projects that supported PHOs in developing Primary Health Care (Garrett, et al, 2007). The ‘Primary Mental Health Organisations: Service development toolkit for mental health services in Primary Care’ (Ministry of Health, 2004a), was released to assist the development of projects. This contains reviews of the current literature in regard to Primary Mental Health as well as providing a framework for service development. Funding for 41 proposals was made available in 2005.
from the Ministry of Health until June 2007 and this was later extended to June 2008. The initiatives were intended to be demonstration models from which “a range of best practice and evidence-based initiatives could be disseminated throughout the primary health sector” (Dowell et al, 2006:6).

These initiatives were evaluated by a research group from the Department of Primary Health Care and General Practice in the Wellington School of Medicine and Health Science. The evaluation began in June 2005 and the final report was published in 2009 (Dowell et al, 2009). A mixed methods approach to evaluation was taken. These methods included: group and individual interviews with operational and clinical groups within the initiatives, face to face, semi-structured service user interviews with selected initiatives, collection and assimilation of quantitative data for each initiative and informal visits to the initiatives for information sharing (Garrett et al, 2007). In total 23 projects were evaluated.

The range of the models of care evaluated were divided into nine models of service provision. Each model had its own advantages and disadvantages (Dowell et al, 2006). These models were:

1) Packages of care allowing a specific dollar amount for each service user to cover one or more of the following: transport, childcare, home help or alternative therapies.

2) Mental Health Nurse usually based in one or several smaller practices. People referred for assessment and co-ordination of services, sometimes counselling or referral on to other agencies.

3) Counsellors or Psychologists either employed by the PHO or on a fee for service contract to provide therapeutic input for service users.

4) Employment of a Mental Health Coordinator with a similar role to that of the Mental Health Nurse but not discipline specific, including Nurses and Social Workers. Some focus on co-ordination only role with a variation in caseload and intensity of input.
5) Relapse-Prevention Nurse working with Secondary Service users who are being referred back to Primary Care. This involves the development of a wellness plan for service users and visits at least four times during the year.

6) Medication review of current medications by a pharmacist.

7) Chronic care management programme which is based on pre-existing chronic care management programmes for other diseases modified for use with depression. This model involves decision support software incorporating a prescribed care pathway.

8) Kaiawhina/Community Support Worker providing more intensive one to one work or group work with consumers.

9) Non-clinical coordinator or project manager coordinating programmes without the clinical component. This may include managing referrals, providing support to referrers and planning and implementation of continued professional development.

Several major themes emerged from this evaluation (Dowell et al, 2009) and included: services evolving over time, the need for a broad definition of mental disorder including life complexity, the majority of work being undertaken by specialist staff (coordinators or therapists), and the importance of integration with SMHS.

The Primary Mental Health Evaluation Report (Dowell et al, 2009: xiv) describes an optimal model for Primary Mental Health delivery. A number of features are considered as core aspects of an optimal model and none of the evaluated initiatives had all of these features. The features include; support from the District Health Board (DHB), an effective Information Technology (IT) platform and incorporated training, health promotion and liaison with secondary care and other sectors. Factors within the programme include; a programme which is adapted to local need; culturally appropriate services; a local Primary Health Organisation champion or leader; infrastructure (including patient management system, IT; links with community and other PHO programmes); continuous quality improvement and a workforce with the required staff; continuing professional development and supervision (Dowell et al: 2009).
Presentation of mild to moderate disorders in Primary Health Care

Mental disorders are extremely common in Primary Care with over one-third of adults attending GP visits likely to meet criteria for a DSM-1V (1994) diagnosis within the past year (MaGPle Research Group, 2003). The most common presenting disorders are depression (18.4%), anxiety (20.1%) and substance use disorders (11.4%). The “Mental Health and General Practice Investigation Research Group” (MaGPIe) explored the prevalence of mental illness in General Practice and the degree of associated disability with this. General Practitioners estimated 54% of female and 46% of male patients seen had experienced some degree of psychological problems in the past year (MaGPle Research Group, 2003).

In New Zealand, Primary Health Care is funded through a capitated payment structure in which GPs receive an annual payment for each enrolled service user. In addition to this patients pay a part payment charge for each consultation (Dowell et al, 2009). This cost can be a barrier to patients attending their GP. As such this can influence the nature of problems that people disclose to their GP and their response to suggestions around treatment for psychological problems (MaGPle Research Group, 2003). Thus while the prevalence of mental health disorders in the general population is high so is the level of unmet need (MaGPIe Research Group, 2005a). Research has also indicated reluctance by patients to discuss mental health concerns (Oakley- Brown et al: 2006).

It seems the identification of common mental disorders is dependent on a number of factors. Although symptoms of mental illness are generally recognised in patients that GPs have seen three or more times identification is lower for patients seen less frequently (MaGPIe Research Group, 2004). Barriers to identification of mental illness included factors such as the GP having either an actual or perceived lack of knowledge; skills; interest; or attitude towards mental health care (MaGPIe Research Group, 2005a).

Barriers to addressing the mental health needs of Primary Care users have historically been: a lack of funding for comprehensive Primary Health Care provision, time constraints, limited availability and access to evidence-based psychological therapies, limited access to multidisciplinary team input and poor interface with SMHS. Additional factors include the
limited capacity of the health care system to implement and sustain new initiatives in Primary Care (Garret et al, 2007).

Bathgate et al, (2001) in a study of the views of Otago General Practitioners about local mental health services and their role in providing mental health services identified cost, time, and access as the main obstacles to their management of psychiatric disorders. As Garret et al, (2007) also note that there are no particular standards for provision of mental health in Primary Care in New Zealand. Parameters that have been identified as important include: detection and recognition of patients needing treatment, access to care, liaison and integration of care, use of Specialist Services and the ability to respond to the different needs of individuals and population groups.

Many of the depressive disorders that GPs treat are below, or just reach, the minimum diagnostic criteria for clinical depression. Depressive symptoms are seen more in terms of fluctuating mood disturbances in response to life situations, often with a background of chronic difficulties, physical illness, insecure relationships and deprivation (bpacnz, 2004).

Recognition of mental illness by GPs

A New Zealand study by Khin (2004), examining 416 GP attitudes, reported confidence and behaviour in relation to the detection, diagnosis and management of mental illness in General Practice. The Attitudes, Reported Confidence and Behaviour Questionnaire (revised) (ARCBQ-R) was used as a tool to gather data.

Khin (2004) found that GPs most confident in detecting, diagnosing and treating depression were also more confident in prescribing antidepressants. The factors that influence GP confidence in detecting, diagnosing and treating depression appear to be: an interest in mental health, previous mental health training, gender and exposure to mental disorders in their practice. Systemic and patient factors played a part in the way that GPs recognise and manage mental illness in their practice. GPs tended to make their diagnosis of mental illness on their knowledge of their patient and their functioning rather than necessarily referring to the DSM or ICD classifications (Khin, 2004).

Khin (2004) also reported that shared care was seen by GPs to be the most effective way to provide optimal care for patients. Issues to address for this to be feasible for practices
were identified as being availability and accessibility of Secondary Mental Health Services and structural issues such as cost, time and extended GP consultations.

**Disclosure of illness by patients**

Research from the MaGPIe Research Group (2005b) examined the reasons why patients do not disclose psychological problems to their GPs. The results indicated that nearly 30% of all patients surveyed said that they had at some time chosen not to disclose psychological problems with their GP. Younger patients were twice as likely not to disclose psychological problems as older patients. Reasons for non-disclosure included an unwillingness to discuss psychological problems with anyone at all, beliefs that a GP is not the appropriate person for them to talk to, a concern about their relationship with their GP, the stigma of disclosure and treatment, time and cost.

These findings are supported by research from Te Rau Hinengaro, (The NZ Mental Health Survey) which showed that only 36% of those with moderate disorder and 18% of those with a mild disorder sought help from their GP (Oakley-Browne et al, 2006).

A further study in New Zealand explored the reasons why patients do not disclose mental health problems to their GP (Dew et al, 2007). Interviews were conducted with 33 patients in the lower North Island. Findings indicated that there are a range of reasons why people do not discuss mental health concerns with their GP. These included: fear of the consequences, lack of encouragement from health professionals, being a burden or seen as whingeing, a lack of trust, stigma of mental illness, the belief that a GP could not help, self-reliance, denial, limit of consultation time, money, gender issues and cultural beliefs.

Factors from Dew et al (2007) which encouraged disclosure to the GP were: a sense of control over the consultation, encouragement from the GP to disclose, and trust in the GP, if there was a physical association with the problem (for example, a lack of sleep). Also factors included: a view that the GPs job was to deal with mental health problems, the situation had reached a breaking point and the GP provided less formal surroundings (Dew et al, 2007).

**Difference between depression presenting in Secondary and Primary Care settings**
There is a difference between the severity and impairment of depression seen in Primary Care to that seen within a psychiatric setting (Klinkman, 2003). The majority of patients seen in Primary Care present with physical symptoms and often have co-morbid physical and mental health conditions. The presentation of physical symptoms can often make depressive disorders more difficult to diagnose. Often physical conditions take priority over diagnosing and treatment of depression. Patients seen in psychiatric settings present with mental health problems. These patients generally accept that they have a mental health issue that requires treatment. Whereas in a primary setting the patient may see their symptoms as physical in origin they are often less receptive to a psychiatric diagnosis of their condition. A considerably higher number of patients in primary settings present with distress, usually as a result of life events, and this may be a trigger for a depressive disorder or heightened anxiety. A study by Keller et al (2007) of 4,856 individuals with depressive symptoms showed that adverse life events relate to distinct patterns of depressive symptoms.

The Michigan Depression Project is a long-term project in America, studying depression in Primary Care (Schwenk et al, 1998). This project looked at the differences between patients presenting in primary and psychiatric services and considers whether the same treatment option is appropriate in both settings. The study examined the role of life events on major depression in Primary Care and psychiatric patients. Using a semi-structured interview the context of the severity of life events was rated. Of those presenting to their family doctor the onset of depression was often preceded by a life event. Episodes of depression in psychiatric patients were less related to life events. The study found that medical and psychiatric co-morbidity has a major impact on the incidence, detection, treatment and outcome of depressive episodes. Medical and psychiatric co-morbidity was seen to differ significantly between Primary and Secondary Care settings.

From personal clinical experience and research findings Schwenk et al (1998) suggest that identifying depression in patients presenting in Primary Care may be more adequate than some studies suggest. In doing so they recognise that the process of identification of depression in Primary Care is a more complex process than generally believed. Depression is frequently associated with somatic distress. The majority of patients presenting do not see
depression as their reason for presenting, thus clinicians have competing demands within a short time consultation time (Schwenk et al, 1998).

Schwenk et al (1998) found that depression diagnosed in Primary Care was not adequately treated. This was seen as most likely due to the presence of chronic medical problems and poor marital support detected in these patients.

Schwenk et al (1998) reported on the results of three focus groups of Primary Care Physicians to explore their views of detection, treatment and collaborative care of depression. Key themes emerging from these focus groups were: detection is based on functional rather than diagnostic criteria; they detected only those patients they believe require treatment using functional status as a guide; there is a high level of resistance to diagnosis and treatment and therefore, doctors had to carefully consider their diagnosis and its implications before discussing it with the patient. Often watchful waiting was used, as ‘time’ is often a limiting factor in consultation. As initiating and continuing treatment required considerable time and negotiation initially this was seen as the best option.

Results of the Michigan study were consistent with a model of depressive disorder particularly for sub-acute or chronic conditions which can exacerbate or improve over time. The severity may change and the condition often has significant co-morbidity. Depression was seen like asthma, a chronic condition that changed over time. All this makes depression difficult to detect as patients are more likely to attend their GP with other complaints and the depression may be hidden. At higher levels of severity, depressive symptoms may be present all or some of the time, they can occur without provocation and may cause significant impairment. At a lower level of severity, episodes may cause minimal impairment and may be self limiting (Klinkman, 2003).

According to Katon and Walker (1998), medically unexplained common physical symptoms account for almost half of all Primary Care presentations. Only 10% to 15% of 14 common physical symptoms are found to be caused by an organic illness over a one year period. Katon and Walker (1998), reviewed evidence that demonstrates an increasing number of unexplained symptoms over a patient's lifetime correlate to the number of anxiety and
depressive disorders experienced, the score on the personality dimension of neuroticism, and the degree of functional impairment.

In a large Australian study involving 10,507 patients Clarke et al, (2008) measured the prevalence of somatisation (multiple somatic symptoms and hypochondriasis) among Australian General Practice attendees, its recognition by GPs and the relationship between symptoms of depression, anxiety and somatisation. Diagnostically, 18% of the patients were diagnosed with somatisation and 9.5% as probable cases of depression and anxiety. High scores of anxiety and depression scores were found in 29.6% of the patients with somatisation; 57.9% of people with depression or anxiety were also diagnosed with somatisation. GPs identified somatic complaints as being mostly explained by a psychological disturbance in 25% of patients. This study concluded that recognition of depression and anxiety can be hindered by somatic presentations and attribution. The importance of dealing with the health anxieties that underpin hypochondriasis attached was recognized.

Clarke et al, (2008) identified six important ideas about the nature of physical symptoms in Primary Care. The first is that the majority of physical symptoms in Primary Care patients are not associated with an organic disease process. The second is that people with distress or a psychiatric disorder have increased use of health services whether or not a physical disease is present. Thirdly, individuals can be more predisposed to developing medically unexplained symptoms depending on factors such as early family environment, prior illness experience and specific personality traits. Fourthly, there is an association between the number of unexplained physical symptoms and the lifetime risk of psychological distress and psychiatric disorder. This association is stronger for those who move into secondary psychiatric services. Fifthly, medically unexplained symptoms account for a significant amount of health care costs. Sixthly, medically unexplained symptoms do have a major impact on the quality of doctor—patient relationship.

**Patient views on what is helpful for anxiety and depression**

There are few studies which explore a patients perspective in relation to their health care needs in anxiety and depression. A British study involving patient interviews and focus groups with people with a diagnosis of depression or anxiety explored what their preferences
were for treatment of their health needs (Kadem et al, 2001). Most participants in the study had been active in using self-help strategies and made use of a range of therapies including referrals to counsellors, acupuncture, relaxation tapes, self-help books, exercises, reflexology, aromatherapy and analytic psychotherapy. The majority were doing their best to live a full life and were open to suggestions about ways of improving their life.

Three themes were identified around patients’ search for sources of help. These were someone to talk to, issues around access to services, and attitudes to medication. Of these themes having someone outside of the situation to talk about their issues was the preferred option. They were seeking someone who would understand them, offer some perspective on their difficulties and suggest ways to cope. Some interviewees were seeking help from someone who had personal experience of the problem and had made a recovery. Finding someone to talk to was seen as a difficulty and the desire for help from their GP to be more active in referrals or follow up was expressed. These in turn also raised issues as some interviewees did not feel comfortable in talking with their GP. Instead they would minimise the importance of their issue and needed to gain courage to discuss this with their GP. Some felt that the GP would not do any more than prescribe medication. A direct approach by GPs asking about personal problems facilitates help, as would the opportunity to talk with someone as soon as possible after the consultation rather than having to wait weeks for an appointment.

The majority of patients were critical of drug therapy. Some identified as feeling “fobbed off” with medication and most did not perceive medication as being an effective response to their distress.

GPs were, on the whole, perceived as an independent and key resource in seeking help for psychological problems. Most of the people interviewed had firm views on treatment preferences and were unwilling to comply with interventions they did not perceive as helpful. More time and faster access were the key treatment preferences. The authors of this study suggest that there is a need to explore within counselling the role of drug therapy education as well as teaching life-coping skills.
A study investigating 403 patients’ perspectives on management of emotional distress in Primary Care settings reported that the majority of participants surveyed felt that it was at least somewhat important to receive help from their GP for emotional distress (Brody et al, 1997). The majority of patients also wanted the opportunity to discuss issues and options with their GP for further counselling rather than a referral to SMHS. About one third desired medication and five percent wanted a referral elsewhere. These findings supported other studies that have found a large proportion of patients suffering from psychiatric symptoms would rather be treated in Primary Care. The study findings certainly indicated that there is a role for GPs to be actively involved in the identification and management of mental health disorders in the community.

**Mental Health Workers in the Primary setting and impact of use of medication**

In a review of the literature Bower and Sibbald (1999) found 38 studies involving 460 Primary Care Workers and 3,880 patients. The review focused on exploring changes in the clinical practice of the Primary Care Providers (PCPs) where mental health workers were employed. This review found there was some reduction in the prescribing of psychotropic medication. Furthermore while this reduction appeared to be short term it was related to patients directly under the care of the Mental Health Worker.

Two models of care were included in the study. A ‘consultant liaison’ model where mental health workers guided the care from PCPs and a ‘replacement model’ where Mental Health Care Workers provided the care. Both models showed evidence of limited short term changes in clinical behaviour. Few studies found long term effects with Primary Health Care Workers involvement. The few that were identified did not provide clear evidence of lasting or widespread changes in clinical behaviour. The review did not indicate the level of psychiatric illness in the studies, the length of time seen, or specify the type of input from the mental health workers. There were a number of health professionals providing care in the studies including Psychiatrists and Counsellors.

Overall this study concluded that longer term studies were needed to more accurately assess whether having Mental Health Care Workers involved has positive effects over time.
Cochrane Reviews provide systematic reviews of health care evidence based interventions (The Cochrane Collaboration, 2009). A Cochrane review of the benefits of having on-site Mental Health Workers in General Practice identified four short term studies where significant reductions in psychotropic prescribing rates had occurred. However two other studies showed no difference. The long term studies reviewed also showed mixed results with three out of the six studies reviewed showing no difference in prescribing rates (Bower & Sibbald, 1999).

A study by Katon et al (1996) of 153 patients receiving a multifaceted Primary Care intervention showed improved adherence to medication and consistently improved outcomes for those with major depression and less of an improvement with those with minor depression.

The Primary Mental Health Initiatives Evaluation (Dowell et al, 2009) used statistics taken from the HealthStat data-base from a random sample from General Practices. Comparisons were undertaken between people who had received an intervention from a Primary Mental Health Initiative (PMHI) and those who had not. The data was divided into periods of one year before and one year after the PMHI intervention (based on the actual date of the first intervention) and from 1 October 2006 for the control group. Data was collected from 310 PMHI patients.

GP consultations in the period after 1 October were seen to have increased for the control group whereas the PMHI group showed a decrease in GP visits in the year after the PMHI intervention.

Differences were also found in the patterns of prescribing medication between the control group and PMHI group. The PMHI group was reported to have had fewer prescriptions over all and significantly fewer prescriptions for antidepressants. Whereas there were 94 prescriptions written for the control group there were only nine in the PMHI group. A year after the PMHI intervention the number of antidepressants prescribed dropped in both groups and in the PMHI group this dropped from seven to two prescriptions (Dowell et al, 2009:57).
Primary Mental Health Care – International Perspective

Research in Australia, England and USA has been attempting to address the need for evidence-based practice. In doing so established Primary Mental Health programmes were reviewed (Christensen et al, 2006, Taylor et al, 2007, Madershield & Berry, 2004).

In 2001, the Australian Better Outcomes in Mental Health Care programme was introduced to improve community access to quality Primary Mental Health Care. The programme provides improved education and training for GPs and more support for allied health professionals (Peters, 2007:17). In an evaluation of 108 projects a notable positive impact for service users on their level of functioning, severity of symptoms and quality of life was found. Internet treatment programmes have also been developed and include MoodGym (www.moodgym.anu.ed.au) and ClimateTV (www.climate.tv). These programmes provide opportunities for doctors and service users to have direct access to self help therapies.

Over the past two decades in England counselling services have been based in a large number of General Practices. There is a large body of literature that reviews some of these practices and the effectiveness of counselling (Bower & Rowland, 2006; Flecture et al, 1995; Layard, 2006; Speirs & Jewell, 1995; Corney, 1990; Taylor et al, 2007; Bower, 2002).

Counselling and models of providing services for GP patients were seen by Bower (2002) as having only weak evidence of effectiveness as there were only a few effective studies of outcomes. Evidence around systematic changes to provide another level of care within General Practice however has increased and the focus of service provision has shifted from counselling based models or replacement care models to collaborative care. This shift has been informed by the National Health Service Plan (Secretary of State for Health, 2000) which proposed a new role of Primary Care Mental Health Worker (PCMHW) to assist with the management of common mental health problems in Primary Care.

Bower (2002) reviewed different models of mental health care provision and looked at the role of the PCMHW in regard to the types of patients that would be managed and the way in which the PCMHW works. Consideration is given to the degree of autonomy and at what stage of a patients’ illness the PCMHW would become involved and their role within
managing care. A number of roles were identified including provision of education, brief therapeutic interventions, monitoring of medication and encouragement of self help strategies.

The need for a change in the delivery of mental health services within Primary Care to focus on depression and anxiety disorders has led to a focus on evidence-based practice, workforce issues and the most effective and cost effective ways of providing services. Key documents that outline recommendations for the delivery of services and best practice at Primary Care level in England are “We Need to Talk” (Mental Health Foundation, 2006), “Management of Depression in Primary and Secondary Care” (National Institute for Health and Clinical Excellence, 2007) and “Commissioning a Brighter Future” (National Health Service, 2007). A document produced by the Mental Health Foundation (2008) in England reviews research of the impact on people who have to wait for psychological treatments and wider impacts on families and communities.

Models of Mental Health Primary Care provision

Doughty (2006), reviewed forty-four international models for the provision of mental health services in Primary Care settings. The focus of this review was around the structure and workforce configuration of mental health services and quality improvement in Primary Care. Collaborative care models were most widely researched and considered more in depth. Evidence showed collaborative care to be of particular benefit to older adults with depression. Such models were also helpful for people with persistent and recurring difficulties. Telephone interventions were found to be useful to those with mild to moderate mental health problems. However evidence of effectiveness in those with minor depression was less clear. The review identified gaps in the literature in regard to treatment outcomes for common mental disorders other than depression. Doughty (2006) also reported that overall there is insufficient evidence to provide a definitive answer as to the clinical effectiveness and cost effectiveness of individual models of care, or to provide a comparison between models.

It also needs to be noted that a number of issues arise when comparing models of care. Firstly, as models use a range of health professionals this makes comparisons across treatment regimes difficult as there are a variety of differing treatments being provided. Secondly, different countries have different ways of delivering care. In the USA systems of managed care are well-established and care often involves a variety of mental health staff on site.
Studies in Britain show that GPs make more referrals to counsellors, both on and off site than in other countries. However, there is a move for specific mental health workers to be located on site. Until recently there have been few examples from New Zealand available about models of care within a primary health setting. Thirdly, studies often do not indicate the number of sessions involved in care. Fourthly, a range of problems are referred for mental health intervention. While many studies focus on depression, statistically, anxiety rates are higher than depression in population studies.

Bijl and colleagues (2004) reviewed the literature in regard to screening and management of programmes for major depression in Primary Care. Treatment results showed that those patients who received interventions that included patient education, drug treatment and staff collaboration had significantly better outcomes in terms of their recovery from depression than patients treated by usual GP care (Bijl et al, 2004).

A systematic review of the effectiveness of organisational and educational interventions to improve management of mental health disorders in Primary Care settings was completed by Gilbody et al, (2006). This review researched articles from electronic medical and psychological data bases from inception to March 2003. A total of 36 outcome studies relating to the management of depression met criteria for inclusion in the review. These studies included 29 randomised control trials and non-randomised controlled clinical trials; five controlled before and after studies and two interrupted time series studies. Of these, 21 studies recorded positive results for patients in the treatment of depression. The most effective were those with complex interventions that incorporated Clinician education, an enhanced role of Nurse (case management) and a greater degree of integration between Primary and Secondary Care. Telephone sessions delivered by the Practice Nurse or a trained counsellor around the use of medication was also found to be effective.

While the most effective programmes used a range of strategies it was not possible to determine exactly what strategies were the most effective. Common elements showed the most successful results were where two or more strategies were used. This was especially so in cases where practices had made changes to the delivery of mental health care, for example using specialist clinics and Nurse case management. Active follow up of patients requiring intervention for depression was effective.
Katon and colleagues (1996) undertook two major studies examining collaborative care models. The aim of the studies was to improve the provision of care for those with an already recognised depression. The programmes examined provided intensive care and education, delivered through the Primary Care Physician, Psychiatrist or Psychologist. The results indicated improved treatment adherence and patient recovery. They also found that further interventions targeted for those who were at higher risk of recurrence of depression improved medication compliance over 12 months. The same findings were found in a study of late life depression (Katon, 1996).

The one strategy in a study from the United Kingdom found to be ineffective was a study involving clinical education and guideline implementation strategy. The programme had involved video tapes, written information and small group teaching sessions and role plays from a multidisciplinary team. However, this study had no organisational support to enhance patient care (Gilbody et al, 2003), thus overall the programme appeared to have had no effect in either assisting the recognition of depression or clinical improvement.

**Stepped Care Models**

The NZ Ministry of Health has proposed that the Primary Mental Health sector adopt a stepped care approach to service delivery (Ministry of Health, 2008). Stepped care is a model in which the service users’ needs are matched with the level of care that is least intrusive but most effective for their need. Less intensive interventions are tried first then, more intensive interventions are offered if necessary. Patients are monitored to allow for treatments to be stepped up if needed. In this way differences between the required level of intervention and the importance of supporting self care is recognised (Ministry of Health, 2008).

Benefits of a stepped care model include; cost effective service delivery, increased recognition of depression; treatment available to a greater number of people with mental health and addiction problems, reduced disability and impairment related to work and family, earlier treatment resulting in reduced costs of treating more severe mental health and addiction problems, shorter waiting times; reduced stigma for patients, enhanced communication between GPs and specialists, increased satisfaction for patients and greater opportunities for preventive care (Ministry of Health, 2008).
Brief interventions delivered through one to one sessions with a health professional provide one level of stepped care. Interventions can include education, strategies to manage anxiety or depression and self help materials. Phone call follow up as another level of care, is seen to be effective (Gilbody et al, 2003, Simon et al, 2000). A stepped care model allows for referral on to community services and use of community resources.

Models of Shared Care

Shared care models involve service users care being shared between mental health specialists and Primary Care. While there are no agreed definitions of shared care, there are three basic models (Ministry of Health, 2004b:42). The first model is a consultant liaison model, in which a Psychiatric Professional works as a consultant alongside the Primary Health Care team. This model is commonly used in the UK with Psychiatric Nurses providing the linkage with Primary Health Care. This model tends to focus on mental health problems arising in General Practice rather than on ongoing mental illness. The second model is an outpatient model in which a team of psychiatric professionals offers a specialist clinic within a General Practice. This model aims to improve accessibility and acceptability to people using the service. The third involves a formal shared care arrangement. In this model, responsibility of care is shared between different providers including Housing, Primary Health Care, Non Government Organisations (NGOs) and Specialist Services.

Christensen et al, (2006) reviewed a number of models for mental health care delivery. The effectiveness of particular approaches and the circumstances in which such models might work were examined. The finding showed better outcomes were achieved when managed care was the main intervention, in comparison to those without managed care. These studies were also known as collaborative care (Christensen et al, 2006:11).

The following are examples of successful managed care programmes:

- Enhanced care provided by health care professionals or computerised programmes resulted in improved care.
- Self-help computerised programmes were found to be successful when supervised by Nurses in General Practice.
Community care interventions such as providing psychological interventions in a number of settings were found to have positive outcomes.

Training, feedback and provision of information to general practitioners were not found to be successful by themselves. Studies on pharmacist interventions were found not to be successful in improving outcomes for depression (Christensen et al, 2006).

Evaluations of collaborative models of care for working with people with depression, anxiety and co-morbid conditions highlight issues of increased communication, cost effectiveness and overall effectiveness. Mental health services provided in a General Practice setting allow for ease of access, less stigma and often less waiting time. Studies exploring whether it is the type of therapy provided or the relationship with the health professional that is a key factor in outcome found that it was the relationship with the person providing the treatment that improved outcome for recovery (Doughty, 2006).

While the literature does contain some references to models of care there are few specific examples and descriptions of how these work in practice. Kates et al (1997) describe an evaluation of an integrated Mental Health Services within Primary Care in Ontario, Canada, providing Mental Health Counsellors and Psychiatrists in the offices of 87 family Physicians in 35 practices. This programme increased mental health care availability and accessibility, increasing continuity of care, provided additional support for the family physicians and offered increased education opportunities. This programme led to a reduction and more efficient use of other mental health services. One evaluation in America explored how phone monitoring by clinicians under supervision of a Psychiatrist showed significant improvements in outcomes (Dietrich et al, 2004).

**Literature on models of Primary Mental Health Care in New Zealand**

One of the few examples found in the literature about models of Primary Care in NZ is a Primary Mental Health website started in July 2009. The website provides a directory and description of 77 Primary Mental Health initiatives in New Zealand (Te Pou, 2009).

Reports by Dowell et al (2009) provide a brief outline of new initiatives for mental health around the country. However they do not provide specific working details. The Nelson et al report (2003) is about services providing links between primary and secondary
care rather than specific Primary Mental Health programmes. The programmes mentioned are aimed towards clients who have had some contact with secondary services and then managed in Primary Care after discharge. As such clients with mild to moderate health disorders are not covered.

The Rural Canterbury PHO Brief Intervention Co-ordination Service (BIC) report prepared for the 2007 Canterbury DHB Quality Innovation Awards, provides a description and results of an evaluation of a service that began in August 2005. The BIC service operates on a consultant liaison model, providing up to five free sessions of psychological intervention, then, if required a referral is made to other services. The findings of the evaluation showed that by discharge client scores on the Kessler self-rating scale for both the moderate and severely distressed clients were significantly lower than on admission to BIC service. Both the clients and the GPs reported satisfaction with the service in terms of access, and quality of care (Rural Canterbury Primary Health Organisation, 2007).

A description of the Timaru Mental Health Brief Intervention Service (Feely, 2005), was the only article found written from a Clinician perspective. Feely discusses the way in which the service provides up to four sessions of intervention for clients with mild to moderate mental health issues within General Practices. This collaborative care model provides specialist care that is accessible and at no cost to the client. The key features of the service are education, support, and the ability to link patients with services in the community.

An evaluation of the Wellington Mental Health Liaison Service describes the development of a service that provides Primary Care for a group of mental health consumers who previously were predominantly cared for by a specialist service (Rodenburg et al, 2004). This study indicated that consumers reported no deterioration in their mental health status while under the care of the GPs and that they were largely satisfied with General Practice care. While initially there was ambivalence about the programme from GPs over a 12 month period this changed and they became more supportive of the service. Appreciation of the education provided to GPs, Nurses and receptionists was also shown. This study also showed that with carefully designed training and support, General Practice can provide high-quality community-based mental health care for people with enduring mental health disorders, thus supporting the introduction of integrated mental health care initiatives.
The MidValley Well-Being Service developed as a PHO Primary Health initiative established to meet the needs of a community with a high percentage of Maori and Pacific Island people (Pack, 2008). This service offers conventional social work and nursing follow-up and psycho-educational programmes. This includes a listener ‘talk back slot’ on Pacific Radio on a range of mental health related topics.

Summary

A review of the literature shows that internationally prevalence of mental health disorders in community populations is high. Furthermore the majority of people are being treated in Primary Care. However, the review also found that a large number of people do not present for treatment at all. This supports the findings of a New Zealand study where it was found the majority of people with mental health problems present to their GP with physical symptoms and only discuss psychological concerns if asked (MaGPIe Research Group, 2005b).

As noted by Schenwk (1998), physical health problems can mask mental disorder. Competing demands for time in the GP consult often result in physical conditions being treated first, with less emphasis being placed on mental health disorders.

A New Zealand Ministry of Health initiative (2004b) saw the emergence of a range of Primary Mental Health Care programmes utilising nine different models. An evaluation of these programmes has added to the overall picture of mental health needs in Primary Care (Dowell et al, 2006).

Time constraints, limited access to psychologically-based therapies and cost have been identified as the main barriers to addressing mental health needs in Primary Care (Garret et al, 2007).

In conclusion, this chapter has considered the national and international literature with regard to Primary Mental Health Care. Collaborative, Stepped Care and Shared Care models have been discussed. Primary Mental Health Services is an area that is evolving in New Zealand with a range of models around the country. However from the studies reviewed there appears to be no significant evidence as to the clinical effectiveness of one model over another.
The next chapter addresses this issue and examines therapies that are most effective in providing treatment within a Primary Mental Health setting. How these models are implemented is also considered.
Chapter Three

Models of Therapy for Brief Mental Health Interventions

In the previous chapter, models of intervention and models of service delivery were discussed. The focus of this chapter is on the delivery of brief mental health interventions using differing therapeutic models.

The two major components of brief intervention services within Primary Care involve both the management of mental illness and the delivery of specific therapies. Each one is discussed below.

Mental health and mental illness

There is some confusion around the notion of mental health and mental illness. Mental illness has attracted a stigma which in turn has led to the use of the term “mental health” to describe treatment and services in relation to mental ill health (World Health Organisation, [WHO] 2004). Mental health is defined by the World Health Organisation as “a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2004:12). Mental illness is usually more specifically defined by a classification through using the Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases (ICD); these manuals are widely used in psychiatry to describe the range of symptoms experienced by an individual as mental illness.

What is brief intervention?

Brief interventions cover a broad range of interventions used to support people to make change over a short time frame. In the context of the Primary Mental Health setting, this can take the form of assessment, psycho-education, talking therapies, skills training, goal setting, lifestyle changes, exercise, guided self-help and referral on to appropriate services or resources and advocacy.
Some forms of talking therapy identified as being useful in this setting are Cognitive Behavioural Therapy (CBT), Interpersonal Psychotherapy (IPT), Problem Solving Therapy (PST) and Motivational Interviewing (MI) (New Zealand Guidelines Group, 2008a [NZGG]). There are distinguishing features to these interventions. The skill of the Clinician in assessing the situation and fitting a treatment intervention to match with the client is often a key factor in making the most of the time available. This ability of the Clinician to engage well and establish rapport with the patient is an important factor for a positive outcome (NZGG, 2008a).

There are few randomised control studies of psychological treatments with patients in Primary Care settings. In practice most therapists use a less structured approach than methods used in research and the impact of this on outcomes is unclear (NZGG, 2008a). The majority of studies reviewed by the NZGG included patients referred to Specialist Services. Some studies included were with volunteers from the community. Studies in Primary Care tend to compare outcomes of treatment programmes with standard care in which there is a range of variance. The numbers of sessions offered also varies as does the background and skill level of those delivering treatment.

A postal survey in 2007 of 293 psychotherapists providing therapy for the Primary Mental Health Initiatives (PMHI) looked at the range of models used by therapists (Dowell et al, 2009). This survey had a response rate of 67.5% with a final total of 158 respondents. The term “psychotherapy” in this survey was used to describe psychological interventions that included counselling and excluded occupational therapy, recreational therapy and physical treatments. Of those surveyed, the job titles were Counsellor (53%), Psychologist (26%), Psychotherapist (21.5%) and Mental Health Coordinator (8.9%), with some smaller numbers having other classifications (Dowell et al, 2009). A high proportion of the therapists in the survey (52.5%) did not indicate their key theoretical model. However, the majority of respondents (91.8%) did endorse one or more therapeutic models from a pre-populated list. The majority of therapists reported using an eclectic approach with the most common being a general CBT model (81.4%). Problem solving (59.3%), person-centred (55.9%) and psycho-education (43.5%) were the next highest rating methods.
In their study Dowell et al (2009) found that models of therapy were adapted to fit the brevity of the intervention. Issues have arisen from this survey about the lack of evidence about which specific components of psychotherapy make a difference to psychological outcomes in Primary Care. General therapist factors were seen to be more relevant in the context of Primary Care than complex techniques or theory (Dowell et al, 2009)

What works?

Thomas (2007) argues that meta-analytic studies of outcome research over the past five decades have shown that as much as 75% of success in therapy is due to therapeutic relationship factors with therapeutic model and techniques employed being attributed to only 25% of the success in therapy. Thomas (2007) challenges the current emphasis on those aspects in therapy that are more easily measured and suggests that a better balance is needed between the more silent and invisible parts of therapy (such as the relationship), and those factors that are empirically supported by research. The New Zealand Guidelines Group, (2008b) found that a significant finding in the research pointed to the strength of the therapeutic alliance as an important indicator of outcome of therapy. The identification of specific common factors in various therapies that may be more significant than the specific therapies is an area for further research (NZGG, 2008b).

Miller and Rollnick (2002) also concur that to whom a person is assigned can make a significant difference as to whether they continue in counselling. Even counsellors working in the same setting with the same treatment approaches can show dramatic differences in final outcome or dropout rates. Thus, the way in which people interact appears to be as important as the approach taken. Research also indicates that counsellors’ empathy can be a significant determinant of a person’s response to treatment. Confrontational counselling has been associated with a high dropout rate. The characteristics of the counsellors style manifest early in treatment and can allow for a significant effect with a single session (Miller & Rollnick, 2002: 7).

The evaluation of Primary Mental Health Initiative pilot studies have shown that a wide range of therapies are used in the Primary Care setting. The project concluded that 80%
of people would make some significant improvement regardless of the therapy used (Dowell et al, 2009).

The NZGG (2008b) reviewed the literature on the evidence of the use of CBT, Dialectical Behaviour Therapy (DBT) and Motivational Interviewing on cultural issues in therapy and the therapeutic alliance. Several studies retrieved from Psychinfo and Medline met the criteria for inclusion in this review. The NZGG (2008b) concluded that no psychotherapy was assessed as universally superior to any other. They also noted the distinct lack of suitable studies meeting the criteria for inclusion in the review regarding NZ Maori, Pacific or Asian responses to psychotherapy.

Culturally appropriate models are important in delivering services to specific populations (Dowell et al, 2009), and in accessing appropriate services this is an issue often faced in providing choices for patients.

**Assessment and monitoring treatment**

Assessment and monitoring of treatment is an important part of a brief intervention service in a primary setting. Assessment using a strengths focused approach can identify a person’s resources which may include supports, personal qualities and coping strategies, housing and financial supports. A strengths focused assessment can identify what further resources are needed (both internal and external) and can link people to assist acquisition of the most appropriate resources.

There is also evidence to show that telephone follow up improves treatment outcomes (NZGG, 2008a). Telephone contact used alone or in addition to face to face contact can be part of a brief intervention treatment.

**Psycho-education**

Psycho-education involves giving the patient information about their diagnosis, including prevalence, symptoms, related problems, and explaining recommended treatment and options available. Psycho-education interventions can be brief and considerably increase the compliance with medication and understanding of conditions and self-help methods. Psycho-education fits well with a stepped care approach to treatment. Education provides
patients with the tools that they can use to help themselves and link in with a range of internet websites, e-treatment programmes such as “Mood Gym” (an Australian online CBT-focused programme) and written information.

Biegler (2008) argues that the use of antidepressants fails to deal with the context in which depression occurs and that psycho-education empowers patients to make the necessary changes in their lives and feel more in control. Psychosocial stressors have been shown to trigger nearly 70% of depressive episodes (Biegler, 2008). Changes in brain chemistry that feature in depression and that are targeted by antidepressants are likely to follow from increased production of cortisol in response to stress (Van Praag, 2004).

Understanding the importance of the relationship between stressors and depression can assist in the way in which a person makes decisions in relation to a stressful event (Biegier, 2004:1046). Negative emotions arise when important goals and interests are threatened such as a relationship break up, death or job loss. Gaining an understanding of the stress that can lead to depression can also strengthen resiliency in managing stress in a more adaptive way in the future and hence prevent relapse.

**Cognitive Behavioural Therapy (CBT)**

There is a large body of literature that supports a strong evidence base for CBT for working with people with depression and anxiety disorders (NZGG, 2008b). Cognitive Behaviour Therapy is based on the concept that emotions and behaviours are the result of a persons cognitive process. It is possible for people to modify such processes to achieve different ways of feeling and behaving (Froggart, 2006). There are a number of cognitive therapies that have many similarities.

Cognitive therapy was pioneered by Alfred Adler and Albert Ellis, a Clinical Psychologist in the 1950s. Ellis trained as a psychoanalyst and sought a faster process to make change, reasoning that if therapy focused on clients’ beliefs, this would enable more effective change. Ellis was the founder of Rational Emotive Therapy (REBT). Other behavioural therapies such asGlassers’ “Reality Therapy” and Berne’s “Transactional Analysis” were initially categorised as Cognitive Psychotherapies (Froggart, 2006). In the 1960’s Aaron Beck developed “Cognitive Therapy” (CT). There have been a number of off-
shoots of these initial therapies and in the 1990s a number of other cognitive approaches were developed. The term, “Cognitive Behavioural Therapy” (CBT), came into use to describe therapies that are cognitive in nature.

The overall factor in these approaches is the view that cognition is a key factor in determining how people feel and behave. Changing the way we think can lead to change in behaviour and dysfunctional emotions (Froggart, 2006).

Due to the structured approach and the ability to measure changes in behaviour CBT has been one of the most studied therapies. Hence, there is a large body of evidence supporting this approach as an effective method of changing maladaptive behavior and dysfunctional thoughts. CBT is regarded to be most effective with 6 to 12 sessions delivered over 10 to 12 weeks (National Institute of Clinical Excellence [NICE], 2007). Where there are only four sessions available for some clients (as in MHBIS) an explanation of the principles of CBT and use of some of the CBT strategies can assist. The benefits of the client pursuing this further, either through reading, e-resources or referral to a CBT therapist are apparent.

Clients need to be at a place in their life where they are able to commit to a programme of CBT. Cost and accessibility of CBT practitioners can often be a barrier to access for people presenting in Primary Care.

**Motivational Interviewing**

Motivational Interviewing (MI) is very useful when a person is contemplating change but remains an ambivalence to change. Motivational Interviewing differs from other therapeutic approaches in that the emphasis is on resolving the ambivalence. Once this has been resolved then making further changes that will facilitate more adaptive changes in behavior will follow (Moyers & Rollnick, 2002). The model differs from other client-centred models by incorporating the therapist’s goals in regard to the appropriate direction of change while providing specific interventions to assist clients to achieve behavioural change.

Moyers and Rollnick (2002) outline four main principles of Motivational Interviewing as:

1) Express empathy using reflective listening to reflect understanding of the client’s message.
2) Develop discrepancy between the client’s most deeply held values and their current behaviour.

3) To roll with resistance, meeting it with reflection and not confrontation.

4) Support self efficacy through building confidence that change is possible.

Open-ended questions elicit information about clients’ values and goals and the discrepancy with their behaviour is explored. The therapist assists the clients to talk themselves into changing rather than using direct persuasion. Through changing the ambivalence experienced around change, a shift occurs to allow readiness for change.

Motivational Interviewing techniques were originally developed to address addictive behaviours (Miller & Rollnick, 2002). However MI has assisted in changing health related behaviours such as diet and exercise, risk behaviours and gambling.

Motivational Interviewing works well in a brief intervention model, allowing the client to seek clarity about the changes they want to make and preparing the groundwork to refer on to further counselling to make these changes.

Miller and Rollnick (2002) have investigated the impacts of brief interventions. A consistent finding of their research is that even brief interventions under certain conditions can trigger change. They report that one to two sessions of counselling often cause much greater change in behaviour than no counselling at all. Studies have shown that on average brief intervention outcomes are similar to those with longer term treatments. Change occurs early in treatment and the length of time to respond varies (Miller & Rollnick, 2002:5). Critical conditions that facilitate change to occur have been identified. Faith and hope have been identified as factors in facilitating change. Asking a person about the likelihood of change occurring has been identified as a reasonable predictor that change will occur (Miller & Rollnick, 2002).

**Interpersonal Psychotherapy**

Interpersonal psychotherapy is a structured psychological intervention that focuses on interpersonal issues. The therapist and patient work collaboratively to identify the effects of the main problem areas related to interpersonal conflicts, role transitions, grief and loss and
social skills and their effects on current problems. Symptoms are reduced through learning skills to cope with or resolve these problem areas (NZGG, 2008a).

A Christchurch study (Luty et al., 2007) of 117 outpatients with depression, anxiety and with co-morbid conditions compared the effectiveness of CBT and IPT. They found that both therapies were equally effective for mild to moderate depression with 55% of patients showing at least 60% reduction in symptom scores over a period of 16 weeks.

**Problem Solving Therapy**

Problem solving therapy (PST) is a structured approach that focuses on learning to cope with specific problem areas. Areas for work are identified with the client and therapist and worked on collaboratively, identifying key problem areas, breaking problems down into manageable tasks, solving problems and developing appropriate coping behaviours (NZGG, 2008a).

Evidence from the National Institute of Clinical Excellence (2004) guidelines indicates that PST provides direct and practical support for patients with mild depression and may be as useful as antidepressants. Studies indicate that problem solving is a useful component to assist patients experiencing a range of difficulties and has been useful in treating depression, anxiety and adjustment disorders (World Health Organisation Collaborating Centre, 2007).

Mynors-Wallis et al. (2000), found that problem solving treatment is an effective treatment for depressive disorders in Primary Care. The combination of problem solving treatment with antidepressant treatment was found to be no more effective than either treatment alone.

A systematic review of 22 studies using problem-solving therapy for depression in adults concluded that the combined use of PST and antidepressant treatment has more favourable outcomes compared with PST alone (Gellis & Kenaley, 2008).

**Other therapeutic models**

The PMHI evaluation report (Dowell et al., 2009) showed that of the range of models used within the Primary Care setting all were seen to provide similar results. It was
recognised that the eclectic nature of interventions meant that not all of the models used have evidence from therapeutic trials behind them. The skill and experience of the clinician appeared to be the ingredients that make a therapeutic difference. Other types of therapeutic models used in this study by clinicians included gestalt, narrative therapy, solution focused therapy, analytical psychotherapy, dialectical behaviour therapy, transactional analysis, person centred, interpersonal, personal construct therapy, self psychology, integrative, strength based, Hokomi, psychodrama and neuro linguistic programming.

Guided Self Help

Guided self help refers to assisting patients with the provision of psychological therapies through written or internet based materials (NZGG, 2008a). The majority of these materials are CBT based. There are a number of programmes available, such as moodgym.org.ac or climatetv, which guide people through a structured programme of CBT. Other self help strategies may include reading material, relaxation CDs or diary keeping.

A study reported by Miller and Rollnick (2002) looked at the difference for people who were placed on a waiting list and told to wait for an appointment compared to people who were given self-help materials and told to initiate change on their own. This study showed a significant difference in outcomes of these two groups. The group receiving self help material showing the most change. It seems that people who seek help show a positive drift to change, no matter what treatment is given (Miller & Rollnick, 2002).

Comparisons of positive change achieved between people given self-help materials and those attending counselling were undertaken. Rates of improvement varied between 25% -100%. The results were similar. On average there was no difference between the two groups. Counsellors who showed high empathy had more successful outcomes. The way in which the counsellor communicated can also make change either more or less likely. This highlights the importance of change talk as used in motivational interviewing.

Summary

Mental health care in the primary health setting focuses on assessment and management of illness and therapeutic input. The treatment provided centres around the
specific needs of the patient rather than formalised care. A review of the literature indicates that the majority of change takes place in the early stages of treatment (Miller & Rollnick, 2002). There is good evidence to suggest that therapist factors such as empathy, skill and engagement are more important than the actual therapeutic methods used (Thomas, 2007). It appears there are a range of therapeutic interventions that provide similar outcomes (Dowell et al, 2009).

Overall, it seems there is good efficacy for brief intervention, particularly in Primary Health Care. This fits with most Government initiatives and the goals of Government strategy as outlined in Te Tahuhu Improving Mental Health 2005-2015. This Second New Zealand Mental Health and Addition Plan (2005) seeks to ensure that all New Zealanders have access to mental health services that provide choice, promote independence and are effective, efficient, responsive and timely.

The South Canterbury MHBIS is an initiative arising from the Government’s strategy for mental health development; this is the focus of this research. The development of the service is discussed in the next chapter.
Chapter Four  

*Development of the South Canterbury Mental Health Brief Intervention Service*

As noted in the previous chapter 20% of the population has a mental health disorder at any one time. Also noted is that Secondary Mental Health Services (SMHS) can only service the 3% of the population that has chronic enduring mental illness. This means that the other 17% of the population suffering from mild to moderate mental disorder are seen in either community agencies or GP practices. Furthermore, while SMHS triage and manage people with personal life crises, unless they meet criteria for a DSM-1V (1994) diagnosis they will be referred back to the referring agency (usually the GP) for ongoing treatment. This of course delays the person involved any opportunity to receive early intervention.

GPs readily acknowledged this was problematic for many of their patients with mental health problems. However, until an alternative was developed the options were very limited.

The Mental Health Brief Intervention Service (MHBIS) a South Canterbury District Health Board (SCDHB) initiative established in 2005, provides a service for this population. That is that people with a mild to moderate mental health disorder can be treated in the community by Mental Health Clinicians without the need to involve more Specialist Secondary Care services such as the SMHS.

The New Zealand Primary Care Strategy (Ministry of Health, 2001) signalled a change in the way that mental health services needed to be delivered. The ‘Review of the opportunities’ document (Ministry of Health, 2002a) outlined the need for further service development to meet the needs of the 17% of the population with mild to moderate mental illness.

This document was quickly followed by the five year South Island Regional Mental Health Strategic Plan for 2002-2007 (Ministry of Health, 2002b). As such it sought to improve the health status of people with mental health problems through assisting early
identification and treatment of people with mild to moderate mental health problems within Primary Care. The plan aimed to: develop systems and infrastructure to improve outcomes for service users, integrate the recovery approach through all mental health services and systems, develop a workforce to enable delivery of these services and remove social and economic barriers to social inclusion for people with mental illness through collaboration with other sectors (Ministry of Health, 2002b:5).

In 2003, the Timaru SMHS reviewed client profiles through a process called “Knowing Your People Planning.” This entailed looking at individual SMHS consumer needs and providing a stock take and needs analysis of consumer needs in South Canterbury. During the “Knowing Your People Planning” process the need to focus services for those with more serious mental illness was identified. The need for further services that enabled people with mild to moderate mental illness to be supported in the community rather than SMHS was also noted.

In addition to this process the SMHS shifted from working with consumers from a predominantly medical focused model to a more Strengths Based Recovery Model (Baxter, 2007). This directed the focus away from symptoms of illness and long term case management to strengths assessment, goal setting with shorter admission periods and follow-up care managed by GPs in the community.

A Primary Mental Health Working Party was established in 2003 by SCDHB. The aim of the working party was to ensure referrals to SMHS were appropriate; to provide facilitated communication between GPs and SMHS to improve clinical support for GPs around issues of pharmacology. The working party included representatives from South Link Health (SLH), two local GPs and two PNs, representatives from SCDHB and Timaru SMHS. The role was to develop a package of Primary Mental Health Services to be available on an ongoing basis to GPs in South Canterbury (South Canterbury District Health Board, 2003). The key objectives identified were to facilitate consultation with Primary Care Clinicians, to identify potential service delivery options, to broadly scope the target population and to develop proposed service specifications. A coordinator was contracted to draw up service specifications and a service provision framework for the MHBIS.
Three programmes were initiated by the DHB. The first was the MHBIS which was contracted to SLH to provide services in a community setting. Secondly, providing the opportunity for GPs to undertake reviews of their patients with the SMHS, and where appropriate discharge reviews. Thirdly, allocating funding to assist GPs and PNs to undertake training and education in mental health (Baxter, 2007).

MHBIS service specifications

The aim of the MHBIS is to provide short term treatment and intervention for GP patients age 18 years and older who are affected by mild to moderate mental illness. Additionally, the service was established to ensure that those individuals, experiencing mild to moderate mental health issues in the community are identified, diagnosed and treated appropriately (South Canterbury District Health Board, 2004).

The specific tasks of MHBIS as outlined in the service specifications are as follows:

- To provide GPs with a referral option that is responsive to the needs of their clients and can assist with referral to the appropriate services where required.
- To give easy access to clients and their family/whanau to a service that may meet their immediate needs and plan a pathway to wellness.
- To enable appropriate referrals to community agencies and psychiatric services and facilitate this where appropriate.
- To meet the mental health needs of some clients who at present are referred to psychiatric services but whose needs would best be met within a primary service.
- To provide a geographically accessible service.
- To provide a resource for GPs to assist with short term follow up and compliment GP services by assisting in gathering further information enabling a comprehensive treatment plan and exploration of treatment options.
- To have strong links with community organisations and resources to enable easier access to the most suitable services.
- To recognise mental health issues as early as possible and to deliver effective treatment.
• To provide self help information, support and appropriate treatment/therapy to assist a person to rapidly resolve the issues causing them to be unwell.
• To effectively link with Specialist Services to facilitate specialist advice in a timely way.

Description of the South Canterbury district

The SCDHB includes Timaru City and Waimate, Pleasant Point, Fairlie, Twizel, Temuka and Geraldine. The boundaries for this district are from the Rangitata River in the North to the Waitaki River in the South. There are 28 General Practice centres in the SCDHB region serving approximately 55,000 patients. The population ratio per GP is lower than many other areas with 6.5 GPs per 10,000 population in Timaru compared with the national average of 8.3. In rural South Canterbury areas this ratio is even lower (Public Health Consultancy, 2001).

Establishment of MHBIS

MHBIS started operating in 2005 with two Clinicians (Nurse and Social Worker) who had previously worked in SMHS. It is a GP referral service. In the initial three months resource materials were developed and all GPs in the SCDHB area were visited. They were informed about the service, referral requirements and procedures. The availability of practice rooms in the Practice Centres for MHBIS to see patients was also arranged. The MHBIS was assisted by two GPs who championed the service with their colleagues. This supported building the relationship with GPs. Visits were also made to 52 community agencies and service providers to inform them of the service and to develop linkages for future liaison or referral.

MHBIS began seeing patients in April 2005. All GPs referred patients to MHBIS during the first six months. There are now four full time equivalent (FTE) positions shared by five staff including two Nurses, two Social Workers and an Occupational Therapist. The roles of the Clinicians and referrers are clearly outlined in the Service Provision Framework in Appendix 11.
Referral process

Referrals to MHBIS are by GPs or PNs with between 80 and 100 patients referred each month. In the first four years 3,201 referrals were received by MHBIS. Electronic or faxed referrals are entered in the SLH database. MHBIS Clinicians are assigned to specific practices and respond to referrals from those practices with a phone call within one working day where possible, or with a letter if phone contact is not an option.

The referral criteria are: That the person has an identified mild to moderate mental health concern or is at risk of developing a mental illness. The person would benefit from a short term treatment option for up to four sessions. That a pathway is needed to explore community referral options. That the GP requires more information around the issues affecting mental health and psychosocial factors that if addressed would assist in treatment. The person is over the age of 18 years and living independently. That people referred live in the South Canterbury Area and there is no immediate safety or risk concern. That issues referred are not solely violence and anger, intellectual disability (with or without behavior problems), learning difficulties, criminal activities (antisocial behaviours), parenting difficulties, alcohol and drug abuse or conduct disorder.

Most GPs have rooms available at specific times during the week. Patients are seen predominantly at their General Practice; however some patients are seen at the SLH office or community resource centers where GP rooms are not available. Home visits are made where access to the GP practice is difficult or due to illness, mobility or transport issues.

Referrals are received for a range of issues including anxiety, bereavement, depression, physical health or adjustment to illness, relationship problems or stress. MHBIS is able to provide a mental health assessment, explore other health related issues and look at referrals to other agencies where appropriate.

Assessment and treatment

The patient is entitled to four free one hour appointments over a 12 month period. The initial visit gathers information regarding patients’ concerns, mental health status and risk.
The initial and ongoing appointments might include education about diagnosis, stress management, strategies to manage anxiety, self-help strategies or information given about available resources or agencies. If referral to another service is appropriate this is discussed with the patient and either MHBIS makes a referral or the patient may self-refer. A plan is made for further contact to ensure engagement with the other service has occurred. Appointment times are often spaced out over a number of weeks especially where medication is prescribed to monitor the impact of treatment and phone calls between sessions provide further help, support and monitoring.

A range of models of working with patients are used by Clinicians including Cognitive Behaviour Therapy, Motivational Interviewing and Interpersonal Therapy approaches. Generally an eclectic focused approach is taken looking at the persons strengths, resources and using community resources where needed. The MHBIS uses a multidisciplinary team approach. Fortnightly meetings allow for review and peer supervision. MHBIS Clinicians also attend monthly clinical supervision with their own identified clinical supervisors.

Communication with Practices

South Link Health designed a database specifically for MHBIS. Clinicians were involved throughout the process of initial and ongoing development. The database links with the Information Technology programmes used by GPs, specifically MedCan and MedTech. This system allows referrals, Clinician notes and letters to be sent electronically. The initial assessment and letter are sent to the GP generally within a day of seeing their patient. A final letter and subsequent patient notes are sent to the GP when the patient is discharged. MHBIS is a resource for practices to discuss concerns regarding patients and ascertain community service information.

During treatment, when concerns arise or SMHS input is required GPs are consulted while the Clinician is at the practice or later with a phone call. All referrals to SMHS are made following consultation with the GP unless there is an emergency situation and there is no time to involve the GP.
Monitoring of MHBIS

Monthly statistics report on the number of new referrals, referrals where people have been previously seen, first face to face and follow up contacts and phone calls, total numbers of people supported during the month, ethnicity, numbers of people discharged and referrals to SMHS. The data base captures demographic and referral information from referrals. Other information is drawn from Clinicians’ clinical notes and on discharge. In addition to required reporting, statistics reports can be accessed on ethnicity and age group referrals, number of times people have been seen, number of presenting issues and types of issues and agencies referred to.

Monthly and quarterly reports are sent to SLH and the SCDHB.

MHBIS was audited by The South Island Shared Service Agency Limited (SISSAL) within the first year of operation (2005) and is to be audited again in 2009. The audit looks at service processes and elicits feedback from consumers and practices. SISSAL is owned by the six South Island District Health Boards. The audit programme provides a reliable and robust audit function that assists in monitoring services provided and funded by DHBs. Only minor changes were requested to processes at the initial audit.

Feedback surveys have been sent to GPs and patients each year and provide ongoing feedback about service outcomes. Permission by patients was given for the 2009 data to be included in this study, and this is discussed later in this chapter.

The Kessler 10 (K10) is used as a rating scale to measure progress of patients. The K10 is a self rating measuring tool administered on admission to MHBIS and again on discharge (appendix 12). The tool measures levels of psychological distress and scores support the identification of mild, moderate or serious depression or anxiety disorders. Although this tool has been widely used in health population surveys there have been few studies reporting on the results of use in Primary Mental Health settings. This scale has been used in the United States National Health Interview Survey and in general government health surveys in Canada and USA as well as World Health Organisation World Mental Health Surveys (Kessler et al, 2002). Results from K10 scores are reported in this chapter.
The K10 was chosen as this is an instrument recommended by the Ministry of Health as a tool for measurement of change for the PHOs starting mental health projects in 2006. The K10 has been widely used as a screening tool to discriminate between DSM-IV (1994) cases and from non DSM-IV cases in general purpose population health surveys (Andrews & Slade, 2001).

The K10 is a measure of non specific psychological distress. It is comprised of 10 questions using a five point scale rated from “a little of the time” to “all of the time”. Scores can range from 10 -50. The K10 has a focus on anxiety and depression with one score relating to the level of psychological distress. This score is a good indication as to whether the person is likely to have a mental disorder. People who score under 20 are likely to be well, scores 20-24 indicate a likely mild mental disorder; people who score 25-29 a likely moderate mental disorder and people scoring over 30 are likely to have a severe mental disorder (World Health Organisation Collaborating Care, 2007). Scores generally decrease with effective treatment.

**MHBIS evaluation 2007**

In 2007 an evaluation of MHBIS was undertaken for South Link Health by Dovey (2007). A random selection of 500 of the 1,548 patients who had attended the service between 31 July 2005 and 16 February 2007 was taken. Clinical data was extracted for analysis. The study looked at the demographic profile of service users, the presenting problems as stated on the referral and medication prescribed; number of appointments attended, agencies referred to and Kessler pre and post intervention scores. The resulting report also discussed feedback from a survey completed after the first 100 referrals to the service. This evaluation showed similar outcomes to those shown in this study. A review of K10 scores showed a mean score of 29.4 at the start of intervention and 21.4 at the end of intervention (p<0.001). There were high numbers of people presenting with a Kessler score over 30 (52.8%) in the 2007 evaluation compared to 57% in this study.

The study reported that most service episodes had successful outcomes in relation to people making needed changes in their lives (N=254; 50.8%), working through their issues to the extent of not needing further help from the service ( N=252; 50.4%), and being better able
to cope with their problems (N=162; 32.4%). Other outcomes included referral to another service or assistance accessing other services (N=125; 25%) and medication review (N=12; 2.4%) (Dovey, 2007).

**Mental Health Brief Intervention Service Statistics 01 January -30 June 2008**

**Data collection**

Service statistics have been extracted from the South Link Health MHBIS programme database for the six month period from 01 January to 30 June 2008. The total number of referrals during January –June 2008 was 474. This time period corresponds to the time period in which the survey and focus groups for this study were undertaken. MHBIS had been operating for three years.

**Who uses the Brief Intervention Service?**

Of the 474 referrals accepted between 01 January and 30 June 2008, 340 (72%) were female and 134 (28%) were male. Referrals under 18 years made up 4% of referrals, 18-24 years 16%, 25-44 years 40%, 45-64 years 28% and 65+ years 12%. Table 1 below shows the breakdown of age groups and gender, number of referrals and ethnicity. Of referrals seen 340 (87%) identified themselves as European and 18 (4%) as Maori; 44 (9%) as ‘other’ ethnicity.

The percentage of Maori seen (4%) is slightly lower than the 5.8% Maori population recorded for South Canterbury in the 2006 census (nationally Maori population is 14.6%). The 1% Pacific Island population in South Canterbury is also low in comparison to 7% for all of New Zealand (Statistics New Zealand, 2009). During the period of study only 1 Pacific person was seen.

*Table 1: Numbers of referrals by age groups and ethnicity*
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female</th>
<th>Male</th>
<th>NZE</th>
<th>Maori</th>
<th>Pacific Island</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>15</td>
<td>5</td>
<td>15</td>
<td>3</td>
<td>_</td>
<td>2</td>
</tr>
<tr>
<td>18-24 yrs</td>
<td>50</td>
<td>25</td>
<td>64</td>
<td>5</td>
<td>_</td>
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<td>25-44 yrs</td>
<td>139</td>
<td>52</td>
<td>162</td>
<td>7</td>
<td>_</td>
<td>22</td>
</tr>
<tr>
<td>45-64 yrs</td>
<td>95</td>
<td>36</td>
<td>118</td>
<td>2</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>65 yrs +</td>
<td>41</td>
<td>16</td>
<td>52</td>
<td>1</td>
<td>_</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>340</td>
<td>134</td>
<td>411</td>
<td>18</td>
<td>1</td>
<td>44</td>
</tr>
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</table>

**How often are people seen?**

As shown in Table 2 below, from the 474 referrals 68 people (16% of total referrals) declined an initial visit with MHBIS. Reasons for this vary and include issues resolving, people changing their mind about the referral, referral to SMHS or people leaving the area. From those that were seen 79 (23%) were seen once only, 105 (30%) two times, 76 (22%) three times and 44 (21%) four times and 14 (4%) more than four times, 68 people did not attend (DNA) appointments arranged.

Of the people referred to the service 20% have had previous admissions. This figure includes those who may have been referred to the service previously during the year but who may not have used all four sessions at that time and have been referred again. The total for this table exceeds 474 as some people DNA appointments more than once in addition to attending some appointments.

*Table 2: Cross tabulation of number of sessions attended by age group and gender (N=485)*
### Presenting issues

The majority of patients (54%) were recorded as presenting with one main issue, 40% with two issues, 4% with three issues and 2% with four issues. When looking at main reason for referral 94 were for depression, 45 anxiety, 64 for relationship problems, 29 grief and loss issues and 30 for stress. Other issues reported were physical health issues 20, work related problems 17, social problems 10, addiction 9, parenting related issues 9, caregiving issues 7, eating disorder 5, pregnancy related problems 5, Post Traumatic Stress Disorder 3, Post Natal Depression 3, social isolation 2, physical or sexual abuse 1 and anger/agresssion 1.

### Referrals to other services

In the six months from 01 January 2008 – 30 June 2008 only 17 (4%) patients were referred to SMHS. Referrals to community agencies have not been accurately recorded for this period as it was a new reporting area requirement. This has since been clarified and these referrals are now recorded.

However, what can be seen is that referrals out of MHBIS were made to a range of community services including; counselling services, parenting support agencies, budget

<table>
<thead>
<tr>
<th>Gender/Age</th>
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<th>1 time</th>
<th>2 times</th>
<th>3 times</th>
<th>4 times</th>
<th>&gt; 4 times</th>
<th>DNA</th>
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<td></td>
<td></td>
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<td></td>
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<tr>
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<td>3</td>
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</tr>
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<td>1</td>
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<td>0</td>
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<td>0</td>
</tr>
<tr>
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<td></td>
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<td>22</td>
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<td>45-6yrs</td>
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<tr>
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<td>79</td>
<td>105</td>
<td>76</td>
<td>75</td>
<td>14</td>
<td>68</td>
</tr>
</tbody>
</table>
advice, career services, Post Natal Adjustment Programme, Supporting Families Aoraki, Mental Health Support Trust, Workbridge and Disability Services. Furthermore as a self help resource the Mental Health Resource and Education Center has been a resource frequently suggested to patients. This is a free internet postal and library service run from Christchurch.

Green prescriptions have been used for some patients for support to increase levels of exercise. Referrals were also made to Quitline and a dietician. Some referrals are made for courses offered such as the Women’s Refuge (Steps to Freedom Course), Violence Intervention Programme, and courses through the Polytechnic.

**Kessler 10 Results**

The Kessler 10 is completed by patients seen at MHBIS at the initial appointment and where possible on discharge, thus allowing for assessment of change over the course of treatment to be determined.

A sample of 100 initial presentation and discharge K10 scores has been extracted from the database for the period January 2007 to June 2008. This period is wider than that chosen for other data to allow for a sample of 100 scores. The scores were entered into the Statistical Package for the Social Sciences (SPSS) for analysis.

As shown in Table 3 below, 57% of the people attending MHBIS scored 30 or more at assessment (a score that is indicative of a serious mental disorder or serious psychological distress). Whereas, on discharge only 3% of people scored over 30. The results indicate a significant change had occurred for patients seen between the first session and discharge. Scores at initial appointment ranged between 15 and 48 with a mean score of 30 (SD=7). The discharge mean score was 20 (SD=6). Thus, a significant change (p<0.001) has occurred between intake and discharge.

**Table 3: Frequency distribution of Kessler 10 score ranges (N=100)**
<table>
<thead>
<tr>
<th>Range</th>
<th>Intake</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20</td>
<td>10</td>
<td>46</td>
</tr>
<tr>
<td>20-24</td>
<td>15</td>
<td>29</td>
</tr>
<tr>
<td>25-29</td>
<td>18</td>
<td>22</td>
</tr>
<tr>
<td>30+</td>
<td>57</td>
<td>3</td>
</tr>
</tbody>
</table>

These findings are very similar to a previous evaluation of clients attending MHBIS where Dovey (2007) used a random selection of 500 from a total of 1,548 patients who had been through the service. This study showed a mean score of 29 at the start of the intervention and 21 at the end of the intervention (p<0.001). In total 53% of the clients in the evaluation had an initial K10 score of over 30 which is close to the 57% of this study.

**Patient feedback survey**

In February 2009 a MHBIS survey was posted to a random sample of 100 patients who had been discharged over the previous 12 months and who had attended the service at least twice during their admission. Just under 25% (23) completed the survey and five were returned as no address. The survey questions and results are in appendix 10.

The surveys returned reflect the demographic statistics taken from the data base for January – June 2008. Of the 23 surveys returned 16 (70%) were female and 7 (30%) were male, 21 (90%) were NZE, 1 was other European and 1 was ‘other’. The age groups were 17-24 years (3), 25-44 years (8), 45-64 years (7), 65-84 years (4).

The majority of people were seen three times (39%), eight people (35%) were seen twice, five (22%) people were seen four times and one person did not respond.

Patients were asked in what ways MHBIS had assisted them. As shown in Table 4 the majority of people (74%) reported that attending the service had made a positive difference in their life, five indicated no differences and one did not comment. The number exceeds 100 as more than one response was able to be recorded for this question.
Patients were asked to rate their progress from their perception since attending the service. The response options were: Recovered, Recovering, No Change and Worse. Seven reported recovered, 12 recovering, 2 no change and 1 worse.

**Table 4: Frequency distribution of ways that MHBIS had assisted**

<table>
<thead>
<tr>
<th>How MHBIS assisted</th>
<th>Responses (N=23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt listened to</td>
<td>20 (86%)</td>
</tr>
<tr>
<td>Received encouragement</td>
<td>15 (65%)</td>
</tr>
<tr>
<td>Helped understand what was happening to them</td>
<td>17 (73%)</td>
</tr>
<tr>
<td>Helped client gain perspective</td>
<td>13 (56%)</td>
</tr>
<tr>
<td>Providing information</td>
<td>17 (74%)</td>
</tr>
<tr>
<td>Help with strategies</td>
<td>14 (60%)</td>
</tr>
<tr>
<td>Help with goal setting</td>
<td>9 (39%)</td>
</tr>
<tr>
<td>Referral to another agency</td>
<td>4 (17%)</td>
</tr>
</tbody>
</table>

**Summary**

This chapter has explored the initiatives that led to the development of MHBIS. In doing so who can refer and how referrals can be made was discussed. While initially MHBIS was available on GP referral only this has now been extended to include referrals from the PNs working in the practice centres.

In regards to who presents at health services the study showed attendees to MHBIS are predominantly European females. The largest cluster were aged between 25-44 years. By far depression was the main reason for referral.

Findings from patient surveys indicated that the majority of patients attending MHBIS found it a positive experience that assisted them make positive life changes. Indeed this is reflected in the considerable reduction that occurred in the mean scores on the Kessler 10 between intake and discharge.
Together the responses to the patient survey and the positive changes in the Kessler 10 mean scores give a service users perspective in regard to how attendance at MHBIS has made a positive impact on their lives. What is not known is whether this impact has a flow on effect in General Practice. That is, does the service improve the mental health status of patients attending GPs? Also unknown is the impact that MHBIS has had for General Practices on the delivery of services and the treatment that they are able to offer patients. Identification of patient groups that MHBIS is most effective with is seen as helpful. The study also sought to examine what difference, if any, MHBIS has made to referrals to Secondary Mental Health Services. Exploring these questions is the overall aim of this study and to examine the impact of the service on patient outcomes from the perspectives of those working in General Practice and in the MHBIS. The methodology and findings are presented in the following chapters.
Chapter Five

Methodology

This chapter canvases the main research methodologies, in doing so the advantages and limitations of each are highlighted. The chapter then discusses the rationale for choosing a mixed method approach to this study.

The two main research methodologies are qualitative and quantitative. The debate over the merits of quantitative versus qualitative methods has been ongoing for well over two decades (Murphy & Matterson, 1992). There are merits to both approaches. The main differences between these two approaches are discussed in the following section.

Each method has its merits, both have something to offer and over time have been viewed as being compatible with each other. Murphy and Mattson (1992) argued that qualitative research methods reflect the focus of primary care medicine and are concerned about people as individuals, and treating the whole person rather than the person as a “carrier of disease”. Primary medicine also takes into account the meaning of events or symptoms to the individual, this is especially so in mental health where social and environmental situations often effect wellness. Quantitative methods on the other hand are more concerned with objective scientific outcomes, the relationship between cause and effect.

Quantitative research

Quantitative paradigms originated from a scientific approach and the desire to apply methods of science to solving and understanding problems from the natural world to the social world (Tolich & Davidson, 1999). Quantitative research has an assumption that social facts have an object reality and can be measured and identified. Research from a quantitative viewpoint is based on an outsider’s point of view. Quantitative research can be generalised to other areas, facts can be predicted and causal explanations offered. A quantitative approach begins with a hypothesis and theories. Tools may be used for measurement, theories applied to observations, and experiments carried out providing results that can be measured and
analysed. Data is then reduced to numbers and thus, the research is reliant on what can be measured. This approach is also referred to as a positivist paradigm.

Critiques of quantitative research have argued that the rigor involved in research may detract from the relevance and the ability to generalise findings, as the context of the research is often not taken into account (Guba & Lincoln, 1994). Furthermore, wider meaning and purpose may be overlooked in the search for objectivity.

**Qualitative research**

In contrast a qualitative approach ends with the hypothesis and grounded theory (Tolich & Davidson, 1999). The research is from a person’s perspective with the researcher being the tool. Qualitative research searches for patterns emerging. The write up is descriptive with lesser use of numbers. In qualitative research reality is socially constructed with the subject matter being the primary focus. This paradigm recognises that there are complex variables and these are interwoven and difficult to measure (Tolich & Davidson, 1999). Research is in relation to the context and relies on interpretation and understanding of the insider’s point of view.

This is a different role from that of the quantitative researcher where the role is one of detachment and impartiality. In qualitative research the approach requires involvement; it is personal and includes empathic understanding.

Tolich and Davidson (1999), introducing the idea of reflexivity say that “…social researchers always remain part of the social world they are studying, their understanding of that social world being their daily experience of life (commonsense)” (Tolich & Davidson, 1999:37). There is no way to remove the effect of the researcher on what is being researched.

Bassett (1995) describes any method that reflects upon and questions its own assumptions as being reflective. The values of the researcher are seen to become an explicit part of the research. Truth then becomes relative.
Mixed methods

The use of a mixed methods approach provides greater validity for studies such as this as, where possible, it captures a wider range of viewpoints. As such, how a service is viewed by those making referrals and the practicalities of the service in the day to day working of the General Practice can be explored. Mixed methods approaches enable triangulation of results. The term triangulation is one that comes from surveying or navigation disciplines as meaning using more than one point of reference (Clarke & Dawson, 1999). Denzin (1970) cited in Clark & Dawson (1999:86) describes four types of triangulation. The first, using multiple data sets, is where a variety of contexts and settings are used at different points in time. Secondly, research where one or more researchers or evaluators investigate a situation. Denzin recognises that the approach taken by a researcher is influenced by the researchers’ discipline, theoretical orientation and methodology preferences. This study involves the views of different disciplines. Furthermore data from patient surveys is also included which gives another source of information. Thirdly, theory triangulation occurs when data is explained by a number of different or competing theories. Fourthly, methological triangulation in which a distinction is made between a “within method” approach and “between methods” approach. “Within method” refers to when the same method is used on different occasions or when using a number of techniques within a given method.

In my own research I have used “between methods” which refers to the mixing of methods within a research design. This is demonstrated in this research by using both questionnaires and focus groups giving a mix of qualitative and quantitative data. Data extracted from the service data base adds a further method of data collection. This triangulation of data allows for greater confidence in research findings rather than relying on a single data collection method. Differences in the perspectives of General Practitioners (GPs), Practice Nurses (PNs) and MHBIS Clinicians emerge through the coding and comparison of data.

The aims of this study

A major aim of this study was to ascertain the level of feedback General Practice staff received from patients and the way in which they were able to engage patients in attending the service. While some of this information can be captured from responses to questionnaires, a
greater depth and understanding can be gained through a collection of data from group discussion.

Focus groups have also been a way of gaining a greater level of participation in the study as they allowed for interaction and sparking of ideas between participants. The different professional groups involved have been able to present the perspective of their discipline and the way that they perceive the service. Differences in the type of relationship and interactions that each group has with patients have also been able to be explored.

The overall aim of the study is to ascertain the service from a GP, PN and MHBIS Clinicians’ perspective and to examine the impact of a mental health brief intervention on patient outcomes. More specifically the aims are:

1) To ascertain a GP perspective in regard to the impact MHBIS has had on outcomes for patients.

2) To ascertain a PN perspective in regard to the impact MHBIS has had on outcomes for patients.

3) To ascertain MHBIS Clinicians perspective in regard to outcomes for patients.

4) To determine if there has been a reduction in need to refer patients into SMHS.

5) To determine the group of patients who benefit the most from MHBIS.

6) To determine the group of patients who benefit the least from MHBIS.

7) To determine how decision making for referral to MHBIS is made.

8) To ascertain the benefits of a General Practice team approach, with the GP as the initial point of contact.

The two main hypotheses are:

1) That Mental Health Brief Intervention does improve the mental health status of patients attending General Practitioners.

2) The Mental Health Brief Intervention Service enhances the interface between Primary Care Health Services and Secondary Mental Health Services.
**Instruments used**

A questionnaire, specifically designed for this study, was employed to survey GPs, PNs, and MHBIS Clinical Staff (Appendices 5-9).

The questions were designed to be easily answered by using tick boxes and rating scales. Space was also allowed for comments to elaborate or give explanations around responses made. Recognising the time demands and perceived general reluctance of participants to complete ‘paper work,’ the questionnaire was deliberately kept short with a yes/no format for questions to allow for easy completion. Some scale questions have been used and some questions have required a written response. Space was also provided for respondents to make additional comments.

The questions arose out of discussion with the MHBIS clinical team about what information would be useful in terms of feedback about the service. Patient and GP feedback surveys had been conducted in the past thus attempts were made not to replicate information already collected. Some of the questions arose from information gained in the previous GP feedback surveys.

All the questions for GPs and PNs were the same with some additional questions that more specifically applied to GPs in regard to medication and referrals to Secondary Services being included. Questions intended for PNs were also discussed with the one Nurse Practitioner (NP) in the study as to their suitability for her role and for PNs. Questions for GPs were discussed with the South Link Health GP representative.

The questionnaires were accompanied by a letter introducing myself and the research as well as an information sheet and consents with addressed and return envelopes (see Appendices 1-2).

For the focus groups semi-structured open ended questions were used. With the omission of several questions for the MHBIS Clinical staff as they were not relevant for this group all questions were basically the same (Appendices 5-9).
Data collection

The questionnaires were delivered to all GPs (39) and PNs (50) in General Practices. Most were hand delivered by the researcher to the reception staff who were informed about the research. Pick up of completed questionnaires was arranged for one to two weeks after delivery. For some rural practices questionnaires were mailed out with a self return envelope. Questionnaires were given directly to focus group participants with a verbal explanation in addition to written information. The researcher either visited the surgeries twice to collect the questionnaires, or contacted the practice by telephone. Some practice staff elected to post the questionnaires back rather than have them collected.

Most of the PNs work part time and have specific roles around smear taking, immunisation or child health. The MHBIS was designed initially for GP referral, but later on was widened to include referrals from PNs. However, the practices differ widely in how PNs refer and follow up of patients seen by the service. The majority of the surveys returned by PNs were from PNs that either do refer or had received feedback from patients about the service.

There is one Nurse Practitioner (NP) included in the sample. This new role, a first in South Canterbury has diagnostic and some prescribing responsibilities. The NP responses to questionnaires have been included with the PN responses.

Focus Groups

The cover letter that went with the survey questionnaire (Appendix 1) invited the participants to contact the researcher directly if they were prepared to participate in the focus groups. There were no direct requests from participants. Four peer groups were approached and asked if they would like to participate, all of whom agreed to do so. Peer groups of GPs and PNs generally meet once a month for ongoing professional development. Peer groups were chosen as a focus group forum as they are an established group meeting that is recognised for credits towards the hours needed to maintain registration and are therefore, generally well attended.
There were two focus groups for the GPs involving 11 GPs in total. One was an evening group with a mix of rural and town GPs. The mix included GPs from three General Practices that the researcher works with and two that the researcher had little contact with. The group was facilitated by the researcher. The other focus group was a lunch time peer group meeting with limited time. This group involved six GPs whom the researcher does not directly work with. A colleague who had recently joined the MHBIS team, and who had not previously met the GPs or PNs involved attended the groups however with the exception of the evening GP group, to take notes and give feedback.

The researcher facilitated two focus groups with the PNs. Both were conducted during their lunchtime peer group meetings. Six PNs attended one group and one PN and NP the other. Only the NP had worked directly with the researcher.

The researcher met with the MHBIS Clinician group as the facilitator but did not participate in answering questions. One member of the team has been involved since the start of the service, one for one year only, one for three months and one for two months.

Five GPs requested to view transcripts and provide feedback. All PNs declined the offer to view transcripts. Two MHBIS Clinicians viewed transcripts.

Non identifying data on 474 patients seen between 1 January and 30 June 2008 was extracted from the MHBIS database for inclusion in the research.

Additionally, MHBIS surveys are sent routinely to discharged patients. Information from 23 returned 2009 survey sheets were also included in this study (Appendix 10).

**Data cleaning and coding**

The questionnaires were coded so that responses could be directly entered onto the Statistical Programme for Social Sciences (SPSS) for analysis. Written responses in the free text sections were coded for emerging themes, transformed into variables and then also entered into SPSS for analysis.
The focus groups were recorded and the responses transcribed. Thematic coding was then used to identify the themes. The themes were then transformed into quantitative variables and entered into SPSS for further analysis. This involved grouping answers to each question together then coding and recording them to form the main emerging themes until saturation point was reached (Tolich & Davidson, 1999).

**Data analysis**

Data from the questionnaires was analysed using SPSS software. Qualitative information from free text questions were thematically coded and also entered into the data base.

Transcripts from focus groups were analysed for primary themes to describe how MHBIS improves the mental health status of patients attending GPs and to explore the change in the interface between Primary Care Health Services and the SMHS.

Information from the questionnaires and focus groups has been cross referenced to provide validity of data.

**Ethical approval**

As part of preparing for the ethics committee process the following people were consulted:

- Bruce Wikitoa, Kaumatua and Cultural Advisor for the South Canterbury District Health Board.
- Wayne Smith – Maori Health Advisor for South Link Health
- Tim Russell – Manager of Whanau Services Temuka (local Iwi Service Provider) consulted with and provided a letter of support from the Arowhenua Marae.
- Vicki Cunningham – Pacific Peoples Mental Health Advisor Representative.
- Dr Ian Smith, GP representative for South Link Health.
- Michelle Baldwin- South Link Health Locality Manager.
- Jane Brosnahan - Performance Management Coordinator for the Aoraki Primary Health Organisation (PHO).
- Clinical staff of MHBIS, Sally Feely, Viv Dalrymple and Sandra Williams.
• Nurse Practitioner Sharon Hansen and Coordinator of Care Plus, Aoraki Primary Health Organisation.

These consultations assisted in the preparation of the questionnaires, focus groups and methodology used.

Ethics committee approval was first sought from the South Link Health Ethics Committee which included input from several GPs. Feedback from this application was the need to include the question “What do you consider are the benefits of a General Practice team approach with the general practitioner as the initial point of contact?” The committee also recommended that patient feedback be included.

Ethics approval was then sought from the Upper South B Regional Ethics Committee to include patient feedback surveys. This committee recommended that in order to include patient feedback from the MHBIS an additional comment on the service survey form informing participants that the information may be used as part of a research study had to be added.

In June 2008 the Upper South B Regional Ethics Committee and Ngai Tahu Ethics committees approved the study.
Chapter Six

Results

This chapter reports on the findings from the questionnaires completed by the General Practitioners (GPs), Practice Nurses (PNs) and MHBIS Clinical staff and the focus groups.

A questionnaire, using a range of methods for data collection from tick box answers, rating scales and free text sections, was sent to potential study participants. The majority of the questions were the same for each group with the addition of questions for GPs around medication and referral to Secondary Mental Health Services. All responses to the survey questionnaire were coded and entered into Statistical Package for Social Services (SPSS) for data analysis.

The focus groups undertaken with the GPs, PNs, and the one with MHBIS Clinical staff allowed for the collection of qualitative data. All basically used the same questions with some exclusions for the MHBIS staff. The findings are reported in two parts; questionnaires and focus groups.

Part One-Questionnaires

Response rate

The sample included all practicing GPs, PNs working in the 28 General Practices in the South Canterbury District Health Board area. Thus, in total, 96 questionnaires were presented to 52 PNs, 39 GPs and 5 MHBIS Clinicians.

Of the 52 PNs surveyed 23 (45%) returned questionnaires. Four returned their questionnaires unanswered stating they did not work with MHBIS patients directly or make referrals and thus felt unable to comment. The one Nurse Practitioner (NP) included in the sample worked for three practices. The NP responses are included with the PN responses to allow for anonymity and ease of coding. A large percentage of PNs work part time and have
specific roles around smear taking, immunisation or child health. The majority of the questionnaires returned were by PNs who either refer to MHBIS or had received feedback from patients about the service.

Of the 39 GPs surveyed 21 (54%) returned questionnaires. All 5 (100%) of the MHBIS Clinicians surveyed returned the questionnaires. The sample of the MHBIS group included one Clinician who had worked with the service for two years but had left three months previously.

Demographic characteristics of the sample

The final sample consisted of 49 participants; 35 female (72%) and 14 (28%) male. As health professionals 21 were GPs; 23 PNs and 5 MHBIS Clinicians. The age range was consistent across all three groups with the majority (84%) being aged between 41-60 years. The overall ethnic distribution was 82% NZ Pakeha; 2% NZ Maori and 10% ‘other’. Table 5 below shows the particular characteristics for each participant group.

Table 5: Cross tabulation of demographics for all participants (N=49)

<table>
<thead>
<tr>
<th>Demographics</th>
<th>GPs (n=21)</th>
<th>PNs(n=23)</th>
<th>MHBIS (n=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 30-40yrs</td>
<td>1</td>
<td>3</td>
<td>_</td>
</tr>
<tr>
<td>41-50 yrs</td>
<td>9</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>51-60yrs</td>
<td>9</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>60+</td>
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<td>1</td>
</tr>
<tr>
<td>Gender Male</td>
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<td>_</td>
<td>_</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>23</td>
<td>5</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZ Pakeha</td>
<td>17</td>
<td>22</td>
<td>4</td>
</tr>
<tr>
<td>Maori</td>
<td>1</td>
<td>_</td>
<td>_</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
General Practitioners

Of the GPs surveyed 14 (66%) were male and 7 (33%) were female, 81% identified as NZ Pakeha, 1 as NZ Maori and 3 as ‘other’ ethnicity. The age group distribution was 30-40 years 5%, 41-50 years 43%, 51-60 years 43% and over 60 9%. The GPs were predominantly located in Timaru city (67%) with smaller numbers (3%) in Temuka and the rest (19%) in the surrounding rural area which includes Pleasant Point, Fairlie, Twizel, Geraldine and Waimate.

Over the three months prior to the survey five of the GPs estimated referring less than five patients to MHBIS; 10 estimated referring five but less than 10; another five GPs referred between 10-15 patients and with two GPs estimating referring 20 patients. Timaru GPs reported more referrals than Temuka or the Rural GPs. This does not necessarily reflect referral rates in the Temuka and rural areas as the response rate to the survey from these areas was lower. Furthermore, while the Waimate and Geraldine GPs did not respond to the questionnaire they frequently make referrals to MHBIS.

Practice Nurses

Of the PN surveyed all were female, 96% identified as NZ Pakeha and one as British (4%). The PNs were predominantly located in Timaru City (57%) with 30% in Temuka and the rest (13%) in rural areas.

The majority of the PNs surveyed (83%) had referred patients to MHBIS and the remaining PNs (17%) reported not making any referrals. Over the three months prior to the survey 13 PNs estimated referring less than five patients, four estimated referring six patients and one Nurse Practitioner (NP) estimated referring 10 patients. PNs in Temuka and rural areas estimated referring 23 patients and Timaru PNs 28 patients. Overall the Temuka and rural PNs referred more patients per practice than the city PNs. The NP is included in the Temuka and rural sample and has referred a higher number of patients than the PNs.
MHBIS Clinicians

All the MHBIS Clinicians were female; 80% identified as NZ Pakeha and one participant was Dutch. As with the GPs and PNs 40% were aged between 41-50 years and 40% between 51-60 years; 20% were 61+ years of age.

Difference MHBIS has made to the Practices

Using a variety of statements GPs and PNs were asked how MHBIS made a difference to their practice. As seen in Table 6 below, all perceived MHBIS offered an accessible treatment option with 98% seeing that the information gained assisted ongoing treatment. Over three-quarters (78%) noted that attendance at MHBIS resulted in a reduction in the number of times a patient presented to the practice centre for the same problem.

Table 6: Frequency distribution of how MHBIS has made a difference to the Practices. (N=44)

<table>
<thead>
<tr>
<th>Differences Noted</th>
<th>GPs (% n=21)</th>
<th>PNs (% n=23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides an accessible treatment option</td>
<td>Yes 21(100)</td>
<td>Yes 23(100)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>N/A*</td>
</tr>
<tr>
<td>Information from MHBIS assists ongoing treatment</td>
<td>Yes 21(100)</td>
<td>Yes 22(96)</td>
</tr>
<tr>
<td></td>
<td>N/A*</td>
<td>N/A*</td>
</tr>
<tr>
<td>Patients referred present less frequently</td>
<td>Yes 17(80)</td>
<td>Yes 17(74)</td>
</tr>
<tr>
<td></td>
<td>No 2(10)</td>
<td>N/A*</td>
</tr>
<tr>
<td></td>
<td>N/A*</td>
<td>6(26)</td>
</tr>
</tbody>
</table>

*N/A = no answer

Additionally 15% of the GPs and 22% of the PNs commented that a patient being seen quickly was beneficial. Furthermore 13% of the PNs noted that having no cost to attend the MHBIS assisted access and 9% believed providing MHBIS at the practice centre was advantageous.

One PN commented that having MHBIS available made a significant difference to the running of the Practice as previously therapy was not an available option. Another PN expressed a similar viewpoint and considerable relief at having qualified mental health staff offering an effective service that was available to the patient so quickly.
It was also expressed that having a treatment option for patients who historically may not have been seen again was important. Previously these patients have fallen through the gap due to cost for extra GP visits or counselling. This was further evidenced by a PN who commented that she felt “able to offer more to our patients...before I needed to refer to counsellors and patients were very wary of this.” Help with triage and referral to other agencies was also valued.

**How has MHBIS helped patients?**

The majority of GPs (95%) and PNs (90%) perceived that MHBIS helped patients recover more quickly from depression or anxiety. Those who did not agree with this statement either did not respond to the question or were unsure. All saw that being able to be referred onto services more appropriate to patients needs was beneficial. Many of the GPs (73%) and PNs (74%) perceived that early intervention resulted in less time off work for depression or anxiety related conditions. One PN commented that she did not have contact with MHBIS patients and another that she had no data on time off work. The responses to this question have been collated and presented in Table 7 below.

**Table 7: Frequency distribution of how MHBIS has helped patients (N= 44).**

<table>
<thead>
<tr>
<th>How MHBIS has helped</th>
<th>GPs (%) n=21</th>
<th></th>
<th></th>
<th>PNs (%) n=23</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients recover sooner from depression and anxiety</td>
<td>20 (95)</td>
<td>_</td>
<td>1 (5)</td>
<td>21 (90)</td>
<td>_</td>
<td>2 (10)</td>
</tr>
<tr>
<td>Patients referred on to other services appropriately</td>
<td>21 (100)</td>
<td>_</td>
<td>_</td>
<td>22 (96)</td>
<td>_</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Patients need less time off work for mental health</td>
<td>15 (71)</td>
<td>1 (5)</td>
<td>5 (24)</td>
<td>17 (74)</td>
<td>1 (4)</td>
<td>5 (22)</td>
</tr>
<tr>
<td>Patients are supported to make lifestyle changes</td>
<td>21 (100)</td>
<td>_</td>
<td>_</td>
<td>23 (100)</td>
<td>_</td>
<td>_</td>
</tr>
<tr>
<td>Patients have strategies to reduce anxiety</td>
<td>20 (95)</td>
<td>_</td>
<td>1 (5)</td>
<td>23 (100)</td>
<td>_</td>
<td>_</td>
</tr>
<tr>
<td>Information given to patients assists treatment</td>
<td>19 (90)</td>
<td>_</td>
<td>2 (10)</td>
<td>18 (78)</td>
<td>_</td>
<td>5 (22)</td>
</tr>
</tbody>
</table>

*N/A = no answer or unsure*
As shown in Table 7 all respondents saw the MHBIS supported patients in making positive lifestyle changes.

All the GPs and the majority of PNs (95%) noted that patients gained strategies they could use to help them reduce anxiety.

In the main, 90% of the GPs and 78% of the PNs agreed that information given to patients assists with treatment. A number of GPs and PNs did not answer this question. However this may be because they do not know what information was given to their patients and how this may, or may not have helped.

Patients prescribed anti-depressant medication are more likely to have follow-up GP appointments and have conversations about their experiences of MHBIS. This ongoing contact assisted GPs respond to the questionnaire more easily than the PNs, who on the whole, are less likely to have contact with patients after MHBIS intervention.

In the comments section of the questionnaire four GPs indicated that referral to MHBIS was less stressful for patients than referral elsewhere, thus they felt safer and were able to work through issues and reduce incidence of relapse more readily.

One GP noted “…generally when depression is diagnosed and addressed MHBIS is helpful. This is especially so if the depression is situational as while it does not decrease the length of the problem it does make it more manageable.”

Of the 40% of the PNs who commented on how MHBIS helps patients 13% noted the ability of the service to see patients quickly as being helpful as patients then did not return as frequently to the practice. Other comments included that patients are seen before problems escalate and are more willing to participate; no cost involved for patients struggling financially is an incentive; patients sometimes feel relieved that they have an illness (problem) that has been recognised and taken seriously. PNs commented that:

“…MHBIS is wonderful for clients as we have limited time to deal with all those with physical, emotional and social problems, it’s great to share these aspects of care as PNs have limited time.”
“…where patients are being treated in combination with medication it is difficult to assess what has helped most.”

**MHBIS Clinicians view on what works well about the service**

All the Clinicians considered that patients being seen at GP rooms; the short waiting times for appointments; patients setting their own goals; information given about their illness and recovery and the ability for patients to learn strategies to assist recovery were key factors that worked well about the service. Communication between GPs and MHBIS Clinicians generally worked well for 80% of the Clinicians. One Clinician recorded being unsure about this factor.

That patients were unlikely to seek help from other counselling services was also seen as being an important factor as was support for patients to talk about their issues and externalise their concerns.

**MHBIS perception on what works less well**

In contrast to the GPs and PNs the service being free was seen by one MHBIS Clinician as some people perhaps not valuing the service. The number of people not attending arranged appointments was cited as evidence of this. The lack of commitment of some practices to provide adequate space to see clients and the limit of four sessions was not always seen as helpful.

**Are four sessions enough?**

The question about whether four sessions is enough is an ongoing debate with divided opinion in regard to this matter, for example two Clinicians answered yes and another two answered no. Overall four sessions was seen to be effective in encouraging proactive interventions. Occasionally having the flexibility to offer a further one or two sessions would be useful.

Two of the Clinicians thought that six sessions would be more beneficial and one stated the literature which shows brief intervention is most effective with 5-10 sessions. One Clinician suggested that “…while the initial cap of four sessions works well to get things going perhaps a fifth or sixth or session could be built into service specifications.”
Patients more likely to attend a referral made to MHBIS than a referral to a counsellor

In response to this question 91% of the GPs and 96% of the PNs thought that patients were more likely to attend a referral made to MHBIS than a referral to another counselling service. One GP disagreed with this statement.

Difference to medication prescribing for patients attending MHBIS (GPs only)

As shown in Table 8 two-thirds of the GPs (66%) reported prescribing less psychiatric medication with 10% commenting that compliance could be attributed to the explanation given about medication. One reported that they perceived that patients felt more closely monitored in regard to compliance with taking medication with contact from MHBIS.

Table 8: Frequency distribution of how attending MHBIS make a difference to GP prescribing (N=21)

<table>
<thead>
<tr>
<th>Difference made to prescribing</th>
<th>GPs n=21 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing remains the same</td>
<td>5 (24)</td>
</tr>
<tr>
<td>Prescribing more often</td>
<td>1 (5)</td>
</tr>
<tr>
<td>Prescribing less often</td>
<td>14 (66)</td>
</tr>
<tr>
<td>Not answered or unknown</td>
<td>1 (5)</td>
</tr>
<tr>
<td>More effective prescribing</td>
<td>18 (85)</td>
</tr>
<tr>
<td>Greater compliance with medication</td>
<td>16 (76)</td>
</tr>
</tbody>
</table>

Frequency of feedback about the service

All the GPs and all the PNs reported receiving some feedback about the service from patients. The GPs reported that as patients referred to MHBIS reduced the need for patients to represent this in turn means they do not necessarily see patients who are not on medication again, thus do not receive feedback about their experiences with MHBIS.

While PNs often see patients in a less formal role than the GP they do not always get as much feedback as the GP. Frequency of feedback is shown in Table 9.
Table 9: Frequency distribution of feedback received by GPs and PNs

<table>
<thead>
<tr>
<th>Frequency of feedback</th>
<th>GPs n=21 (%)</th>
<th>PNs n=23 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Occasionally</td>
<td>2 (10)</td>
<td>6 (26)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>4 (19)</td>
<td>3 (13)</td>
</tr>
<tr>
<td>Often</td>
<td>9 (43)</td>
<td>11 (48)</td>
</tr>
<tr>
<td>Very often</td>
<td>6 (28)</td>
<td>3 (13)</td>
</tr>
</tbody>
</table>

How do patients generally rate the help received from MHBIS?

GPs and PNs were asked how patients rated the help they received from MHBIS. The options were; no help, a little help, some help, helped a lot and extremely helpful. As shown in Table 10 below overall the comments were very positive: 29% of the GPs and 35% of the PNs reported the patients rated MHBIS as being extremely helpful, 71% GPs and 12% PNs as helped a lot and 13% of PNs as being of some help.

Table 10: Frequency distribution of level of help from MHBIS

<table>
<thead>
<tr>
<th>Rate of help</th>
<th>GPs n=21 (%)</th>
<th>PNs n=23 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No help</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>A little help</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Some help</td>
<td>–</td>
<td>3 (13)</td>
</tr>
<tr>
<td>Helped a lot</td>
<td>15 (71)</td>
<td>12 (52)</td>
</tr>
<tr>
<td>Extremely helpful</td>
<td>6 (29)</td>
<td>8 (35)</td>
</tr>
</tbody>
</table>

Decision to refer to MHBIS

The decision to refer to MHBIS for GPs was primarily based on presenting symptoms; the patient’s willingness to accept help, the level of emotional distress, and the patients’ level of functioning. The same reasons were rated highly also by the PNs. Some GPs (67%) refer to MHBIS as a first treatment option; 43% of the GPs and 22% of PNs referred if more
information was needed and 57% of GPs and 52% of PNs would refer if the patient requested the referral. Occasionally, rating scales were used to assist in making a decision in regard to referral. The factors involved in decision making about referral to MHBIS are shown in Table 11.

**Table 11: Frequency distribution of factors in decision to refer to MHBIS (N=44)**

<table>
<thead>
<tr>
<th>Decision to refer to MHBIS</th>
<th>GPs n=21 (%)</th>
<th>PN n=23 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>On presenting symptoms</td>
<td>21(100)</td>
<td>_</td>
</tr>
<tr>
<td>On patients level of functioning</td>
<td>20 (95)</td>
<td>1 (5)</td>
</tr>
<tr>
<td>If psychiatric medication is prescribed</td>
<td>4 (19)</td>
<td>16 (76)</td>
</tr>
<tr>
<td>If considering prescribing try MHBIS first</td>
<td>14 (67)</td>
<td>7 (33)</td>
</tr>
<tr>
<td>Willingness to accept help</td>
<td>21(100)</td>
<td>_</td>
</tr>
<tr>
<td>Patient presents in emotional distress</td>
<td>21(100)</td>
<td>_</td>
</tr>
<tr>
<td>Need for more information about patient</td>
<td>9 (43)</td>
<td>11 (52)</td>
</tr>
<tr>
<td>Request from patient</td>
<td>12(57)</td>
<td>6 (29)</td>
</tr>
<tr>
<td>Rating scale scores used</td>
<td>2(10)</td>
<td>19 (90)</td>
</tr>
</tbody>
</table>

Effectiveness of service for different disorders

All the GPs, PN and MHBIS Clinicians were asked to rate how effective they thought MHBIS was in treating depression, anxiety, adjustment disorder, grief, co-morbidity (physical and mental) and relationship or family distress.
Likert (Trochin, 2008) rating scales were used to determine the areas where MHBIS was seen to be the most effective. The rating options were 1) not at all 2) poor 3) little 4) mostly 5) effective 6) very effective 7) highly effective.

To determine the areas where the service is most effective mean scores were computed for each disorder. MHBIS was found to be very effective in the treatment of Depression, Anxiety, Grief and relationship distress (mean score 6: SD=1) this was closely followed by Adjustment Disorder and Co-morbidity (mean score 5: SD=1).

The MHBIS service was rated by GPs to be very effective for anxiety, relationship distress and depression. The service scored mostly effective for co-morbidity and adjustment disorder.

PNs rated the service effective for grief, anxiety, relationships /family distress and slightly less effective for adjustment disorder and co-morbidity (mostly effective).

MHBIS Clinicians rated the service very effective for anxiety, depression and grief and slightly less effective for adjustment disorder (effective).

In the comments section several GPs noted:

- “Great results-less medication needed, we are fortunate to have excellent providers.”
- “Effectiveness depends on patients’ readiness for change.”
- “Ratings relate to personality and of patients issues and are not a reflection on the service.”

Comments from PNs were:

- “Often all these problems have ‘peaked’ and the chance to unload onto someone skilled and yet not associated with the client in any way is of great benefit to them.”
- “Often follow up is required, advice from the MHBIS team is invaluable about who to follow on with.”
- “Diagnosis not obvious. I can see patients would benefit from a listening ear and time.”
“Some need more than four sessions.”

Comments from MHBIS Clinicians were:

- “Effectiveness obviously depends on the engaging on the client and the skill of the MHBIS Practitioner.”
- “All of these situations can be addressed except where longer input is required.”
- “Brief intervention is aimed at presenting issues. Other research required to determine longer term effect.”
- “Co-morbidity scored less because in my experience more serious physical conditions require more input and longer term if often useful and they are referred on.”
- “I use CBT which I think is excellent for a short term service.”

Relationship with Secondary Mental Health Service

The majority of GPs (81%) reported that there had been a change in the relationship with Secondary Mental Health Services (SMHS).

The responses to the frequency of GPs referring to SMHS are presented in Table 13. As shown some changes had occurred in the need to refer to SMHS; 71% of GPs reported referring less to SMHS since the establishment of MHBIS; 5% reported no change in levels of referring; 5% reported referring more and 19% did not answer the question.

<table>
<thead>
<tr>
<th>Frequency of referrals</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referring the same</td>
<td>1 (5)</td>
</tr>
<tr>
<td>Referring more</td>
<td>1 (5)</td>
</tr>
<tr>
<td>Referring less</td>
<td>15 (71)</td>
</tr>
<tr>
<td>N/A - Unknown</td>
<td>4 (19)</td>
</tr>
</tbody>
</table>
As shown in table 13 below the majority of GPs (86%) agreed that MHBIS does assist in making referrals to SMHS. There was an indication that GPs (33%) were making more use of the medication review process offered by SMHS. Patients are perceived as more likely to be accepted for treatment by SMHS by 43% of GPs. All GPs agreed that patients with a moderate mental illness preferred to have contact with MHBIS than a referral to SMHS.

A variety of reasons were given for the change in relationship with SMHS. Patients seen by MHBIS have already had an assessment and SMHS know that other options have been tried and that patients referred have been screened. There have been some structural changes at SMHS with two Psychiatrists now available. One GP noted concerns about patient privacy when discussed in a Multi Disciplinary Team setting at SMHS.

Table 13: Frequency distribution of change in relationship with Secondary Mental Health Services (SMHS)

<table>
<thead>
<tr>
<th>GP perceptions of the change in relationship with SMHS</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHBIS assists in making referrals to SMHS</td>
<td>18</td>
<td>(86%)</td>
</tr>
<tr>
<td>Increase in use of Medication review by Psychiatrist</td>
<td>7</td>
<td>(33%)</td>
</tr>
<tr>
<td>Patients more likely to be accepted by SMHS</td>
<td>9</td>
<td>(43%)</td>
</tr>
<tr>
<td>Patients with moderate mental illness prefer MHBIS as point of contact rather than referral to psychiatric service</td>
<td>21</td>
<td>(100%)</td>
</tr>
</tbody>
</table>

All the GPs and MHBIS Clinicians agreed that patients with a moderate mental illness preferred to be seen by MHBIS rather than SMHS. Reasons given in free text responses were: patients feeling more comfortable and the service being non threatening (2), in rural areas patients did not have to travel (1), more privacy (3), less stigma (1), seen promptly (1), remaining under the care of the GP (1), familiarity of surroundings (1), better outcome (1), patients probably have little choice anyway (1).

MHBIS Clinicians reported that most patients would not get the option of SMHS referral if they had moderate mental health illness. There is perceived to be less stigma attached to the MHBIS service (2 comments). Quick access to appointments, no fuss and
seen by only one person (1 comment). One Clinician commented that “all the patients I have referred on to Secondary Services have been appreciative of MHBIS input”.

Benefits of a General Practice team approach with the General Practitioner as the initial point of contact

This was a free text question answered by all groups. Responses can be divided into two: benefits for the practice and benefits for the patient.

Benefits for the Practice

In regard to General Practice they are generally perceived as being able to provide holistic care and are the foundation of family medicine. A team approach allows for the care of a patient to be spread over the team thereby allowing for ongoing follow up and consistency of care. As one GP said “We know the patients and they know us i.e. there is no need to relate to a stranger, especially in terms of past medical history. We know which ones are likely to benefit from referral compared to those who might need a drug for a recurrent episode.”

The Practice Staff have information about the family and contextual information that is important with assessment and treatment (7 comments).

Feedback between Practice Staff and MHBIS Clinicians was seen as a major benefit (10 comments) including the importance of face to face discussions.

The relationship between MHBIS and the practice was seen as very positive.

Feedback from MHBIS was seen to help with the coordination of care and working as a team, physical conditions can be taken into consideration or ruled out. Feedback affects treatment plans and helps with ongoing treatment.

PNs often see patients in a different context to GPs such as taking smears and issues around grief and loss are sometimes picked up in this context and referred on.

Patients seen by MHBIS remain linked with the practice if a higher level of care is needed after discharge.
MHBIS was seen by one PN as adding skills and experience to the practice.

GPs know who will benefit most from a referral to MHBIS and referrals are perceived as appropriate from practice staff and MHBIS. There is an ease of transition from seeing the GP to MHBIS referral.

Earlier detection and ongoing prevention were noted as an advantage by a MHBIS Clinician.

A further advantage is “being part of a family.”

A GP commented that the team should not be exclusive but be able to include other staff members, school counsellors as part of this.

**Benefits for the patient**

The ease of access to MHBIS with patients seen at the practice is perceived as an advantage making this a more acceptable option to some patients. Several staff commented that this helped with improved compliance of treatment.

The service was seen as being less threatening than other care (3 comments) and some people may access care that may not have approached other mental health services. Confidentiality was perceived as important with information staying within the practice.

There were several comments relating to a perception of less stigma in accessing MHBIS. As one GP described: “It avoids the social stigma of psycho-phobia”.

A team approach was seen by one MHBIS Clinician as strengthening “the whole Primary Health connections and illustrates to clients the importance of GP team.” “Patients/clients trust immediately. GP often has other contextual information that is useful in the referral – feels good for patients – being held.”

**What would enhance MHBIS?**

All groups commented that they would like the service expanded to cover a younger age group. When administering the questionnaires this was being negotiated and it has since been implemented. The service for young people is now offered through Adventure
Development Counselling who also offer Youth Alcohol and Drug Services. The Youth Mental Health Brief Intervention Service has been modeled on MHBIS.

Comments from the GPs to improve the service were; to have good support for the staff. Increase salary for staff to allow recruitment success and for improved cover during times of staff shortages. Other suggestions were a routine telephone call 6 months after the first contact, ability to access a Clinical Psychologist and increased sessions (two respondents) and increased staff to cover times of staff shortages.

Some PNs commented on the need for information for new PNs (2) and more communication with PNs.

The need for an improvement in rooms available to see patients was identified as an issue for three MHBIS Clinicians. Patients are seen in a variety of rooms at practices and at times there are interruptions by Practice Staff needing to access equipment while patients are being seen.

These comments reflect the changing face of Primary Care with GP rooms designed for GP practice only. With the advent of PHOs a variety of staff are now offering services to GP practices and issues of space to see patients is a major issue for a number of practices.

Some patients are seen in community resource centres and one Practitioner commented that these venues do not provide the privacy as the GP practices do being public place. This is also a reflection of the lack of space at GP practices.

Patients not showing for appointments were seen by one Clinician as a possible indication of incorrect referrals, or inadequate information and discussion by the GP with the patient about the referral to MHBIS.

Provision of the ability for those clients with no GP (through supply or choice) to be seen by MHBIS was identified by one Clinician as a possible enhancement. Only people registered with a GP can be referred to MHBIS through the GP or PN.
Summary

Results from the questionnaires support the two main hypotheses.

1) Mental Health Brief Intervention does improve the mental health status of patients attending General Practitioners.

MHBIS was seen across all groups surveyed as providing an accessible treatment option and providing information that assists treatment. Since the establishment of MHBIS patients were perceived to present less frequently than before to GP practices.

The main reasons for accessibility of the service were: the ability to see patients within a short time (usually within a week), being seen at the practice and no cost. The GPs and PNs reported that the majority of their patients who gave feedback rated the services as being either very or extremely helpful.

The MHBIS was found to be most effective in treating depression, anxiety, relationship/family distress and grief. This was followed closely by co-morbidity disorders and adjustment disorder.

The service was recognised as making a difference to General Practices by the lowering of overall prescribing rates for psychiatric medication. Greater compliance with medication was also noted by the GPs.

2) The Mental Health Brief Intervention Service enhances the interface between Primary Care Health Services and SMHS.

The majority of GPs agreed that there had been a change in their relationship with SMHS since MHBIS. The major change noted was the need to refer less to the SMHS. Patients with a moderate mental illness preferred to be referred to MHBIS than the SMHS.

A further aim of the study was to explore the benefits of a General Practice team approach with the General Practitioner as the initial point of contact. Benefits for General Practices
included greater consistency with care and a more holistic approach. Feedback from MHBIS to the General Practice assisted ongoing treatment. Benefits for the patients were an extension of GP care and the ease of access to timely intervention.

**Part 2: The Focus Groups**

Focus groups were undertaken to gain a greater depth of understanding about how MHBIS is perceived by GPs, PNs, NP and MHBIS Clinicians. While the information from the groups largely supported the findings from the questionnaires they also added another layer about the impact of MHBIS on General Practices and patient outcomes.

Two groups of GPs consisting of six and five participants respectively agreed to participate in the focus groups. A number of GP peer groups meet on a regular basis. Peer groups had the advantage of participants being comfortable with each other and having an organized time to meet.

One group was held in the evening which allowed more time for discussion. Of this group four participants were GPs that the researcher works with and two that the researcher has little contact with. Five were from city practices and one from a small town practice.

The second group was a lunch time meeting with limited time (20 minutes). The researcher was not working with any of these GPs at the time of the study although had worked with three of them previously. All were from city practices.

The PN focus groups were also peer groups. One urban group included four PNs (none of whom the researcher works with) and one was a rural group with two participants including one Nurse Practitioner. The second group was smaller than anticipated due to staff being away on leave or sickness. These were lunch time meetings and the groups ran from 20-30 minutes.

The MHBIS group included all the Clinicians. The researcher facilitated this but did not participate in the group discussions. One of the Clinicians had worked in the service since it had started, one for a year, one for five months and one for three months.
Demographics of participants

The four MHBIS Clinicians all were female, three identified as NZ Pakeha and one as Dutch. Two were between 41 and 50 years old and two over 50 years.

Of the 11 GPs involved seven were male and four were female. Six were under the age of 50 years and six over 50 years. Nine identified their ethnicity as New Zealand Pakeha, one as Maori and one as Other.

The number of referrals to MHBIS made by the GPs varied from three to twenty. Five had referred three-six referrals in the past three months, four between 8-12 referrals, three had made 12 referrals and one 20 referrals.

The six PNs involved all were female. One was under 40 years, three between 41-50 years and two over 51 years. All identified as NZ Pakeha. Three worked in city practices and two in rural practices. One had referred two patients in the previous three months; one referred three patients and one ten patients. While three of the PNs did not refer to the MHBIS some made recommendations to the GP about referrals.

Indicators of the long term impact of MHBIS

To gain an understanding of how mental health is managed in General Practice participants were asked firstly, what indicators are there that MHBIS had made an impact and secondly, what changes had occurred as a result of MHBIS, (for example; earlier treatment, more men accessing treatment and greater compliance with treatment.) (See appendix 9 for focus group questions). A summary of the indicators of MHBIS of the long term impact of MHBIS is shown in Table 14.

These questions generated discussion about the impact of MHBIS within the General Practice and the benefits provided by the service. The aim was to gain a sense of the longer term impact of MHBIS for patients and General Practices.

There is an overlap between questions one and two. The first question focuses on indicators of longer term impact and the second on other changes as a result of the service.
The answers generated are interlinked so results and discussion of these two groups have been analyzed together.

In looking at longer term benefits of MHBIS it was found that: patients received earlier treatment; MHBIS increased effectiveness of treatment as opposed to GP only treatment; GPs reported prescribing less medication, and fewer referrals were made to SMHS.

Consistent with the questionnaires other changes noted were: patients returned less frequently to their GP; greater compliance with treatment; a more acceptable treatment option; assistance for GPs in treating patients with mental health conditions; smoother running of the practice; more men accepting treatment; resolution of situational crises; patients referred on to a greater range of services.

This data collected can be broken down to four primary themes:

1) The benefits of early intervention

2) Impact of MHBIS as a treatment option, including effectiveness for different disorders

3) Impact of MHBIS on the practice

4) Changes in regard to SMHS

**Early intervention**

The advantages of early intervention were identified as: prevention of escalation of symptoms and reduction in number of referrals to SMHS. MHBIS provides an accessible treatment option for people who would not meet criteria for admission to SMHS.

Patients often present to their GP in crisis. Referrals made at this time of crisis enable patients to resolve their issues more quickly. MHBIS is perceived as being able to educate people on problem solving. This in turn, assists them to establish routines and learn positive coping strategies. This enables people to deal more effectively with presenting issues and to move more quickly through treatment. One PN described the advantages of MHBIS in the following way:
I personally see early treatment as being a major advantage and they are not waiting on lists for a long time and it’s quite practical, so it is very effective. It’s not a counselling based service per se, so you know some of the people I see struggle with day to day stuff. They cannot organise themselves at this point of their depression or anxiety. So getting some routine in their lives and being able to deal with some of the little things. I think that’s the real benefit of the brief intervention.

Early intervention also assisted with treatment compliance as issues discussed by the GP are usually reinforced by the Mental Health Clinician. In MHBIS sessions patients have time to process what has been discussed with their GP. Quick follow up by MHBIS on GP referrals helps to keep the momentum for change going rather than a lengthy wait to access another service. One GP described this process (which was confirmed by other group members) as: “I think that when you (MHBIS) are seeing them you are reinforcing issues and talking over issues. I think they are more compliant (with treatment).”

Both GPs and PNs commented that there has been a wait for patients to access other services. The MHBIS generally is able to see patients within one to two weeks of referral. Consequently patients are able to move on quickly into treatment. The cost involved for other services was also identified as a barrier for some patients.

One GP clearly articulated this by saying:

They see whoever is there for two or three visits and get themselves sorted out and away they go and it’s all done in a timely fashion. They are seen within a week, whereas if we refer them to another counselling service there is quite a wait, they have to pay for it and often they have financial stress.

The initial phone call to patients by MHBIS, usually within a day of referral, is seen as helpful as the process of engagement is begun when the appointment is made. This takes away some urgency as people know that they will have the time to work things through and receive help. Calls made directly to a persons cell phone has helped with quick response and confidentiality rather than a call to work or home. The initial phone call also provides the patient with some understanding about the service and what they might expect, thus lessening any anxiety about attending and costs involved. Contact by telephone between sessions was also seen as a valuable part of treatment for some people.
Impact of MHBIS as a treatment option

MHBIS provides a treatment option in addition to GP care. Prior to MHBIS GPs managed patients that did not meet criteria for admission to SMHS themselves, or they referred them to other counselling services.

One GP stated that men generally preferred not to take medication. Thus a referral to MHBIS provided a treatment option for men that previously may not have accessed help. Furthermore men who present less frequently to GPs than women, now can quickly access a Mental Health Clinician that offers education and treatment.

GPs, also reported that they are prescribing less medication. Some GPs referred to MHBIS in the first instance rather than prescribing. Where medication was prescribed patients had support from MHBIS while this took effect. Some GPs reported that they valued the opinion of MHBIS Clinicians when considering the need for medication.

Impact of MHBIS on the Practice

MHBIS feedback to GPs after the patients’ initial appointment is often on the same day or within a day or two. In some of cases the patient is also discussed with either the PN or GP by the MHBIS Clinician. This has the advantage of further medical intervention being initiated quickly if required. GPs reported valuing both verbal and written reports from MHBIS.

That MHBIS feedback was viewed as a strength of the service was emphasised by one GP who reported: “One of the great beauties about it is the feedback. The patients are often seen while we’re at work and it only takes a minute or two for …. or somebody else to come and say I’ve seen such and such and I think he could possibly do with some medical treatment as well. It’s great.”

GPs and PNs had confidence that the patients referred would be followed up quickly and receive assistance. In this way MHBIS aids the smoother running of surgery appointment
times as patients know that following a referral contact with a Mental Health Clinician will occur within a day or two.

Some GPs and PNs reported that while they had a lack of knowledge of services available in the community they did know that a referral to MHBIS would result in referral to an appropriate agency if warranted.

The confidence that GPs and PNs have in referring to MHBIS also is apparent to patients accessing the service. The Nurse Practitioner (NP) described the difference that the service makes in practical terms for the surgery she works with as:

The days before MHBIS someone would come in and they would clearly be in a crisis or depressed and the consultation times for those patients were much longer and would really muck up our system. To be honest it was sometimes a bit of a heart sink because we have something concrete to offer them it’s going to be really useful for them and based in General Practice we can work our way through those consultations and develop an action plan quite quickly to the satisfaction of both of us.

Both GPs and PNs commented on the ease of being able to “sell” the service to patients thus increasing acceptance of a referral. GPs reported that patients were more likely to attend if they were seen at the practice. This is particularly so of men as one GP said:

Men in particular wouldn’t go to Kensington (SMHS) and wouldn’t go to counsellors either but we have to sell it. I think that it is reasonably easy to sell. They are quite accepting that you are seen in the surgery, it’s very private, one on one and doesn’t cost, all of that. I don’t think I have ever had any refusals.

Having patients seen at the practice was reported as a major advantage as patients are familiar with this environment. Patients were perceived as more likely to attend because of the location of the service as one GP clearly articulated.

They’re much more likely to attend because if they’re waiting in the waiting room they could be seeing one of us or you and they sort of feel quite secure about that. The fact that they’re called by you nobody else knows and they’re released by you. They are coming down the corridor and they could be coming from us. It’s very safe that way.
MHBIS is perceived as filling a gap in the community and therefore is a plus for General Practice. Concern was expressed by a PN about what would happen if the service was no longer there. “I think it’s been a huge plus for General Practice. We use the service a lot and I think why was it not there five or 10 years ago? It amazes me. I think gosh if it wasn’t there now what would we do?”

The NP commented: “Thinking back to the pre MHBIS days. Oh, just a nightmare to think that we would have to return to that if ever the powers that be pulled the funding. I would hate to return to those days it would be a nightmare.”
Table 14: Indicators of the long term impact of the MHBIS

<table>
<thead>
<tr>
<th>Themes</th>
<th>GnP=12</th>
<th>PN n=6</th>
<th>MHBIS n=5</th>
<th>Total N=23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allows earlier intervention</td>
<td>8</td>
<td>3</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td>Referring less to SMHS</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Patients need less GP visits</td>
<td>7</td>
<td>1</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Improved long term management</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Patients seen more quickly/timely</td>
<td>2</td>
<td>3</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Seen at practice helps/privacy important</td>
<td>15</td>
<td>3</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td>Feedback to practice helpful</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>More men accessing help/likely to attend</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Provides another treatment option</td>
<td>6</td>
<td>3</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>Helps life crisis</td>
<td>2</td>
<td>3</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Resolve issues quicker/insight</td>
<td>1</td>
<td>4</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Helps practice time management</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Greater compliance with treatment</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Phone contact helps</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Referrals on to other services</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>MHBIS Clinician known to practice</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Support while medication works</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Prescribing less</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>MHBIS helps prescribing decisions</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>More time for medication discussion</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Part of continuum of GP care</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Patients less unwell on re referral</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Preventive help</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Specific disorders where the service is helpful

A range of issues where MHBIS has been successful were suggested by each of the focus groups. The number of times specific disorders or issues were mentioned has been noted in Table 15. Five respondents reported MHBIS as being helpful in all emotional situations. Specifically mentioned presentations were depression (8), stress (5), anxiety (4), grief (4) alcohol and depression (2), obsessive compulsive disorder (1) and food issues (1).

One PN commented: “I always found that people who were grieving were very difficult. They desperately needed support and we just weren’t able to give it to them.”

The service was perceived as offering timely input and able to defuse emotional or personal crisis situations (4) and relationship problems (3). Parenting problems and a family members’ mental health problem were given as examples where the service had been of help. Work place stress or bullying (2) and pregnancy counselling (1) were perceived as useful.

Several GPs commented on the difficulty of managing co-morbid situations. As noted mental health issues in relation to physical health are often complicated and there is often little other help available for these patients, this was articulated by several GPs as:

“No one else is interested in them. So you people do it and you do it very well I think.” “Otherwise we are on our own.” “They fall back on us because really the other services are not picking it up.”

The NP explained the value of working in conjunction with MHBIS to look at underlying emotional issues impacting on a patients physical health.

I really value as a practitioner the contribution the MHBIS has made. I have seen some amazing stuff happen with some of the people I have worked with, particularly with motivational counselling that has been done in the past. When I was working with severely obese people and I still do from time to time. Often I would refer them to MHBIS as well to deal with some of the emotional issues that have contributed to obesity and that was absolutely wonderful and together we have actually made some progress with some of the underlying depression and underlying issues. I’m not sure but I think there have been one or two where I have suspected sexual abuse but not in a position to get to the bottom of that and that has consequently come out and we have then been able to appropriately refer
on through ACC etc. So yeah, that is something that people would say that is not a mental health problem but I consider obesity to be one of the physical problems that has a mental health component to it.

Knowledge of other services in the community and the ability to refer on was perceived as a help for patients as one GP described and acknowledged the role of social work:

I think you pick up on some things that we may not have done on a non psychological basis...there have been various services that you have got involved with people that weren’t really directly related to the emotional issue. Things I wouldn’t have been aware of, particularly WINZ access. So there is that Social Worker side to it.

Functional aspects of MHBIS that contributed to good outcomes were: four available appointments, home visiting an option, having an independent person to talk to, phone calls, time for people to talk and further assessment, people feeling more secure and the privacy the service allows, no cost; seen quickly, availability for a range of age groups and seen at the General Practice.

The service assisted in helping people recognise a depressive illness and acted as a stepping stone to SMHS or further help. A PN commented “...they don’t always recognize that their depression, clinical presentation is that bad and you know you are going to strike this resistance. This is often a good stepping stone for them.”

Communication from MHBIS to the practice and working within the practice is valued as the NP commented:

I like the fact that there is such good communication about what is going on and it’s still ‘in house’. Some patients at a time of crisis don’t want to be seen with a mental health problem. Whether that is my perception or theirs and I think they do better and cope better when it is in house as it is seen as coming to the GP and it’s just another service they are getting.
### Table 15: Disorders and aspects of MHBIS that have been helpful

<table>
<thead>
<tr>
<th>Themes: Where service has helped</th>
<th>GP n=12</th>
<th>PN n=7</th>
<th>MHBIS n=5</th>
<th>Total N=23</th>
</tr>
</thead>
<tbody>
<tr>
<td>All emotional disorders</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Stress helpful</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Anxiety helpful</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Depression helpful</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Food issues/ Obsessive compulsive disorder</td>
<td>1 - 1 2</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Relationship breakups</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Co-morbid physical health do well</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Pick up non psychological issues</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Referral to other services for help</td>
<td>3 - 2 5</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not seen back in practice as in the past</td>
<td>4 - - 4</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol and depression helpful</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Stigma around Alcohol and Drug Service</td>
<td>2 - - 2</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home visiting has been helpful</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Independent person to talk to</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Phone calls helpful</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>GPs don’t have time to go into things</td>
<td>3 - - 3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People feel more secure and private</td>
<td>4 - - 4</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No cost/ seen quickly</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Crisis situation ones do well</td>
<td>3</td>
<td>-</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>MHBIS as a stepping stone to SMHS</td>
<td>4 - 1 5</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategies/education help patients</td>
<td>2 1 2 5</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work situations helpful</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Grief counselling helpful</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Parenting/family/ pregnancy issues</td>
<td>2 1 - 3</td>
<td>3</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
Situations in which the service was found to be less helpful

Few specific situations were reported where respondents found the service less than helpful.

Co-morbid physical issues were identified as they had been in the survey results as an area where often further help is required. Pain was identified by one Clinician as something that sometimes hindered the ability of a patient to engage in psychological therapy.

Referrals of patients with mental illness that was more suitable for the SMHS were identified as an area of difficulty. Some patients did not want to be referred on to Secondary Service and were referred to MHBIS as an option for the patient and to assist them in accepting a referral on.

It was also noted that patients aged between 18 and 24 were less likely to keep appointments with MHBIS.

One MHBIS Clinician commented that referrals made for both people in a relationship to be seen separately created issues around impartiality. Another was confident that the situation could be managed within the service by involving another MHBIS Clinician.

The changes in relation to the Secondary Mental Health Service as a result of MHBIS

The themes emerging from discussion about the change in the relationship with SMHS are:

- Improved relationship with SMHS
- More appropriate referrals for SMHS
- MHBIS has a role in assisting with referrals and supporting patients prior to referral
- Patients on the cusp of moderate to severe prefer to have contact with MHBIS

These changes are reported in Table 16.
<table>
<thead>
<tr>
<th>Themes identified changes of GP relationships to SMHS as a result of MHBIS</th>
<th>GP(n=12)</th>
<th>PN(n=6)</th>
<th>MHBIS(n=5)</th>
<th>Total N=23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good relationship with SMHS at present</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Phone contact with Psychiatrists now possible</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>MHBIS helps support decision making for referral to SMHS</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>More appropriate referrals to SMHS</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Provides a stepping stone to SMHS</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Some referrals do not need referral to SMHS after seeing MHBIS</td>
<td>4</td>
<td>1</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Recommend see MHBIS first</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Greater acceptance of referrals by SMHS</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Seen quicker by MHBIS (non emergency)</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>MHBIS able to reinforce medication issues</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>MHBIS acceptable option for moderate illness</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Assessment prior to SMHS referral helpful</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>MHBIS expertise assists access to SMHS</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Two different groups of patients</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Less burden on SMHS</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Helps rule out mental illness prior to medical referrals to secondary services</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>SMHS report seeing new as opposed to chronic illness</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Some patients wouldn’t accept SMHS referral</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>MHBIS perceived no stigma</td>
<td>5</td>
<td>-</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>
Improved relationship with SMHS

GPs in both focus groups commented on the improvement in the relationship with SMHS. There appears to be better communication. As one GP commented they liked being able to speak by phone to a Psychiatrist if they needed to in regard to a patient.

More appropriate referrals for SMHS

MHBIS provides a referral option that had not been available for GPs prior to the establishment of the service.

While the problems identified were often not severe enough for the criteria of psychiatric services the patients were in significant distress or moderately unwell. If patient referrals were declined by SMHS it left the GP with few other options for support. Furthermore there was then often a time delay before a referral elsewhere could be made. These patients are now being referred to MHBIS. Patients where GPs are unsure if they will meet the criteria for SMHS are seen by MHBIS and if there is no improvement they can then be referred to SMHS. A GP commented on the difference this has made:

It’s a huge difference for those people as before our referral may have been declined and the person left with nothing or left with us and we don’t have those skills. It’s really good as far as this goes. Those on the cusp if Kensington (SMHS) is really busy those are just not being seen or the wait is so long it them becomes a crisis.

Five GPs commented that some patients who may in the past have been referred to SMHS did not need referral on to SMHS after their contact with MHBIS.

SMHS was perceived to be more accepting of referrals if they had been seen first by MHBIS as they were aware there had been an initial assessment and often other interventions had been initiated. As one GP described: “If we need to talk to Secondary Services about the patient, they now realise it is someone who is quite ill and requires specialist intervention or
otherwise we would have gone through MHBIS. The communication with SMHS is good at the moment.”

**MHBIS has a role in assisting with referrals and supporting patients prior to referral**

GPs concurred with the survey findings that MHBIS assisted in making referrals to SMHS. Assessments completed by MHBIS Clinicians were seen as helpful in supporting referrals. A GP commented “If they do need some input from Kensington (SMHS) they are seen quicker because they have already been assessed rather than just a GP referring them.”

**Patients on the cusp of “moderate to severe” prefer to have contact with MHBIS**

The survey results indicated that patients with moderate mental health needs preferred contact with MHBIS over SMHS. This finding was supported in all the focus group discussions.

It is perceived there is less stigma attached to referrals to MHBIS. As expressed by a MHBIS Clinician:

There are some people in the community who would never want to go near the Secondary Service but because we are at the GPs they see us. So I guess this is a huge benefit to them. Whether it changes anything for the secondary service (or not) it does mean that that person is seen. In relation to the Secondary Service it means that we don’t carry the same stigma.

**Deciding factor for referral**

The major deciding factors for referral were: presenting symptoms, patients’ level of functioning, willingness to accept help and emotional distress. The overall deciding factor for referral identified by nine focus group participants was “time”. Some GPs or PNs believe they do not have enough time to spend to meet a patients needs. The need for more time had not been listed on the options for GPs regarding reasons for referral on the survey. One GP describes the time factor as: “It’s our time and the amount of time that the intervention team spends which gives them a great advantage. We can’t so it is time either way. You’ve got a surgery waiting room and they don’t.” Another GP commented that: “It’s a personal thing, some people just need time, they are that sort of person. Even aside from their illness, it can take an hour to get to the nitty gritty.”
One GP identified the need for more expertise as a reason for referral. Four participants identified that GPs were able to identify the appropriate opportunity arising in a consultation to refer a patient to MHBIS. Other deciding factors were a new presentation or an altered mental state from a patients’ normal functioning.

There was a difference noted in the reasons for referral between PNs and GPs. One PN described the context in which emotional issues arise:

They don’t make the appointment specifically for those issues they make the appointment for something else and that is their opportunity and I’m sure they tell us more than they tell their GP because they feel that we have got the time to listen and so if I get someone who is opening up and they have issues I will tell them that the service is available.

PNs perceived they were seen as less threatening, therefore, patients disclosed personal situations more readily to them. They perceived themselves as being “safer” to talk to and that patients were not concerned about getting a label of depression or being prescribed medication. The NP describes this from the patients’ viewpoint: “They say ‘do you think that maybe I am going a little bit mad?’ or ‘I am not coping.’ This coping thing, we are all supposed to cope, for some people it’s ‘am I allowed to admit I’m not coping?’ and it’s the final straw and out it all comes.”

A PN commented in regard to safety in talking with a PN over a GP that: “There is some fear that if they go to the GP they might be started on medication.
Table 17: Deciding factors for referral

<table>
<thead>
<tr>
<th>Deciding factors for referral</th>
<th>GP (n=12)</th>
<th>PN (n=6)</th>
<th>Total (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>8</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Need for expertise</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>It is necessary</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>New presentation</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Need more input</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Opportunity arises</td>
<td>-</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Altered state from normal functioning</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Situation needs further investigating regarding risk</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Summary

The results from the focus groups have added another layer of information regarding the way the MHBIS is perceived and how the service works within the Primary Care setting.

Fuller and more in-depth information was gained about the relationship between SMHS and General Practice. Generally the results have supported the findings from the survey undertaken in part one.

The Practices’ valuing of communication with MHBIS Clinicians was especially of note.

The decision making process GPs and PNs use to decide to refer was expanded upon. Overall time was the deciding factor in making referrals. This had not been captured by the survey results.

Focus group findings also supported the two hypotheses:

1) That Mental Health Brief Intervention does improve the mental health status of patients attending General Practitioners.
The focus groups also highlighted the main impact of the service was that patients receive earlier treatment. Increased effectiveness of treatment, less prescribing of psychiatric medication and fewer referrals to SMHS were also noted as key factors. Patients’ not needing to see their GP as often was another important aspect as was having a treatment option which is accessible and very acceptable to both patients and General Practices.

2) That MHBIS enhances the interface between Primary Care Health Services and Secondary Mental Health Services.

Again the findings of the focus group support the findings in part one. That is that the benefits of MHBIS included improved communication with SMHS, more appropriate referrals, assisting in making referrals and supporting patients prior to referral to Specialist Services.

Furthermore, some patients who may have been referred to SMHS in the past are now being seen by MHBIS thus referral to SMHS after the intervention is complete is no longer required.

These findings are discussed in relation to the available literature in the following chapter seven.
Chapter Seven

Discussion

As discussed in chapters two and three, a number of systematic literature reviews concluded that collaborative models of mental health delivery in Primary Care deliver improved outcomes for patients. Overall this study supports the evidence of these studies in regard to what works in a Primary Mental Health setting.

This study considered whether offering a Mental Health Brief Intervention Service (MHBIS) does improve the mental health status of patients attending General Practitioners. It also considered whether the MHBIS enhances the interface between Primary Care and Secondary Mental Health Services. Mixed methods were used to address the research questions.

While there are two main hypotheses the overall aim of this study was to determine the effectiveness of the model of service delivery and to identify changes that may be useful. In doing so both a medical practice perspective and a MHBIS Clinicians perspective was sought. Also examined was the impact a MHBIS may have on patient populations.

This chapter considers the findings from the perspective of the participant groups and the literature in regard to brief intervention.

Response rate of questionnaires

The response rate in this study was 54% for GPs and 45% for PNs. This response rate for GPs is consistent with previous mental health questionnaires using samples of GPs where response rates have been between 23% -86% (Khin, 2004). The rate for PNs however is lower than anticipated. As Cartwright (1978) explains 78%-99% of studies response rates to questionnaires are estimated to be higher for PNs than for GPs. The lower response rate from PNs is likely to be related to the high numbers of PNs working part time (approx 80%) with often defined roles such as immunization or smear taking. Furthermore many PNs are not directly involved in referring patients to MHBIS.
Service accessibility

A number of factors have been identified as barriers for people to access mental health services. A study of the views of Otago General Practitioners about local mental health services and their role in providing mental health services in 2001 identified cost, time, and access as the main obstacles to their management of psychiatric disorders (Bathgate et al, 2001).

The delivery of mental health services in the Primary Care setting requires more time than that needed for other Primary Care services. Assessment of the problem generally takes more time as a detailed history is required rather than a brief description of the symptoms and physical tests (Ministry of Health, 2002a).

Interventions are also often time consuming requiring more frequent face to face contact and telephone contact. Other difficulties for GPs are providing longer appointment times, necessary telephone follow up and the development of multidisciplinary teams within the General Practice.

Cost for ongoing consultation is often an issue for consumers and may result in not attending appointments. SMHS do not incur charges and may be able to provide follow up. This has been identified as a reason for SMHS being a preferred option for GPs and consumers (Ministry of Health, 2002a).

The practicalities of time, cost and multi disciplinary input for GPs providing the level of care needed to treat mental health issues within Primary Care have been alleviated by the provision of MHBIS within the practice. This allows for an accessible system of referral, treatment and communication for ongoing care. Barriers of cost and waiting times which have hindered patients seeking help elsewhere have made this an acceptable service for patients.

All GPs and PNs agreed that the service provides an accessible treatment option.

This was reflected in both the questionnaires and the focus group discussions. The model of service delivery is a key to the accessibility of the service. The majority of patients are seen in the practice rooms which have the advantage of being a familiar environment, are private and provides patients with continuity of care. The service is seen as an extension to
the care provided by the practice and the MHBIS Clinicians are viewed by most GPs as an integral part of the practice.

Referral to the service is accepted more readily by patients than referral to other services.

GPs know that patients will be contacted within a day or two of referral and have confidence in patients being seen quickly and followed up appropriately. In this sense the option is very accessible to GPs. Feedback from the MHBIS allows for a smooth flow of communication. Frequently there is discussion about patients to the GP or PN and further medical care is easily accessed. All GPs surveyed reported that information from MHBIS assisted in treatment. Where medication is prescribed this can be monitored and any concerns from the patient or Clinician reported directly to the GP enabling changes to be made in a timely way.

The service fits well with recommendations contained in the ‘Guidelines in the Identification of Common Mental Disorders and Management of Depression in Primary Care’ (NZGG, 2008a). The initial management of moderate depression in Primary Care has been recommended as active support, advice on exercise and self management and consideration of a referral to a psychosocial agency or for a psychological therapy (NZGG, 2008a).

MHBIS provides the role of active support and advice on self management and can provide a brief psychological therapy or referral for further long term work.

The confidence that GPs have in the service provides an accessible option for follow up for patients. GPs reported that the service was easy to sell to patients and readily accepted by them. Patients were more likely to accept a referral to MHBIS than to other helping services. Patients were more willing to be referred to MHBIS than to SMHS. This may reflect the perceived stigma of psychiatric services and the accessibility of a service at GP level without the need to go elsewhere.
Patients presenting less frequently to GP

The majority of GPs (81%) perceived that patients seen by MHBIS represented less frequently. This question did not define frequency of presenting in any way so it is unclear what time frame this represents. GPs know that if there are any difficulties arising with patients referred MHBIS will report this back to them, therefore patients do not require as many follow up appointments. There was some anecdotal evidence from the focus groups that suggested that patients do not represent as frequently at the practice. The reasons for this are unclear and further research in this area is needed.

Patients with depression and anxiety disorders generally report higher levels of physical symptoms and present more often to their GP (Schwenk et al, 1998). Research has also identified that people with distress or a psychiatric disorder have increased use of health services whether or not a physical disease is present (Katon & Walker, 1998; Clarke et al, 2008). These findings suggest that if depression is treated through attendance with MHBIS that physical symptoms occur less and patients are therefore less likely to attend their GP.

How MHBIS has helped patients

Patients recover sooner from depression and anxiety

Research has shown that those patients that received interventions within Primary Care including patient education, drug treatment and staff collaboration had significantly better outcomes in terms of their recovery from depression than patients treated by usual GP care (Bijl et al, 2004). A systematic review of 36 studies in the United States also concluded that collaborative care is more successful than standard care in improving depression outcomes in short and longer terms (Gilbody et al, 2006).

The majority of GPs (95%) and PNs (91%) agreed that patients recovered sooner from depression and anxiety.

There are a number of contributing factors as to why patients might recover sooner with the assistance of MHBIS. Patients referred early with depression or anxiety are more likely to make a faster recovery as they have not lost the confidence and functioning that occurs when depression and anxiety are untreated. Psycho-education plays an important part in helping
patients understand what is going on and enables them to develop some strategies to manage symptoms.

In this study it was found that a range of strategies including exploring the situation that may have contributed to the illness, cognitive strategies, relaxation, daily planning, establishing routines and lifestyle changes such as eating, exercise and sleep habits contribute to improved levels of wellness.

The NZ Guidelines Group (2008a) has recommended that self management strategies should be encouraged and information given to patients about physical activity, diet, sleep hygiene, activity scheduling, stress management and avoiding the use of alcohol and recreational drugs. Structured problem solving is considered to be effective.

Patients often visit their GP when they are in a personal crisis and this provides the ideal opportunity for change. The option of having someone to talk through issues and formulate a plan at these times can turn a crisis into a more positive outcome. Relationship breakdown is a situation frequently referred along with social problems, stress, and workplace issues. Early intervention can prevent the situation where stress or distress escalate to depression or increased levels of anxiety. There is an association between different adverse life events with distinct patterns of depressive symptoms and different types of life events have been found to relate to different depressive symptom profiles (Keller et al, 2007).

Middleton, (2005) discusses how patients present with sub threshold disorders and how often these disorders are labeled as depression to enable access to treatment. MHBIS can be accessed for patients with life events issues without the need for psychiatric diagnosis. Depression can result as a response to stressors (Beilger, 2008). Early intervention may well prevent ongoing stress from becoming a depression and the subsequent impairment that follows this. The Kessler 10 pre and post intervention scores as reported in chapter four indicate that the majority of patients seen do have a moderate to severe risk of anxiety or depression. It was also noted that the scores decreased during the course of intervention with MHBIS.
MHBIS Clinicians are able to reinforce the messages that GPs and PNs give to patients regarding treatment and medication. Research indicates that follow up by a health professional can significantly improve the adherence to treatment and therefore facilitate a quicker recovery (Doughty, 2006).

The majority of patients responding to the patient survey indicated that they were either recovered or recovering after their contact with the service.

**Patients referred onto other services appropriately**

The social services environment is one of constant change. Knowing which services to access, how to access and the most appropriate services to access requires a depth of knowledge and networking which most GPs and PNs are unable to sustain given their roles.

The networks developed by the Clinicians allow them to constantly update local resources.

Network meetings with physical and mental health organisations are attended monthly by MHBIS Clinicians. In addition to these each discipline has their own networks allowing for a wealth of contacts. The team is a resource for the Clinicians to discuss patients together and for the Practice Staff.

Patients are able to be linked with the most appropriate services and resources. Costs of counselling can often be met through Family Court Counselling, Accident Compensation Corporation (ACC) or Disability Allowance and these can be facilitated to prevent cost being a barrier to further help.

The ground work needed prior to counselling can often be accomplished in the sessions attended enabling patients to be clear about what they want from further counselling.

MHBIS is often the first experience of seeking help for many people referred. If this is a positive experience for people then it gives them the confidence to seek help again if needed, or for referral on.

Referral on to other services is part of a stepped care model where the needs of patients can be assessed and matched with the most appropriate community resources.
Patients need less time off work for depression and anxiety related conditions

There is no quantitative evidence on the length of time patients have off work from depression or anxiety or a way of specifically measuring this; however a high percentage of GPs (71%) and PNs (74%) believed that patients were able to return to work sooner, only one GP and one PN thought that this was not the case.

The economic impact of absence from work affects individuals, families, communities and the economy. MHBIS Clinicians frequently see people who are still in work and who try to minimise time off by using strategies to manage in the work place. Work place supports such as workplace chaplaincy or support people are accessed as needed as well as linking patients into Employment Assistance Programmes where appropriate. Patients are encouraged to talk with their employer about their situation and are often pleasantly surprised by the amount of support from employers and the flexibility to allow time for appointments or assistance to reduce stress in the workplace. MHBIS Clinicians can liaise with employers when needed.

Good use is made of Workbridge (an organisation which supports people with disabilities to assist people back into work) and to work with employers at times. Referrals to the Career Service help people to make changes and career choices or explore further avenues for career development.

Patients are supported to make lifestyle changes

MHBIS provides support to talk through changes that are necessary to reduce stress and improve quality of life. All GPs and PNs saw this as an important role of the service.

A study exploring the views of patients with depression and anxiety identified that patients wanted someone outside of their situation to talk to (Kaden et al, 2001).

Medication alone may improve symptoms however the social changes needed often require a different level of support.

Lifestyle changes occur on many levels from improvement in relationships, parenting, work, sleep, exercise or healthy eating. Information is an important part of supporting these
changes as well as encouragement and support in planning strategies and goal setting. Lifestyle change can contribute to reduced stress and reduction in reoccurrence of symptoms.

Linking in with programmes in the community can contribute to ongoing support such as Green Prescription, ‘Living Well with a Chronic Illness’ a course run by the Arthritis Foundation and a ‘Living Well’ course for people with a mental health condition run by the local Polytechnic.

**Information given to patients assists treatment**

The majority of GPs and PNs and all MHBIS Clinicians agreed that information given to patients assisted with treatment.

Psycho-education is an important element as it empowers patients to make the necessary changes in their lives, feel more in control and allows the underlying issues for the depression to be addressed. The use of antidepressants alone fails to deal with the context in which depression occurs (Biegier, 2008). Information about the relationship between stressors and depression is important to assist people develop new responses to stressful situations. Thus building resilience and the ability to respond to stress in a more adaptive way and hence prevent relapse.

Psycho-education, cognitive strategies, sleep hygiene, physical activity and relaxation all contribute to patients learning ways to reduce anxiety. A range of education methods are used from verbal explanations, reading material, suggestions for web sites and self help books. Self monitoring techniques such as diary keeping can be helpful as can daily planning schedules (NZGG, 2008a). The NZGG (2008a) recommend the encouragement of self management strategies by providing relevant information and directing people to resources available.

**Patients are more likely to attend a referral made to MHBIS than a referral to a counselling service**
The majority of GPs and PNs agreed with this statement. This was reinforced in focus group discussions. The main advantages that MHBIS has over community counselling services was; accessibility for cost, being located at the Practice, recommended by the persons GP and confidentiality. The contact from the MHBIS Clinician within a few days allows for an appointment to be made and patients able to attend this usually within the following week or two. Cost and time to wait for appointments were perceived to be barriers to access community counsellors.

A study which investigated patients’ perspectives on management of emotional distress in Primary Care reported that the majority of patients wanted counselling and wanted to be treated within Primary Care (Brody et al, 1997). Patients would talk about their emotional distress and the impact of this on their functioning if asked by their GP. Having a service accessible within the practice makes asking patients about emotional distress or screening for depression or anxiety more viable as there is a clear pathway for referral and follow up within the practice.

**Changes to psychiatric medication prescribing**

The majority of GPs agreed that there had been some changes to prescribing of medication since the service started. Only 25% of GPs returning questionnaires reported no change to prescribing.

Focus group discussion around prescribing indicated that prescribing had changed in a number of ways.

The main changes are frequency of prescribing and more effective prescribing.

While no hard data was collected in regard to any change in prescribing or the rates of prescribing what was captured by this study was the GPs perception of their own prescribing.

Of those surveyed 67% reported prescribing less. Some GPs referred patients to MHBIS as a first option rather than prescribing as they may have done prior to the service. There appears to have been a “let’s try this and wait and see” approach especially in situations of reactive depression or anxiety. Some GPs reported that they wanted to have another opinion as to whether medication was necessary. Time is also a factor here in that the
Clinician can spend more time exploring the situation around the illness or distress and seek out other solutions that may be more effective.

Some GPs reported valuing the input that the MHBIS Clinicians gave through reports and verbal feedback about the use of medication.

Only one GP surveyed reported using more medication. This could link in with the overall perceptions from GPs that they are prescribing more effectively.

Effectiveness of prescribing was not fully explored however four themes emerged. Firstly; that GPs prescribed medication as a more appropriate option and therefore medication was more effective when it was prescribed. Secondly; that patients were more compliant with medication as the need for this was reinforced by the MHBIS Clinician and education given assisting compliance. Thirdly; MHBIS was able to monitor medication and report back to the GP where there were side effects and medication was not effective allowing a change in dose or medication and therefore making treatment more effective. Fourthly; the ability for GPs to access SMHS for advice around medication changes rather than having to refer a patient directly.

In a literature review 38 studies involving more than 460 Primary Care Practices conducted by Bower and Sibbald (1999) found that there was some reduction in prescribing of psychotropic medicine where mental health workers are employed in the Primary Care setting. There was no clear evidence of lasting or widespread change in clinical behaviour and the review concluded that there was a need for further research in this area to assess if changes in clinical behaviour endured over time.

The change in prescribing may reflect that having an accessible service allows for people who were not previously recognised as having mental health problems to receive treatment.

This study indicates that there has been a change in prescribing behaviour since the provision of the service.
There is evidence that suggests that patients often prefer an option that does not involve prescribing of medication (Kaden et al, 2001; Brody et al, 1997).

There is evidence of greater compliance with medication where patients are closely monitored with some therapeutic input in Primary Care (Katon et al, 1996).

**Feedback about the service provided by MHBIS from patients to GPs and PNs**

Patients provide a good level of feedback to GPs and PNs about their experience of MHBIS. The majority reported that MHBIS either helped a lot or was extremely helpful. How GPs and PNs elicit feedback was not explored. Patients prescribed medication generally have three monthly follow up by their GP which presents an opportunity to discuss progress. Patients who recover without medication may not represent to the practice unless a further issue arises.

Annual feedback surveys are sent to patients to monitor the effectiveness of the service. The feedback from surveys indicated that patients do find the service to be effective.

**Deciding factors for referring to MHBIS**

The survey offered a range of yes/no options to GPs and PNs about factors on which they based their decision on to refer. This question was asked in focus groups which showed overwhelmingly that “time” was the major factor in a referral being made.

Time was defined in several ways; firstly, the lack of time that the GP or PN was able to spend with the person and the impact this has on the running of the practice and secondly, the patients’ need for someone to spend more time with them to help with the presenting issues.

The factors rating most highly in the survey for GPs were: presenting symptoms (100%); patients’ emotional distress (100%); willingness to accept help (100%) and level of functioning (95%).

MHBIS was seen as a first option rather than prescribing by 14 GPs (67%). This links with the opinion by some GPs that prescribing is now more effective.
Of lesser importance were request from the patient 12 (57%), need for more information about the patient 9 (43%) and if psychiatric medication is prescribed 4 (19%).

**Effectiveness of the service for different disorders**

Results taken from 100 completed K10 scores indicate that the majority of patients (57%) referred to MHBIS obtained scores above 30 which is indicative of a serious depression or anxiety disorder. On discharge the majority (51%) of these patients scored in the mild or moderate range of risk for disorder (scores between 20 and 30) and 46% scored at low risk (score below 20). The mean difference in initial presentation and discharge scored was 9 points. Thus, attendance at the MHBIS had made a significant positive difference in their overall score (p<0.001).

Further analysis of these scores show that the service is reaching the patient population for which it is intended (mild to moderate mental illness). However there were a significant number of patients (57%) who would at first presentation appear to meet the criteria for a more serious mental illness. This may relate to the high levels of distress that people experience in response to life events such as relationship break-up and bereavement where there are often major disturbances in mood and functioning. The reduction shown in scores after one to four sessions indicates that MHBIS is effective at reducing distress and symptoms of depression and anxiety. This has reduced the need to refer some patients to SMHS.

These results indicate that the service is effective in treating anxiety and depressive disorders. The results also indicate that those with a higher level of acuity on entering the service make the greatest amount of change. Those patients with low K10 scores under 20 indicating mild levels of disorder showed smaller overall gains.

The MHBIS over all was perceived to be very effective in treating depression, anxiety, grief and relationship/family distress and effective in treating co-morbidity (mental and physical) and adjustment disorder.
GPs have indicated in the questionnaire and focus groups that some referrals made to MHBIS initially can prevent a referral on to Secondary Services. The results of the K10 scores would support this view.

The questionnaire indicated that the service was not as effective with co-morbid mental and physical health conditions. GPs in the focus groups also found patients with these disorders were more difficult to treat effectively. Several GPs noted that there is little other help available for this group of patients with few options for referral onwards. MHBIS has been able to look holistically at the situation for this patient population and ensure social, financial and mental health needs are addressed where possible. One GP specifically noted that social work input for these patients is helpful.

Meeting chronic health needs has been a priority of the Primary Mental Health Strategy (Ministry of Health, 2001). A report produced by the National Advisory Committee on Health and Disability in 2007 defined chronic conditions as “any ongoing, long-term or reoccurring condition that can have a significant impact on peoples lives” (National Health Committee, 2007:1). This report explores the impact of chronic conditions on individuals, families/whanau, financial and social costs, inequities of care and changes needed to address these needs.

Care Plus is a programme introduced by PHOs for practices. This programme is for patients identified with chronic illnesses with the aim of improving chronic care management, reducing inequalities, of improving Primary Health Care teamwork and reducing the cost of services for high-need Primary Health users (Ministry of Health, 2007). Referrals to MHBIS would include people registered on Care Plus. This is an area of practice where there could be improved linking in with MHBIS for input towards developing a comprehensive plan of care. There was no mention of this programme from any of the focus group participants.

**Relationship with Secondary Mental Health Services**

The second hypothesis of this study is that MHBIS enhances the interface with Secondary Mental Health Service. The results of the questionnaires and the focus groups
concur that the service does enhance the interface with SMHS. The majority of GPs (81%) agreed that there had been a change in the relationship with SMHS.

MHBIS was seen to enhance this interface by assisting with referrals to SMHS and giving another opinion around the need for referral to SMHS. Overall 71% of GPs reported that they were referring fewer patients to SMHS than they had prior to the service.

Focus group discussion indicated an improved relationship with SMHS with greater access for GPs to talk directly with a Psychiatrist if needed and able to access medication reviews.

There have been a number of changes within the SMHS so it is not possible to directly attribute how much of the change is a result of MHBIS, however there are indications that MHBIS has helped GPs particularly with referring and seeing people who in the past may have needed referred and that with a referral to MHBIS this has been avoided.

As discussed in chapter four part of the South Canterbury District Health Board initiatives were to include GPs in reviews at SMHS. Increased education opportunities offered for GPs with training by Psychiatrists has also increased this interface.

Information from MHBIS assessment is made available to SMHS and this is seen as helpful. SMHS is able to refer patients back to GPs and onto MHBIS where they do not meet SMHS criteria.

One of the aims of the study was to determine if there had been a reduction in need to refer patients onto SMHS. This appears to be the case. A number of patients who would have presented to SMHS in the past are now being seen by MHBIS and this will impact on the number of referrals to SMHS. Patients are more willing to accept a referral to MHBIS than to SMHS. GPs often use this avenue for those on the cusp of moderate to severe illness as evidenced by the K10 scores and the questionnaires. GPs reported that there had been difficulties prior to MHBIS for some patients being accepted by SMHS. This issue appears to have resolved as there is now an option for these patients.
Benefits of a General Practice team approach with the General Practitioner as the initial point of contact

Benefits were identified for both the practice and patients with a practice team approach.

One factor that had not been considered prior to the study was the impact that MHBIS has had on the smoother running of practices. Easy access and no cost for patients from the practice make this an acceptable option for both patients and referrers. Practice staff can refer without having to spend more time with patients affecting patient waiting times. Patients are generally contacted by MHBIS within a day and can usually be seen within a week.

Communication was seen as being greatly enhanced by being practice based and through information technology and the ability to send reports directly to the practice allowing fast feedback. Informal discussion about patient treatment is enhanced and issues arising from concerns by practice staff or MHBIS Clinicians can be more easily attended to.

General Practices know their patients and family situation and are in a good position to talk with patients about the service and to judge when a referral is most appropriate. GPs are more likely to be able to detect mental disorders in patients who have attended three or more appointments (MAGPIe research group, 2004).

The majority of patients referred to MHBIS are seen at least once with only 16% declining the offer of a first appointment. There can be a number of reasons for this including issues resolving.

Data base information

Information taken from the MHBIS data base indicates that a range of age groups are referred to the service with a range of issues. The majority of people seen identified as European (87%), referrals indicate Maori are underrepresented at 4%. South Canterbury census statistics indicate a rate of 5.8% Maori in this area. Maori are over represented in mental health statistics (Oakley Browne, 2006). South Canterbury European population is 78.9% (NZ 64.8%) New Zealander 16.5% (NZ 10.6%) and Pacific Island Population .8% (NZ 6.6%) (South Canterbury District Health Board, 2009).
The main reasons people present to the service with are; depression, anxiety, relationship issues, grief and loss and stress. These are similar to those reported by other Primary Care Services (Dowell et al, 2006).

The K10 is a tool used to measure outcome and where possible is completed at the initial and last appointments. As people generally present to the service less than four times and many only on one occasion (23%) discharge K10 statistics are not collected for a number of patients seen.

Patients are often referred to the service when they are at a crisis point and some may rate high on the scale and significantly lower when the crisis is over. However there are also a significant number of people seen who are significantly unwell and the K10 provides a measure of change in depression and anxiety. This tool has been designed for general population studies and further research into the use of the K10 in Primary Health Care populations is warranted (Andrew & Slade, 2001).

This study has highlighted the need for robust recording systems. This has been reported as an issue in the evaluation of mental health in Primary Care settings from the PHO initiatives and overseas research (Dowell et al, 2006).

Regular feedback from service users and referrers is also a good indicator as to service outcomes. MHBIS has yearly service user andreferrer surveys. Results from surveys prior to 2009 have not been able to be included due to informed consent issues. Including permission for inclusion of results for research purposes on future surveys might overcome the issues around informed consent and give a broader base of information. The returns from the 2009 patient survey were low with 23% returned, which are compatible with postal survey return results, which have estimated a response rate between 20%-40% of postal surveys without follow up (Franfort-Nachmias & Nachmias, 1996:226). The results from this survey however were similar to those from past surveys.

The majority of people returning surveys indicated that the service had made a positive difference to their life. Their responses to what was important to them in treatment were similar to the responses in the studies of what patients want from their Primary Health
provider for their mental health needs (Kadam et al, 2001), namely having someone to listen to them, encouragement, help in understanding what is happening to them and help with strategies or goal setting.

**Optimal Primary Mental Health Model**

The Primary Mental Health evaluation report (Dowell et al, 2009) describes an optimal model for Primary Mental Health delivery. There are a number of features that are considered as core aspects of an optimal model and none of the researched initiatives had all of these features.

The features include; support from the District Health Board (DHB), an effective Information Technology (IT) platform and incorporated training, health promotion and liaison with secondary care and other sectors. Factors within the programme include; a programme which is adapted to local need, culturally appropriate services, a local PHO champion or leader, infrastructure (including patient management system, IT, links with community and other PHO programmes), continuous quality improvement and a workforce with the required staff, continuing professional development and supervision (Dowell et al, 2009).

The MHBIS has the majority of these features. The programme was developed by the South Canterbury District Health Board (SCDHB) and has ongoing support from the SCDHB and within South Link Health which has the contract for the service. Two GPs championed for the MHBIS and were involved in the initial development of the service. Their involvement assisted GPs accept the service. The IT programme was developed in collaboration with the MHBIS Clinicians meeting the needs for reporting and note keeping and allows direct communication to GPs. The interface with SMHS allows for shared training and access for advice, discussion and referral for patients. Although there have been some difficulties with recruitment of suitably trained staff at present there is a strong and experienced clinical team. Team members have individual supervision and regular team reviews of more difficult cases. Professional development is on going with study days allocated for staff members and study opportunities locally provided.

MHBIS Clinicians retain good links with local community agencies and programmes provided through the PHO and SCDHB. A regular meeting has been established for those
Primary Mental Health Services with SCDHB contracts which include MHBIS, the Youth Mental Health Service, Maori Primary Mental Health Service and the Plunket Post Natal Support Service to allow for sharing of information, support and education opportunities.

This method of service delivery is suitable for the population size of South Canterbury and may not be appropriate in other areas. A number of PHOs in the South Island are now basing their services on the MHBIS model and service specifications. The MHBIS team has had contact with Southland, Nelson, West Coast and Oamaru services. The Rural Canterbury Brief Intervention service is based on the model initially developed by the South Canterbury District Health Board for the MHBIS and adapted to meet local need with the addition of extended GP consultations and education for GPs.

In Timaru education for GPs is organized through the PHO. There are no extended GP consultations specifically for mental health as there are in other areas of the country.

This model has advantages over “packages of care” models used by some other areas where patients are funded directly for counselling or other services. MHBIS is well resourced with the workforce with the advantage of a multidisciplinary team, there is no set limit on patient numbers and patients can access the service the following year if necessary allowing a pathway for people with chronic depression to remain well. MHBIS provides a more comprehensive service than counselling alone including assessment, education, monitoring of progress, therapeutic input and ongoing communication with GPs and PNs. Referrals to other services including SMHS are easily facilitated.

**What would enhance MHBIS?**

Changes identified as enhancing the service were the addition of a youth service, increased salary for staff to help recruitment of staff, routine telephone call six months after first contact, access to a Clinical Psychologist, availability of six sessions, information for new Practice Staff, improvement in rooms to see people and the ability to see people who do not have a GP.

Since this study a Youth Mental Health Service has been established. Recruitment issues have been addressed.
There are a number of advantages to keeping available appointments to four. This enables patients to be seen quickly and allows a faster turnover of work. Four sessions only, encourages patients and staff to make the best of the short time. Often a lot of work can take place in this time. Phone calls between sessions or a follow up phone call afterwards help extend contact where needed. Clinicians can use their clinical judgment and see people for a further session if indicated but this does not make this an expectation. The need for more than four sessions was only raised on a few occasions indicating that this is not a major issue for referrers or Clinical Staff. The majority of patients use less than four sessions with only 21% seen four times and 4% more than four times. Having more available sessions has been mentioned by only one patient in the patient survey.

Four sessions allows for the identification of needs and referral on to appropriate community agencies and prevents the service from becoming a “counselling service” and referring on to counselling at an earlier stage where this work is needed. A small group of patients has been identified who would benefit from additional sessions. The most appropriate situations would be where there is a change of medication and further monitoring is needed, for patients with co-morbidity where there are more complex needs and for those with chronic depression where they may represent within the year.

Patients are able to use the four sessions within a year from referral and be eligible for further sessions a year from the initial referral. This provides an opportunity to meet again if the situation relapses after a year or another issue arises. MHBIS staff are then known to the patient and they are able to access the service easily to help prevent a situation deteriorating.

Patients remain in the care of their GP after discharge from MHBIS and if they have been prescribed medication will continue to be monitored by their GP at least three monthly.

Depression is a chronic illness for some people and having the sessions available yearly recognises the nature of the illness and need for ongoing care.

Guidelines from the National Institute for Health and Clinical Excellence (NICE) suggests 6-8 sessions of structured problem solving therapy over 10-12 weeks delivered by a member of a Primary Health team as being the most accessible form of psychotherapy for
Primary Care practice (NICE, 2004). This time frame for delivery of Cognitive Behavioural Therapy has also been suggested by NICE and the New Zealand Guidelines Group Evidence based practice guidelines (NZGG, 2008a:74). These guidelines suggest that if there is no change after six sessions then it is reasonable to consider changing or augmenting antidepressant treatment.

Experience from MHBIS suggests that the majority of patients do make a significant recovery over the four sessions and these are spaced to allow for the effectiveness of medication to be monitored and the integration of change strategies in peoples lives. The service statistics suggest that people only use those sessions that they need at the time. If the number of sessions available was to increase to six then it is likely that only those with more severe presentations would use these and that people who reaccessed the service within a year would have further follow up available.

Evidence from this study suggests that those people with co-morbid mental and physical health conditions are more difficult to treat due to the complexity of these situations. These patients may benefit from further sessions to manage some of the complexities that present. Where patients are on Care Plus there could be a closer relationship with PNs to educate and support around the mental health needs which present for those with chronic conditions so that these needs can continue to be addressed at the practice level after patients are discharged from MHBIS.

The issue of rooms in which to see patients is ongoing and does not have an easy solution if the service is to remain GP based. Practices in South Canterbury are varied in their ability to be able to accommodate patients being seen by MHBIS on site. A central location of several rooms where patients can be seen comfortably would assist in the smoother running of the service and this has now been facilitated by a GP offering a room for other GPs patients if needed and changes in accommodation at the South Link Health Office.

South Canterbury has been an area where many GP practices are unable to take on new patients. This has lead to some difficulties of patients not being registered with a GP which is a requirement of MHBIS referral so that overall clinical responsibility of a patient remains with the GP. This has excluded some patients from being able to access the service.
The local Maori Health Provider (He Oranga Pai) has now extended their contract to include provision of adult mild to moderate mental health services for Maori which will complement the MHBIS and allow for increased access and a choice for patients.

**Conclusion**

This was an important study with a number of key important findings all of which are supported by international literature.

The key findings show that access is a critical factor in the provision of Primary Mental Health Services both for the service user and the Primary Care Providers. Of major importance is that MHBIS allows easy access to mental health care that is acceptable and valued by both General Practices and service users.

This study has shown with the establishment of MHBIS there has been a reduction in mental health visits to General Practices. GPs report that patients seen by MHBIS are less likely to represent.

What is also obvious is that patients who are involved in collaborative care recover sooner and reports from GPs support this.

This model provides a different level of access to mental health services from traditional services for mental health which in turn reduces the overall health burden.

Both GPs and PNs reported that people require less time off work which also reduces costs for families and individuals as well as work places.

Medication is one aspect of treatment for depression; however, other aspects of care assist positive change. People are supported to make lifestyle changes to enable them to have longer term control of their health. They are more informed about how to remain well and how to use self help strategies, or seek help early to prevent future relapse.

The final chapter presents the major key findings of this study and recommendations for future service development and research.
Chapter Eight

Conclusions and Recommendations

This study has established that MHBIS is a successful programme, with good outcomes is well used and supported by GPs and PNs and Primary Health Care.

Patient feedback indicates positive change as evidenced by feedback surveys and the outcomes of Kessler 10 scores taken for patients on admission and discharge from the service.

This model concurs with international evidence of a collaborative care model for delivery of Primary Mental Health Care as providing improved outcomes. This model also meets criteria for an optimal health model as proposed by the Evaluation of the Primary Mental Health Initiatives (Dowell et al, 2009).

Key findings from the study are:

- That MHBIS provides an accessible mental health intervention for GPs, PNs and patients. Factors contributing to this are patients are seen in GP rooms at no cost for patients and being seen quickly.

- Information from MHBIS assists in treatment and improved outcomes for patients.

- Patients referred to MHBIS represent less frequently to their GP.

- GPs report that access to MHBIS has made some difference in psychotropic prescribing with the majority of GPs reporting prescribing less medication and more effective prescribing. Greater compliance with medication was reported by the majority of GPs.

- All GPs and PNs reported that they receive positive feedback from patients referred to MHBIS with a high frequency of feedback to practices.
• The main deciding factors for making a referral to MHBIS are; presentation of symptoms, patients level of functioning, willingness to accept help, patient presenting in emotional distress and pressure on GP time.

• MHBIS was found to be most effective for treating anxiety, depression, family or relationship distress and grief and slightly less effective for co-morbidity and adjustment disorder.

• A change in the relationship with Secondary Mental Health Services was reported by the majority of GPs who reported referring fewer patients to SMHS. Very few patients (four percent) needed referral on to SMHS after contact with MHBIS.

• MHBIS was reported to assist in making referrals to SMHS by the majority of GPs and referrals were reported by some GPs as being accepted more easily. Medication reviews by SMHS are used more frequently by a third of GPs.

• The majority of the people referred to the service had initial visit Kessler 10 scores of over 30 indicating a high risk of having an anxiety or depressive disorder. On discharge the majority of patients scored significantly lower and in the well range (<20) (p<0.001).

• MHBIS has filled a gap in service delivery for patients with a moderate mental illness and this group reported to prefer MHBIS as the first point of contact as opposed to a community referral or Secondary Mental Health referral. Patients are more likely to attend a referral made to MHBIS than a referral on to a community counsellor.

• Information from the service data base shows that the majority of patients are seen only one or two times and around twenty-five percent use the four visits allowed, indicating that for the majority of patients seen four visits are enough.

• Patients report that they are mostly recovered or recovering after their contact with the service.

• The benefits of a General Practice approach with the GP as initial point of contact are; easier access for treatment, acceptance by patients, smoother running of practices,
enhanced communication with GPs and earlier detection and intervention of mental health disorders.

**Limitations of this study**

The response rate from GPs was lower than expected. However it is consistent with predicted response rates from questionnaires as international studies (Khin, 2004, Cartwright, 1978). There was a lower than predicted response rate from PNs. This is reflected by the high numbers of PNs who work part time and do not refer to MHBIS or have direct contact with the service.

The focus groups had limited time for discussion as these meetings were part of the GP and PN peer group meetings with other business to also attend to. However, it was probably possible to access a greater number of GPs and PNs by attending these meetings rather than creating another forum. Further time in these meetings would have allowed for more in depth discussion.

There was limited input by MHBIS Clinicians. The time period of this study coincided with changes of staff within the team with the loss of experienced staff and new staff starting who had been in the position for less than two months. The team is small and the researcher did not participate in discussions and was unable to share experience from four years of being in the service.

The researcher was known to many of the GPs and to a lesser extent PNs. This may have influenced responses either in a negative or positive direction.

The study could have been extended further to have had greater input from service users and the opportunity to follow up with people who had used the service and explore the impact that contact with MHBIS had had on their mental health.

This study has highlighted the limitations of knowledge gained from the K10. Although this gives a good overall measurement of change for patients this could be enhanced by including information regarding whether patients are taking medication and length of time in the service and number of visits attended. The degree of positive change recorded on K10
scores may be due to a number of variables such as time or other changes in circumstances. However, as there was no control group with this sample no comparison could be made.

There was only a limited patient perspective providing input into this study. The patient survey had a low return response rate of only 23%. Results from previous patient surveys were not able to be included with this study due to not having consent for inclusion at the time of the surveys.

There was no discussion or analysis of the cost of provision of the service.

**Recommendations**

Further research around the long and short term impact of the service would add to this study. Greater input from the service users’ perspective would also add to this study.

The K10 provides a good base line outcome measurement however information gathered with this could be extended. Comparison of results for those people taking medication or without medication, length of time in the service and outcomes for number of sessions attended could add a further measurement to enhance research about the outcomes of MHBIS.

This study has highlighted the role that PNs have in relation to patients presenting with symptoms of depression and anxiety or distress. PN roles within surgeries vary with some PNs having a lot of contact with patients and making referrals and others with more limited roles and no experience of referring. This study has shown that patients are often more likely to talk about distress to PNs in the context of a consultation for a physical problem. When MHBIS was established GPs were seen as the group that would be referring however as the service has evolved there appears to be a greater role for PNs and hence further education and discussion with practices around referring may allow a pathway for more patients to be referred.

The role that MHBIS has in providing a clear pathway for referrals to SMHS has been shown. The relationship with SMHS is crucial to assist with transition of patients and for advice from Psychiatrists for management in Primary Care. The document “Identification of common mental disorders and management of depression in Primary Care” (NZGG, 2008a)
gives evidence based guidelines for management of depression and clear indicators of when referral on is warranted. There is a clear emphasis on management of depression in Primary Care in the initial stages with medication and need for ongoing monitoring. A more formal memorandum of understanding between MHBIS and SMHS may assist in strengthening this relationship and ways of working together.

Further research into the optimal number of sessions for people would inform future service development. There appears to be a group of patients who would benefit from further sessions. Consideration needs to be given to identify people who would gain greater benefit from extended visits. However this needs to be weighed against provision of care to a number of people and cost. Another consideration is the provision of extended GP consultations for follow up where extra GP input is needed.

Health policy is moving in the direction of preventive care and people gaining more control over their health especially in relation to chronic conditions. Research from the literature review has highlighted the role that psychological factors have on physical conditions and the number of people presenting to their GP with unexplained physical symptoms. MHBIS could have a greater role in educating people around management of stress, anxiety and lifestyle changes that contribute to poor mental health for those with chronic health conditions. MHBIS can have an integral role to play in the overall health of patients.

Research indicates that patients are more likely to attend their GP with physical symptoms rather than in relation to their mental health. Routine screening of patients for depression in higher risk groups might allow for these needs to be addressed in conjunction with physical health needs which literature shows tend to win out in the competing needs for GP time and attention.

**Conclusion**

This major study has highlighted that MHBIS is indeed an effective service. Overall it is well accepted and provides good support for General Practice in Primary Health.
MHBIS fills a gap for patients that do not meet the criteria for Psychiatric Services thus allowing for mental illness to be identified and treated earlier within a Primary Care setting. This serves to improve patients overall functioning.
References


Mental Health Foundation. (2006). We Need to Talk: The Case for Psychological Therapy on the NHS. London: Mental Health Foundation.

Mental Health Foundation. (2008). While we are waiting. London: Mental Health Foundation.


South Canterbury District Health Board. (2003). *Primary mental health services working group agenda, meeting 11 December 2003*. Timaru: South Canterbury District Health Board.


Appendices

1. Letter sent to all General Practitioners, Practice Nurses and MHBIS Clinicians
2. Information sheet
3. Consent form for questionnaire
4. Consent form for focus groups
5. Demographic data information sheet
6. Questionnaire for General Practitioners
7. Questionnaire for Practice Nurses
8. Questionnaire for MHBIS Clinicians
9. Focus group questions
10. Questionnaire and results for patient survey
11. MHBIS service provision framework
12. Kessler 10
Appendix 1: Letter to General Practitioners, Practice Nurses and MHBIS Clinicians

Dear

This year I am undertaking a research study on the Mental Health Brief Intervention Service. I am a member of the MHBIS team and have been involved since the start of the service. The study is part of a Masters Thesis for a Master of Social Welfare through Otago University.

I intend to investigate the impact that MHBIS has had on General Practices and patient populations from the perspective of General Practitioners, Practice Nurses and the MHBIS clinical staff. This study will provide information about groups of patients that gain most from the service and those that gain least. The study will ascertain any perceived change in relationship or referring to Secondary Mental Health Service and determine how decisions are made around who to refer to MHBIS.

I will be asking Doctors, Practice Nurses and MHBIS Clinicians to complete a questionnaire and I am seeking peer groups, or practices to participate in a focus group to gain more in depth information. This would require 30-45 minutes to discuss specific questions about the service which will be recorded. From this the emerging themes will be pulled and coded for analysis along with data from questionnaires. Some qualitative data may be used as examples.

Your participation will assist in pulling together information about MHBIS to look at the efficacy of this model of practice and to form some basis of evidence for this model.

MHBIS has been operating since 2005 and is in the forefront of Primary Mental Health initiatives. The service covers 28 practices in the South Canterbury region. The service won an award in the Primary Care section of the Health Innovation Awards in 2007.

This thesis intends to pull together existing information from this proposed research and the South Link data base and to link this in with theory and practice models around Healthcare in New Zealand and abroad.

I enclose an information sheet about the service, consent form and questionnaire; I will be approaching peer groups regarding participating in a focus group.

Thank you for your interest and assistance

Yours sincerely          Sarah Taylor
Appendix 2: Information Sheet for participants

Thank you for showing an interest in this project. Please read the information sheet before deciding to participate.

This project has been approved by the Upper South B Ethics Regional Committee.

What is the aim of the study?

The aim of this study is to determine the efficacy of the model of service delivery for the Mental Health Brief Intervention Service and to identify any changes that may be useful. The study will evaluate the service from the perspective of General Practitioners, Practice Nurses and the MHBIS Clinical staff to ascertain the impact the service has had on practice and patient populations.

The study aims to collect information on the impact of MHBIS on general practices and the health status of patients, to provide information about which groups of patients tend to gain most from the service and those who gain least. To ascertain any perceived change in the relationship and referrals between General Practice and Secondary Mental Health Services and to determine the decision making process when referring to MHBIS.

By participating in the study you will provide some valuable information towards evidence of outcomes for this model of care which could inform practice in other areas. This study will add to knowledge of how GPs make decisions regarding referral to mental health services.
Who can participate?

Any General Practitioner who refers to MHBIS. Any Practice Nurse who refers or works with patients referred to MHBIS. All MHBIS Clinical staff.

What will my participation involve?

I would like you to complete a questionnaire which will require approximately 10 minutes of your time. If the practice or peer group you work with would like to be part of a focus group to discuss the issues in more depth please contact the researcher and a time and place will be organised at your convenience. Around 30-45 minutes would be required for the researcher to meet with staff together to discuss the impact of the service on the practice and patients attending. This interview would be recorded and transcribed. Transcripts will be made available to participants to view should you wish to.

What will happen to the information?

Each participant will be allocated a study number. Only the researcher will be able to identify participants from the study number. Information from the study will be coded and entered into a database for analysis. Information will be stored in a locked cabinet with only the researcher, research assistant and supervisor having access to original data. Responses will not be identified back to any particular participant or practice. Care will be taken with any examples of patients given to ensure anonymity.

Will I be given the results?

At the completion of the study participants will be given a summary report of the study.

Who pays?

There is no funding available to reimburse participants for time or expenses.
**What happens to the information?**

This information is part of a thesis research project towards a Masters of Social Welfare at Otago University for the researcher. A report will be provided for all interested parties. Findings from this study may result in publications in relevant journals and presentations at local or national forums.

**Other information**

I would value your contribution to this study. The Mental Health Brief Intervention Service was not included in the evaluation of practice models for primary mental health interventions funded through the Ministry of Health primary mental health initiatives. MHBIS started prior to these initiatives and is funded by South Canterbury DHB.

MHBIS is one of the larger and more developed primary mental health services operating in the country. The service and has been fortunate to have an excellent data base designed to collect relevant statistical information from the start which can provide evidence for the service. This study aims to pull together all relevant information available to form a case study of a model of practice. This study will add to the body of research evaluating other national programmes by the Wellington School of Medicine and Health Sciences, University of Otago. Comparisons will be able to be made with other services nationally.

**Questions**

If you have any queries or concerns regarding is study please contact Sarah Taylor tel: 6877116 or email: sarah_taylor@southlink.co.nz or Dr Lynne Briggs (supervisor) lynne.briggs@otago.ac.nz
Appendix 3: Consent for Questionnaire

Mental Health Brief Intervention Service: Does it work? Study Number

Consent for questionnaire

Principal Investigator: Sarah Taylor

Participants Name: ________________________________________

I have read the information sheet concerning this project and understand it is to collect information on the impact of MHBIS on general practices and the health status of patients, to provide information about which groups of patients tend to gain most from the service and those who gain least. To ascertain any perceived change in the relationship and referrals between General Practice and Secondary Mental Health Services and to determine the decision making process when referring to MHBIS.

All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

1) My participation is entirely voluntary;

2) I agree for non identifiable demographic information and clinical information to be included in the data base;

3) I agree for my answers to the questionnaire to be included in the data base;

4) The information collected will be stored in a locked cabinet by the researcher for a period of 10 years and then will be destroyed;

5) I have had time to consider whether to take part;

6) I know who to contact if I have any further questions about this project.

Statement by participant: I hereby consent to take part in this project:
Full Name: _______________________________________________

Signature: ____________________________________________ Date: _____________

Statement by attending researcher:  I have given written information about the aim and procedures involved in this project with the above named person:

Full Name: ______________________________________________

Signature: ________________________________ Date: ____________
Appendix 4: Consent form for Focus Groups

Mental Health Brief Intervention Service: Does it work? Study Number

Consent form for focus group.

Principal Investigator: Sarah Taylor

Participants Name: ___________________________________________

I have read the information sheet concerning this project and understand it is to collect information on the impact of MHBIS on general practices and the health status of patients, to provide information about which groups of patients tend to gain most from the service and those who gain least. To ascertain any perceived change in the relationship and referrals between General Practice and Secondary Mental Health Services and to determine the decision making process when referring to MHBIS.

All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

1) My participation is entirely voluntary;

2) I agree for non identifiable demographic information and clinical information to be included in the data base;

3) I understand the discussion in the focus group will be recorded;

4) I am aware that I can see the transcript from the group and check for accuracy;

5) I agree for my answers to the focus group questions to be coded and included in the data base;

6) I agree for any examples given at the group to be included in the study in a non identifying way;
7) The information collected will be stored in a locked cabinet by the researcher for a period of 10 years and then will be destroyed;
8) I have had time to consider whether to take part;
9) I know who to contact if I have any further questions about this project.

**Statement by participant:** *I hereby consent to take part in this project:*

Full Name: _______________________________________________

Signature: _____________________________________________ Date:_____________

**Statement by attending Clinician or researcher:** *I have discussed the aim and procedures involved in this project with the above named person:***
Appendix 5: Demographic Information

Mental Health Brief Intervention Service: Does it work?  
Study Number

Background data

1) Gender: Male/Female

2) Age: 30-40 / 41-50 / 51-60 / 60+

3) Ethnicity: NZ Pakeha / NZ Maori / Pacific Peoples / Other (please specify) ______________

4) Role: 1) Doctor  
       2) Practice Nurse  
       3) MHBIS Clinician

5) Practice situation: In Timaru / outside of Timaru

6) How many patients do you estimate you have referred in the past 3 months? ______________

7) Practice Nurse only: Do you refer to MHBIS? YES/NO

8) How many doctors work at this practice? ______________

9) How many nurses work at this practice? ______________

10) Are you participating in the Questionnaire/focus group/both?

11) Focus group participants only: Would you like to check typed transcripts of the interview? YES/NO

Full Name: ______________________________________________

Signature: ___________________________ Date: ____________
Appendix 6: Questionnaire for General Practitioners

1) How has MHBIS made a difference to this practice? (please tick)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Provides an accessible psychological treatment option</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2) Information from MHBIS assists in ongoing treatment</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3) Patients referred to MHBIS presenting less frequently</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Other:

2) How has MHBIS helped patients? (please tick)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Patients recover sooner from depression and anxiety</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2) Patients are able to be referred on to services most appropriate to their needs</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3) Patients need less time off work for depression/anxiety conditions</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4) Patients have been supported to make lifestyle changes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5) Patients have strategies they can use to reduce anxiety</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6) Information given to patients assists treatment</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7) Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3) Are patients more likely to attend a referral made to MHBIS than a referral on to counselling services?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
4) Has the service made any difference to psychiatric medication prescribing? (please tick)

1) Prescribing

<table>
<thead>
<tr>
<th>The same</th>
<th>More often</th>
<th>Less often</th>
</tr>
</thead>
</table>

2) More effective prescribing

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

3) Greater compliance with medication

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

4) Other

Comment:

5) How often do you get feedback from patients about the service? (Please tick)

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very often</th>
</tr>
</thead>
</table>

6) How do patients generally rate the help received from MHBIS? (Please tick)

<table>
<thead>
<tr>
<th>No help</th>
<th>A little help</th>
<th>Some help</th>
<th>Helped a lot</th>
<th>Extremely helpful</th>
</tr>
</thead>
</table>

Comment:
7) How do you decide to refer? (please tick)

1) Decision based on presenting symptoms
   - Yes  No

2) Decision based on patient’s level of functioning
   - Yes  No

3) If psychiatric medication is prescribed
   - Yes  No

4) If considering prescribing and want to try MHBIS 1st
   - Yes  No

5) Patients willingness to accept help
   - Yes  No

6) Patient presents in emotional distress
   - Yes  No

7) Need for more information about patient
   - Yes  No

8) Request from patient
   - Yes  No

Other/comment:

8) Do you use any rating scales for depression/anxiety in decisions to refer?
   - Yes  No
If so which one/s?

9) How would you rate the effectiveness of the service for treating the following disorders? (please circle)

   1) Depression
      1---------2---------3---------4---------5---------6---------7
      Not at all poor a little mostly effective very effective highly effective

   2) Anxiety
      1---------2---------3---------4---------5---------6---------7
      Not at all poor a little mostly effective very effective highly effective

   3) Adjustment disorder
      1---------2---------3---------4---------5---------6---------7
      Not at all poor a little mostly effective very effective highly effective
4) Grief
1----------------2-----------------3-----------------4-----------------5-----------------6-----------------7
Not at all    poor            a little           mostly         effective     very   effective    highly
effective

5) Co-morbidity (physical and mental)
1----------------2-----------------3-----------------4-----------------5-----------------6-----------------7
Not at all    poor            a little           mostly         effective     very   effective    highly
effective

6) Relationship or family distress
1----------------2-----------------3-----------------4-----------------5-----------------6-----------------7
Not at all    poor            a little           mostly         effective     very   effective    highly
effective

Comment: ________________________________

10) Has the relationship with secondary mental health services changed in any way since MHBIS?

Yes  No

11) If yes, how has this changed? (Please tick)

1) Referring to secondary service is:
The same  More  Less

2) MHBIS assists in making referrals to secondary service

Yes  No

3) Use of medication review by psychiatrist increased

Yes  No

4) Patients are more likely to be accepted by secondary services than in the past

Yes  No

If yes why?

Comment

12) Do you consider patients with a moderate mental illness prefer this point of contact rather than being referred to Psychiatric Service?

Yes  No

Comment:
13) What do you consider are the benefits of a general practice team approach with the general practitioner as the initial point of contact?

14) Is there anything you think would enhance MHBIS service?

| Yes | No |

Comment:

Thank you for your assistance.
Appendix 7: Questionnaire for Practice Nurses

Mental Health Brief Intervention Service: Does it work?      Study Number

Questionnaire for Practice Nurses

1) How has MHBIS made a difference to this practice? (please tick)
   1) Provides an accessible psychological treatment option
      Yes  No
   2) Information from MHBIS assists in ongoing treatment
      Yes  No
   3) Patients referred to MHBIS presenting less frequently
      Yes  No

   Other:

2) How has MHBIS helped patients? (please tick)
   1) Patients recover sooner from depression or anxiety
      Yes  No
   2) Patients are able to be referred on to services most appropriate to their needs
      Yes  No
   3) Patients need less time off work for depression/anxiety conditions
      Yes  No
   4) Patients have been supported to make made lifestyle changes
      Yes  No
   5) Patients have strategies they can use to reduce anxiety
      Yes
   6) Information given to patients assists treatment

   7) Other – comment

3) Are patients are more likely to attend a referral made to MHBIS than a referral on to counselling services?
   Yes  No

4) How often do you get feedback from patients about the service? (Please tick)
   Never  Occasionally  Sometimes  Often  Very often
5) How do patients generally rate the help received from MHBIS? (please tick)

<table>
<thead>
<tr>
<th>No help</th>
<th>A little help</th>
<th>Some help</th>
<th>Helped a lot</th>
<th>Extremely helpful</th>
</tr>
</thead>
</table>

Comment:

6) How do you decide to refer? (please tick)

1) Decision based on presenting symptoms
2) Decision based on patient’s level of functioning
3) Patients willingness to accept help
4) Patient presents in emotional distress
5) Need for more information about patient
6) Request from patient

Other/comment:

7) Do you use any rating scales for depression/anxiety in decisions to refer? (please tick)

If so which one/s?

8) How would you rate the effectiveness of the service for treating the following disorders?

(please circle)

1) Depression

1---------2----------3---------4-------------5---------------6-----------------7
Not at all poor a little mostly effective very effective highly effective

2) Anxiety

1---------2----------3---------4-------------5---------------6-----------------7
Not at all poor a little mostly effective very effective highly effective
3) **Adjustment disorder**

1--------------2--------------3--------------4--------------5--------------6--------------7  
Not at all    poor            a little           mostly         effective     very   effective    highly effective

4) **Grief**

1--------------2--------------3--------------4--------------5--------------6--------------7  
Not at all    poor            a little           mostly         effective     very   effective    highly effective

5) **Co-morbidity (physical and mental)**

1--------------2--------------3--------------4--------------5--------------6--------------7  
Not at all    poor            a little           mostly         effective     very   effective    highly effective

6) **Relationship or family distress**

1--------------2--------------3--------------4--------------5--------------6--------------7  
Not at all    poor            a little           mostly         effective     very   effective    highly effective

Comment: ______________________________________

9) What do you consider are the benefits of a general practice team approach with the general practitioner as the initial point of contact?

___________________________________________________________________________

10) **Is there anything you think would enhance MHBIS service?**

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

Comment:

___________________________________________________________________________

Thank you for your assistance.
Appendix 8: Questionnaire for MHBIS Clinicians

1) What works well about the service? (Please tick)

- Patients being seen at GP rooms  
- Short waiting time for appointment  
- Communication between GP and MHBIS Clinician  
- Patients setting their own goals  
- Patients are given information about their illness and recovery  
- Patients learn strategies to assist their recovery

Other:

2) What works less well?

3) Are 4 sessions enough?

Yes  No

Comment:

4) How would you rate the effectiveness of the service for treating the following disorders? (please circle)

1) Depression

1-------------2-------------3-------------4-------------5-------------6-------------7
Not at all    poor      a little  mostly    effective   very effective  highly effective
2) Anxiety

<table>
<thead>
<tr>
<th>Not at all</th>
<th>poor</th>
<th>a little</th>
<th>mostly</th>
<th>effective</th>
<th>very effective</th>
<th>highly effective</th>
</tr>
</thead>
</table>

3) Adjustment disorder

<table>
<thead>
<tr>
<th>Not at all</th>
<th>poor</th>
<th>a little</th>
<th>mostly</th>
<th>effective</th>
<th>very effective</th>
<th>highly effective</th>
</tr>
</thead>
</table>

4) Grief

<table>
<thead>
<tr>
<th>Not at all</th>
<th>poor</th>
<th>a little</th>
<th>mostly</th>
<th>effective</th>
<th>very effective</th>
<th>highly effective</th>
</tr>
</thead>
</table>

5) Co-morbidity (physical and mental)

<table>
<thead>
<tr>
<th>Not at all</th>
<th>poor</th>
<th>a little</th>
<th>mostly</th>
<th>effective</th>
<th>very effective</th>
<th>highly effective</th>
</tr>
</thead>
</table>

6) Relationship or family distress

<table>
<thead>
<tr>
<th>Not at all</th>
<th>poor</th>
<th>a little</th>
<th>mostly</th>
<th>effective</th>
<th>very effective</th>
<th>highly effective</th>
</tr>
</thead>
</table>

Comment:

5) Are there any issues or trends you have noticed in patients referred by GPs? (E.g. range of issues, severity of disorders, age groups, gender issues, ethnic issues)

6) Do patients with a moderate mental illness prefer this point of contact rather than being referred to Psychiatric Service?

| Yes | No |

Comment:

7) What are the benefits of a general practice team approach with the general practitioner as the initial point of contact?
8) Is there anything you think would enhance the service?

Thank you for your assistance
Appendix 9: Questions for Focus Groups, GPs /Nurses

1) The service appears to have changed how mental health is managed in general practice are there any indicators of this having a longer term impact in anyway?

2) Has anything else changed as a result of this service? (e.g. people being treated earlier, more men accessing treatment, less reoccurrence of depression, greater compliance with treatment).

3) The service appears to be helpful in specific disorders. Can you give some examples of where the service was helpful?

4) There are some situations where the service is less helpful are you able to give any examples of any of these situations?

5) What would you consider the change in relation to secondary service has been as a result of MHBIS?

6) Can you tell me what is the deciding factor for referring?
Appendix 10: MHBIS Client Survey Results

MHBIS Client Survey Results Summary 2009

A client feedback survey was undertaken by postal survey in February 2009 with 100 surveys posted to a random sample of patients discharged from the service over the last year that had been seen at least twice.

23 completed surveys were returned, while an additional 5 were returned due to change of address.

The demographics of individuals that returned the completed surveys are illustrated in the table below.

### Age and gender of respondents

<table>
<thead>
<tr>
<th>Age Group</th>
<th>17 – 24 Years</th>
<th>25 – 44 Years</th>
<th>45 – 64 Years</th>
<th>65 – 84 Years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>2</td>
<td>7</td>
<td>3</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

### Ethnicity

Of the 23 respondents 21 were New Zealand European, 1 was other European and 1 was other.

1) When your GP referred you to the service, did you understand what we could do for you?

#### Summary of findings

The majority of clients were aware of what the service could do for them when they were referred. Yes (18); no (5)

#### If no, what would you have liked to have known?

*Comments in entirety*
• Would have like to have known more about who I would meet with and for how long

2) Prior to your referral to MHBIS, how long did you feel depressed / anxious / stressed / not coping / other?

Summary of findings

The majority of clients had been unwell for 6 months or less (9); 6 months to a year (6); 2 from 1-2 years and 5 indicated over two years. 1 did not respond.

3) Have you experienced previous episodes of depression / anxiety?

4) If, yes have you received help before?

5) If yes, what was the treatment?

Summary of findings

The majority of clients had experienced previous episodes of depression /anxiety (12) 10 had not. Of the 12, six had received help in the past. This included medication (2) and counseling (2), two did not indicate past assistance.

* 1 did not respond

6) How many times did you see the person from MHBIS?

Summary of findings

The majority of clients attended three sessions with MHBIS (9), (8) people had 2 sessions, (5) people had four sessions, 1 did not respond.

7) Was the MHBIS Worker on time for your appointments?

Summary of findings

20 clients answered yes and one indicated sometimes, one indicated No, one did not respond.

8) Do you feel the MHBIS worker understood you and what you needed?

Summary of findings

19 clients indicated that the Clinician understood what they needed; 2 indicated no, 1 yes and no and 1 did not indicate.
9) Did you receive good information about your illness or concerns?

**Summary of findings**

20 replied that they had received good information about their illness or concerns; 1 indicated no and 2 did not comment.

10) In what way did MHBIS assist?

**Summary of findings**

20 felt they were listened to; 15 received encouragement; 17 were helped to understand what was happening for them; 13 indicated help in getting perspective; 17 indicated information was provided, 14 received help with strategies; 9 received help with goal setting and 4 were referred to another agency.

11) What did you find most useful about the service?

**Summary of findings**

Of the 20 comments provided, these could be divided into 4 distinct areas. These were information and understanding (7), Someone to listen (9), Strategies and goals (3), Not a lot (1).

*A selection of comments in entirety*

The MHBIS person was understanding of what I was going through and was supportive in helping me to move on.

Helped me understand why I did things and helped me sort myself out to be a better person and not to get so stressed and anxious about little things.

The counsellor's prior knowledge of my condition (and how she helped me to see my reactions from another perspective) signs to look out for, if my condition got worse.

She knew how to apply realistic goals instead of setting me up for failure

Was excellent explained to me exactly what anxiety was which no GP has never done.

Realising what was happening and things would get better

Just being able to talk out what was happening and being very supportive to me

Kindness, compassionate and someone outside of the family to talk with. I found my
referral helpful and now able to cope better (most of the time)

12) Did MHBIS make a positive difference to how you are?

Summary of findings
The service made a positive difference to 17 clients and 5 indicated no difference, 1 did not comment.

13) Since you were first referred to the service, how would you rate your progress?

Summary of findings
Clients were asked to rate their progress since first referred to the service.
12 recovering; 7 rated recovered and 2 no change, 1 Worse. 1 did not respond

14) The service mostly sees people at their GP surgery. Where were you seen?

<table>
<thead>
<tr>
<th>GP Surgery</th>
<th>Own Home</th>
<th>South Link Health Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

15) Was the venue.....

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Yes &amp; No</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy to find</td>
<td>23</td>
<td>-</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Comfortable</td>
<td>18</td>
<td>-</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Appropriate</td>
<td>16</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

Comments in entirety

Disturbed on a couple of occasions at GP Practice

It was a relaxed atmosphere

Someone 'staff’ of medical centre walked in on one meeting

The receptionist was somewhat confused as for the reason for my visit - they had no record and were not expecting me
16) Did the service refer you on to another agency?

**Summary of findings**

5 clients were referred to another agency and all indicated they were happy with this referral.

17) If you answered yes to the above question, do you feel it was the right place?

**Summary of findings**

5 clients indicated it was the right place. Clients were referred to CCS, ACC Counsellor, Family Works and their GP for prescribing.

18) Can you think of anything that would make this service better?

**Summary of feedback**

Of the 5 comments 4 reported they were satisfied with the service as it is.

Some suggestions for improvement were an extension from 4 appointments to 6 (1), and a designated clinic or rooms for the service instead of being seen in General Practice (1).
Appendix 11: Service Provision Framework for MHBIS

GP REFERRAL PROCESS

<table>
<thead>
<tr>
<th>Process</th>
<th>Standards/Tasks</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person visits GP</td>
<td>Engage with person and gather information regarding the nature of their concerns. Ensure that information is gathered regarding mental state and risk/safety issues. Ascertain if person has a mild to moderate psychiatric disorder and would benefit from short-term support/intervention. Identify Urgency.</td>
<td>GP</td>
</tr>
<tr>
<td>Would the person meet criteria for Counselling Service?</td>
<td>Consider other options</td>
<td>GP</td>
</tr>
<tr>
<td>Yes</td>
<td>Discuss the option of attending the Primary Service. Explain the role and function and potential benefits to the individual/family/whanau. Discuss other aspects of client rights. Highlight the service is for up to 4 face to face sessions only. Obtain confirmation of acceptance for referral to be made.</td>
<td>GP</td>
</tr>
<tr>
<td>No</td>
<td>Complete referral form/or letter. Following information to be included: Name, DOB, NHI, phone number and contact address. Brief outline of what is required, any safety issues. Either give referral form to the person to present at first appointment or fax/send referral to Primary service.</td>
<td>GP</td>
</tr>
<tr>
<td>Give Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrange Appointment</td>
<td>Option 1 Through GP's Receptionist. Option 2 Direct phone contact GP to Primary Service. Option 3 Faxed/mailed to Primary Service Option 4 Person referred contacting Primary Service directly.</td>
<td>GP/Patient</td>
</tr>
<tr>
<td>End</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

End
**Primary Service Referral Process**

**Process**
- Written/Verbal Referral Received
  - Enter information on: Client Information Form
  - Make-up file
  - Allocate to Primary Worker.
  - Primary Worker/Supervisor/Secretary?

**Standards/Tasks**
- Determine Urgency
  - Confirm whether referral appears to meet criteria.
  - Ascertain urgency/prioritisation.
  - Primary Worker

**Who**
- Does person fit criteria?
  - No

**Process**
- Arrange an appointment
  - Discuss with GP and carry out recommendations as required.
  - Contact person within one working day of receipt of referral and arrange a meeting time.
  - Confirm if family/whanau to be invited.
  - Answer any queries.
  - Arrange an appointment.
  - Send Information leaflet about the service.
  - Copy of Health and Disability Consumer Code of Rights
  - Primary Worker

**Initial appointment**
PROCESS INITIAL APPOINTMENT/ONGOING RECOVERY/INTERVENTION

**Process**

**Standards/Tasks**

**Who**

**Person arrives for first appointment**
- Introduce self, check referral details.
- Discuss the role of the service, what can and cannot be provided i.e. Number of sessions available.
- Client rights.
- Process for the sharing of information with GP.
- Privacy/Confidentiality highlighting what will need to happen if risk/safety issues are identified.
- Discuss/Document process of consent.

Primary Worker

**Engagement**
- Ask the person (Family/Whanau) what they want from the service.
- Explore issues
- Assess for potential or actual risks/safety issues.
- Formulate plan with the person around the options considered.
- Where appropriate set goals until the next appointment.
- Discuss and document information in collaboration with the person either in person's file or on separate casenotes the outcome of the meeting and proposed action.
- Enter statistics.
- Arrange follow-up appointment.
- Feedback to GP if required.

Primary Worker/Person

**Recovery/Intervention tools**
- Treatment that maybe offered includes:
  - Problem solving
  - Goal Setting
  - Cognitive Behavioural Therapy
  - Psychosocial interventions
  - Crisis Resolution
  - Stress management
  - Education around illness
  - Prevention (Wellness Recovery Action Plan)
  - Strengths Assessment.
  - Evidenced-based Brief Interventions.
  - Referrals to other services where appropriate.

Primary Worker/Person

**Review**
- Review with the GP in the following circumstances:
  - During appointments where the person asks to be reviewed by GP.
  - Person appears to have a decline in his/her health status and is considered to be at high risk and/or is unable to progress or meets the criteria for discharge.

Primary Worker/GP

**Referral to other agencies**

NB: If the person is assessed to have an increase in risk/safety factors that may put him/herself at risk, immediately discuss situation with the GP and notify the appropriate agencies, which may include: Ambulance, Police, TACT, (Treatment Assessment and Crisis Team)
Appendix 12: Kessler 10

During appointments always consider the use of the existing community resources. If an issue is best met by another service, discuss with the person the available options in particular the benefits, length of time to access, and general information about what can be provided. Establish with the person if a referral to another agency will meet their ongoing needs. Complete the referral form in collaboration with the person. Give copies of brochures. Wherever possible encourage the person to self refer. Phone and/or send referral to appropriate agency if required. Inform GP.

Where necessary follow-up with the referrer to ensure process has been commenced. Written feedback to the GP at the end of the fourth session or earlier if there are concerns/discharged.

This does not include referrals to Emergency and Specialist Services i.e. Timaru Psychiatric Services.
K10 Kessler Scale

This questionnaire is designed to measure the intensity of your feelings. By repeating it at intervals we can find out if our treatment plan is working or not. For each question, tick the box that best matches your response.

**Date:** / /

<table>
<thead>
<tr>
<th>In the <strong>past 4 weeks</strong> about <strong>how often</strong> did you <strong>feel</strong> …</th>
<th>None of the time (1)</th>
<th>A little of the time (2)</th>
<th>Some of the time (3)</th>
<th>Most of the time (4)</th>
<th>All of the time (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tired out for no good reason?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Nervous?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. So nervous that nothing could calm you down?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Hopeless?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Restless or fidgety?</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>6. So restless you could not sit still?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Depressed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. That everything is an effort?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. So sad that nothing could cheer you up?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Worthless?</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Sub Total

Total

**People who score 10 – 15** are at **low risk of an anxiety or depressive disorder (78% of population)**

**People who score 16 – 30** are at **3 times the population’s risk of having an anxiety or depressive disorder (20% of population)**

**People who score 30 – 50** are at **10 times the population’s risk of having an anxiety or depressive disorder (2% of population)**

Adapted from the Eyre Peninsula Division of General Practice