Evaluation of Mental Health/Primary Care
Shared Services

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Disclaimer

The views held in this report do not necessarily reflect the views of the Graduate School of Nursing and Midwifery or the Health Services Research Centre, Victoria University of Wellington.

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Executive Summary

This report presents the findings of an evaluation of New Zealand mental/primary health shared care programmes as of March 2003. The evaluation was undertaken in response to a request by the Mental Health Research and Development Strategy team to understand the status, operations, policy and service implications of shared care developments. The overall aim of the project is to assist in the development of shared care services in the future by: i) describing each individual shared care programme currently established (and those being developed/planned) in New Zealand; ii) where existing evaluations have been undertaken, summarising these; iii) where evaluations have not been undertaken, devising a brief process for evaluation which can be conducted with minimum intrusion and time; and iv) recommending a way forward.

Approach to the evaluation

To establish the status of shared care in New Zealand all District Health Boards (DHBs), Independent Practitioner Associations, Health Care Aotearoa, and a network of Non-Government Organisations were approached in writing advising about the project and requesting information regarding whether they were involved in a shared care programme. A framework for description was designed by the evaluation team to format all data from programmes to ensure consistency and focus on key areas. Three main data sources, written material, evaluation reports, and stakeholder interviews, were used to gather data about programmes. Programmes “signed off” their programme descriptions presented as appendices in the report.

The status of shared care

Of the 21 DHBs in New Zealand, 11 had programmes (one had two programmes) that were in operation at the time of this research. Two DHBs had programmes recently ended and were in the process of reviewing how to restart. Another DHB was planning to introduce a programme in the very near future, and seven DHBs either had no formal arrangements planned or were discussing the possibility if introducing a programme. There was substantial variation in the organisation, funding, operations and services provided by the programmes.

The organisation and management of shared care

There was a wide range of models of shared care in operation, many of which were variations of the consultant-liaison, shared care, and shifted outpatients models described in the literature. No one model dominated service arrangements within New Zealand, and no programmes were found that did not involve general practice. Levels of management and governance varied greatly between programmes, as did the input of consumers and Māori.

Māori involvement in shared care

Formal Māori involvement in shared care ranged from mostly consultative or advisory roles, to some governance roles, through to participation in some DHBs as service providers. Some programmes worked in a complementary way with the DHB Māori Mental Health Services. The level of Māori consumer participation in programmes varied; some saw moderate numbers of Māori, while others saw few Māori consumers.

Shared care at an operational level

Some programmes built on the existing roles of mental health practitioners and general practice staff, and others created new positions. Most new positions were filled by mental health nurses who were employed as primary liaison workers. Eligibility to programmes was determined using clinical and financial criteria, with decisions regarding entry mainly being made by health practitioners. Actual numbers of people on programmes varied from 20 to 297. Most
programmes had some form of shared care-oriented training, which was usually targeted at GPs. Care arrangements were often built around some form of care plan. Most programmes did not appear to have set review and exit systems in place. Continuity of care was not always evident as some programmes transferred people out of the programme if their mental health deteriorated to the extent where they needed increased mental health service support.

**Evaluations of shared care programmes**

Just over half the programmes had completed formal evaluations; many of which were carried out at the end of a pilot phase. Other programmes had more informal arrangements to evaluate their service, usually based on feedback from consumers and GPs. Consumers and GPs were consulted or were surveyed in all evaluations and mental health staff in only some. Evaluations reported that in spite of obstacles encountered during the establishment and operation of the programmes, that shared care was a good idea and efforts should be made to ensure future developments. There was limited reporting of the impact of shared care programmes on health status and health service utilisation. Most programmes reported that consumers found shared care to be an acceptable arrangement that they wished to continue with.

**Discussion**

A number of issues need to be considered if shared care is to be adopted and extended in New Zealand. Issues include: sustainable funding; the complexity and time involved in establishing programmes; level of infrastructure support; equity and ethical issues; staff workloads; the type and level of support and training required for shared care; attitudes of some practitioners towards shared mental health care; and the lack of evidence of the impact and effectiveness of such programmes in maintaining or improving general and mental health status of people with mental illness.

**Conclusion**

New Zealand is now at a crossroads where decisions need to be made on what should happen nationally, regionally and locally for the future development of mental/primary care services. These decisions need to be mindful of the current primary health reforms that involve the establishment of Primary Health Care Organisations. In this context, there is potential for an increased role for nurses and other primary practitioners in the care of people with mental illness. While there is a need for local variation, national direction for further development of shared care is imperative. Given what is known about the general health needs of consumers, steps need to be taken to encourage and support people with mental illness to have some involvement with general practice. New Zealand needs to plan for mental health and primary services delivering integrated care as the norm. In the meantime a developmental approach will continue. This process would be accelerated through the opportunity for stakeholder groups to meet and share their experiences.
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List of Abbreviations

AIMS - Abnormal Involuntary Movement Scale
BPRS – Brief Psychiatric Rating Scale
CCT – Continuing Care Team
CEO – Chief Executive Officer
CME – Continuing Medical Education
CMH – Community Mental Health
CMHC – Community Mental Health Centre
CMHN – Community Mental Health Nurse
CMHT – Community Mental Health Team
CNS – Community Nurse Specialist
CPN – Community Psychiatric Nurse
CRHA – Central Regional Health Authority
CSC – Community Services Card
DA – Disability Allowance
DHB – District Health Board
DSM IV – Diagnostic and Statistical Manual of Mental Disorders
DWI – Department of Work and Income
EuroQol – European Quality of Life Outcome Scale
FTE – Full-time Equivalent
GMS – General Medical Subsidy
GP – General Practitioner
GST – General Service Tax
HFA – Health Funding Authority
HoNOS – Health of the Nation Outcome Scale
HSRC – Health Services Research Centre
IPA – Independent Practitioner Association
MHA – Mental Health (Compulsory Assessment and Treatment) Act
MHS – Mental Health Services
MoH – Ministry of Health
MRHA – Midland Regional Health Authority
NGO – Non-Government Organisation
PANSS – Positive and Negative Symptom Scale
PCLN – Primary Care Liaison Nurse
PCLW – Primary Care Liaison Worker
PHO – Primary Health Organisation
PLW – Primary Liaison Worker
PMHN – Primary Mental Health Nurse
RCT – Randomised Control Trial
SF-36 – Short-Form Health Survey
An introduction to terms used in this report

Unless otherwise noted, when using the term shared care, the authors incorporate a range of primary mental health programmes including consultant-liaison, shifted outpatients and shared care. The term programme is used to describe all shared care services, whether they be an integral feature of the mental health services or a pilot service. The District Health Board (DHB) geographical location is used to identify the programmes instead of their official title, with the exception of the Capital and Coast DHB which has two programmes in operation; these are identified as Newtown and Wellington (see Table 1 on page 8).

For the main text we mainly use the terms “people with mental illness” or “consumers” when referring to people receiving shared care services. For the individual programme descriptions included as appendices, we largely adopted the terminology used by the programme. The term consumer representative is used when referring to those people representing service users.

Unless otherwise referred to, the term mental health services describes DHB-provided services such as community mental health teams and continuing care teams.

Primary care, unless otherwise referred to, is in reference to general practice.
Introduction

In 1993 the New Zealand Department of Health released a discussion paper on *Primary Mental Health Care* (Department of Health, 1993) proposing a framework to “enhance innovative service delivery mechanisms and reduce barriers to access primary mental health services” (p.6). While this discussion paper cannot be credited to starting shared care programmes it was an indication of a significant policy change supporting the need for mental health and primary care services to work closer together. Since 1993 increased knowledge about the health needs of people with mental illness has resulted in the emergence of primary mental health shared care programmes. These programmes, which are general practice based, are the subject of this report.

Although general practice has always had a role in mental health, developments in mental health therapies and changing community attitudes to mental illness have led to an increased awareness of the health needs of those with mental illness (Strathdee, 1993; Wilkinson, Falloon, & Sen, 1985; Wilkinson & Wright, 1994). The emergence of shared care programmes is also a result of the increased incidence of people newly presenting with mental illness and the need for people with mental illness to have health services closer to the community where they are living (Nelson, Cumming, Duncanson, & MacEwan, 1997). In addition, information regarding the level of co-morbidity that people with mental illness have with physical illness supports the need for general health practitioners to be involved in providing health care to people with mental illness (Cohen & Singh, 2001).

Many countries, including Australia, Canada and the United Kingdom (UK), have developed shared care programmes to increase the role of general practice in mental health (Kates et al., 1997; Royal College of Psychiatrists & Royal College of General Practitioners, 1993; The Royal Australian College of General Practitioners & The Royal Australian and New Zealand College of Psychiatrists). Unlike these countries, New Zealand has had to devise ways to overcome the cost barrier to involve general practice in mental health care. The co-payment cost of a GP visit is thought to have worked against the mental health system encouraging people to use the GP (Nelson et al., 1997).

This report presents the findings of an evaluation of New Zealand shared care programmes as of March 2003. The research was undertaken in response to a request by the Mental Health Research and Development Strategy team to understand the status, operations, policy and service implications of shared care developments in New Zealand.

Aims of the evaluation

The overall aim of the project was to assist in the development of shared care services in the future by:

1. Describing each individual shared care programme currently established (and those being developed/planned) in New Zealand.
2. Where existing evaluations have been undertaken, summarising these.
3. Where evaluations have not been undertaken, devising a brief process for evaluation which can be conducted with minimum intrusion and time.
4. Recommending a way forward.
The research team

The research team included staff from the Victoria University of Wellington’s Health Services Research Centre (HSRC) and the Graduate School of Nursing and Midwifery. Staff involved were: Jackie Cumming (Director of HSRC), Sandy Fowler (Research Fellow), and Debbie Peterson (Research Fellow) from the HSRC and Kathy Nelson (Lecturer) and Brian Phillips (Mental Health Research Nurse) from the Graduate School. More recently Debbie Peterson has been based at the Mental Health Foundation. Associate Professor Chris Cunningham of Massey University provided advice on matters pertaining to the evaluation and Māori.

The layout of the report

The report is structured as follows. The first sections introduce the project, cover the findings of a literature review on shared care and summarise the approach used for this evaluation. The middle sections of the report cover what we found about shared care programmes in New Zealand. This section is supported by a series of appendices that provide detailed descriptions of all the programmes reviewed as part of this evaluation. The final sections discuss the implications of the findings, identify issues for consideration and provide recommendations for the future development of shared care.
Literature review

Models of shared care

New models of care aimed at increasing mental health care in a primary setting have developed in many countries during the late 1980s and 1990s. The most common models of sharing mental health care between primary and secondary services fall into one of three main service arrangements: consultation liaison, shifted outpatients and shared care. These arrangements exist along a continuum involving mental health care providers and general practice working together (Craven & Bland, 2002; Meadows, Nelson, & Wilhelm, 1999)]. In the report Shared Care of Patients With Mental Health Problems (Royal College of Psychiatrists & Royal College of General Practitioners, 1993) advantages of arranging mental health care in the general practice setting were reported as reducing stigma for patients, enhancing communication between the GP and the specialist, increased chances of accepting a psychiatric assessment if it does not involve going to the hospital, and providing a more relaxed environment for the patient.

Consultation-liaison services

The consultation-liaison model (sometimes called liaison attachment) involves a psychiatric expert — psychiatrist, psychiatric registrar, social worker, psychologist or nurse — providing a consultant and liaison service by working alongside the GP, providing advice to the GP on the care and treatment of people not seen by the specialist services, and overseeing the treatment of people through supervision on a regular basis (Carr, Lewin, Walton, Faehrmann, & Reid, 1996; Carr & Donovan, 1992). The consultation-liaison model is based on a belief that with support and guidance, GPs will obtain additional skills and knowledge to enable them to increase their involvement in mental health care. This form of service has been part of the UK health system for over 20 years with community psychiatric nurses appearing to be the most common psychiatric expert working in this model (Gournay & Brooking, 1994). The role of the psychiatric consultation liaison nurse has also increased substantially in popularity over the last few years in Australia (Sharrock & Happell, 2001). A recent proposal in the UK is to recruit a new type of mental health worker called Gateway workers who will have specific responsibilities to provide a liaison service to enable people to better access “appropriate specialised mental health services” (Neary, 2003).

In the main, studies on the consultant-liaison model have focused on how the model works for the general population (i.e. minor psychiatric problems) served by the GP as opposed to those with ongoing mental illness. Studies have generally found it to be cost-effective due to the psychiatric expert contributing to the care of more patients than they could in a mental health setting (Carr et al., 1996; Carr & Donovan, 1992; Epstein, Gonzales, Stockton, Goldstein, & Green, 1996; Gournay & Brooking, 1994; Nickels & McIntyre, 1996; Strathdee, 1993; Tyrer, Ferguson, & Wadsworth, 1990). However, the clinical benefits of the liaison model are unconvincing (Emmanual, McGee, Ukoumunne, & Tyrer, 2002). While most consultant-liaison services involve a one-on-one arrangement, Midgely, Burns and Garland (1996) reported on group liaison sessions. Midgely et al. found the group liaison meetings between GPs and CMHTs were well attended, and were a useful way of sharing information, particularly regarding people whose care was jointly managed.
**Shifted outpatients**

The shifted outpatient model involves mental health professionals running specialist clinics in general practice rather than at a mental health service (Jackson et al., 1993). This model is based on the belief that mental health services may be more acceptable and accessible to people if they are delivered in an environment closer to where people live and in a service that does not carry the “stigma” attached to mental services. Shifted outpatients was increasingly used in the UK during the 1990s when regulation changes removed funding restrictions on the range and number of disciplines that GPs could employ (Corney, 1996).

Jackson et al. (1993) described and analysed the first year of development of a community mental health team (CMHT) that was based in primary care. They found the presence of the CMHT resulted in a doubling of the prevalence of treated psychiatric disorders. Simultaneously, there was a reduction in the number of hospital outpatient referrals; there was no effect on the use of inpatient resources. It was concluded that no change in the use of inpatient resources was partly a consequence of the CMHT not offering an extended service to cover out-of-hours and liaison services. Research on shifted-outpatients suggests that the presence of this model may be effective in reducing overall inpatient admissions for mental health (Ferguson, Cooper, Brothwell, Markantonakis, & Tyrer, 1992; Williams & Balestrieri, 1989).

Saltman et al. (1993) evaluated a pilot scheme in Australia – Community health and medical practitioner scheme (CHAMPS) – that involved integrating the provision of some community mental health (CMH) services within a general practice setting. The CMH staff were salaried while the GPs were fee-for-service. The aims of the CHAMPS initiative were to improve access to mental health services, improve liaison between community health staff and GPs, and to broaden the range of services available at general practice. An evaluation six months after implementation identified problems arising from different work practices in the mental health component of the pilot. Once the pilot was completed, the mental health workers did not continue to work out of the general practice setting.

**Shared care**

The shared care model applies when the responsibility for the health care of a person is shared between individuals who are part of separate organisations (Pritchard & Hughes, 1995). A critical component of shared care is the relationships between the providers involved in a person’s care (Kates et al., 1997). The shared care model is based on a similar belief to the consultation-liaison model, in that with support and guidance GPs will obtain additional skills and knowledge to enable them to increase their involvement in mental health care and that this will reduce the demand for mental health services (Wilheim, 1997). In addition, the model is based on the belief that improved health gain will occur if people with mental illness have their care delivered by both the mental health and primary health services; each provider complementing, rather than competing with the work of the other.

Shared care in the mental health services is not limited to primary and secondary services working together, it also involves partnerships between Trusts and housing associations (Millar, 1996). Shared care involving general practice ranges from merely sharing records (Essex, Doig, & Renshaw, 1990; Nazareth, King, & Davies, 1995; Wolfe & Stafford, 1997) to actually planning care together, including improving the working relationship between GPs and community mental health services (Keks et al., 1995; O’Connor & Willcock, 1997).
**Combination of models**

The models described above are not mutually exclusive; there are some services that use more than one model and other services that draw on elements of more than one model to create a more locally appropriate way of working. Australia and the UK are the two countries where most of these combination developments are reported to have occurred. For example, the Australian CLIPP project (Consultation Liaison in Primary Care Psychiatry) combined the consultant-liaison model with shared care (Meadows, 1997, 1998). The early evidence from Meadow’s work was that combining these models was a cost-effective way of delivering mental health services. The combination enabled the service to transfer care of a group of people to the GP who would normally be managed by the mental health service, and it facilitated the GP to manage other people's care without them entering the mental health service. There was also evidence that consumers and providers were satisfied with this way of delivering services, and that it had the potential to increase the number of people who receive mental health care. Some “UK health trusts have … created primary mental health teams consisting of a link-worker (CPN), practice counsellor and/or psychologist, practice nurse and GP” (Walters & Tylee, 2003).

The localised adaptation of the basic models has inevitably resulted in opening up “shared care”, as a concept, to interpretation.

**Primary practitioner models**

The models discussed above, all involve the mental health services working with the primary services. While these mental health staffed models provide a solution to primary mental health, some recent approaches to primary mental health shared care have been entirely based on primary care practitioners (Cohen, 2003). The emphasis of the primary practitioner models has been about nurses and GPs becoming more skilled and involved in providing mental health services (Walters & Tylee, 2003) and addressing the general health needs of people with mental illness (Cohen & Singh, 2001). It has been suggested that some GPs and practice nurses could be accredited as having enhanced diagnostic and management skills in mental health (The Sainsbury Centre for Mental Health, 2001).
Approach to the evaluation

Identifying the projects

All DHBs, Independent Practitioner Associations (IPAs), Health Care Aotearoa, and a network of Non-Government Organisations (NGOs) were approached in writing advising about the project and requesting information regarding whether they were involved in a shared care programme. Once the research team was informed about the existence of a programme a request was made to the programme for written material, including any evaluations, and for permission to interview key informants.

Ethical issues

The Wellington Ethics Committee was approached regarding approval for the evaluation. While a formal ethics application was not required, it was understood that at no point in the evaluation would the research team talk about individual consumer’s health. The only consumers that would be spoken to were those nominated by the programmes as consumer representatives.

Information summary sheets and consent forms were developed as part of ensuring that those interviewed understood the purpose of the interview and how information was to be used by the research team. Prior to most interviews permission of the DHB or programme management was obtained, and individual’s who were formally interviewed signed a consent form.

The descriptions of each individual programme summarised in Appendices A-M were “signed off” as an accurate account by each programme before inclusion in this report. The programme descriptions were largely developed from the written material provided by the programmes. While this written material is referenced as part of each description, quotation marks have been omitted.

Data sources

There were three main data sources for most programmes. These were: i) written material about the programmes, ii) evaluation reports, and iii) interviews.

Written material provided by programmes ranged from pamphlet descriptions of programmes through to formal evaluation reports that included comprehensive findings. Interviews were both formal and informal and included individuals or groups of people involved with a programme. In the various interviews a systematic approach was used to ensure that all programmes were described using the same framework.

Although the aim was to interview consumer representatives, general practice, and mental health staff in all programmes, those who were interviewed were determined by the project management of each shared care programme and the availability of people. Where possible interviews were held after written material was reviewed and focused on clarifying the content of the material and finding out more about how the shared care programmes worked and what plans, if any, there were for review. In those programmes that had recently completed a formal evaluation, interviews were limited to key informants as many of the stakeholders had just been engaged in a research process. Similarly, with the new and
developing programmes, interviews were also restricted to a key informant as often the programmes were still in the start up phase.

Data from the programmes were collated from the documentation and interviews using a framework that was devised to draw out key features of a programme. The framework included the background or history of the programme, type of programme including aims, governance and funding arrangements, roles of practitioners, day-to-day operational arrangements including who joined programmes, how did consumers join, and what evaluations had the programmes undertaken. In gathering the data, attention was also made to consumer and Māori input and experience with the programmes. This data was then formulated into an abridged description that was signed off by each programme. At the time of signing off, programmes were invited to note any updates.

**Analysis**

The analysis involved three phases: i) describing the individual programmes so as to capture the programme’s unique features; ii) looking for similarities, common themes and differences in how the programmes worked and identifying issues that programmes encountered in their development and delivery; and iii) looking at the implications of the experiences in shared care in relation to New Zealand’s health policy and delivery systems and the literature relating to primary/secondary mental health service development.

**Limitations of the evaluation**

Given that there is not a consensus of what defines a shared care programme, a limitation of this evaluation may be that we have not identified all shared care programmes in operation within New Zealand.

As not all stakeholders were interviewed in each programme it is possible that some people working within a programme may disagree with what is written about their programme. In particular, consumer representatives were not always available for interview. To compensate for this potential, limitation all programme documentation and evaluations were reviewed by the research team to assess consumer input. Also, prior to the inclusion of the programme descriptions into the report, they were returned to all programmes for approval. Some programmes took this opportunity to circulate the descriptions to stakeholders who had not been interviewed to get further feedback before signing off the content as accurate.

Finally, the full findings of some more recent evaluations and research (e.g. Wellington’s second evaluation) and the Auckland pilot randomised control trial (RCT) were not available for public release at the time of writing this report.
The status of shared care in New Zealand

Of the 21 DHBs in New Zealand 11 had programmes that were in operation at the time of this research. One of these DHBs, Capital and Coast Health, had two programmes in operation. The names of all the programmes are provided in Table 1 below. Two DHBs had programmes that had recently ended and were in the process of reviewing how to restart. Another DHB was planning to introduce a programme in the very near future, and seven DHBs had no formal arrangements in place. Details of the actual locations of programmes in existence and in planning by DHB are provided in Figure 1 and Figure 2.

Of the seven DHBs with no formal programme, some have indicated that they are interested in developing a programme but require more information, funding or are awaiting the development of Primary Health Organisations (PHOs).

Although the names of particular programmes utilise similar language to that referred to in the literature review, an analysis of the features of the programme indicate that what is in fact delivered is not necessarily reflected by the title of the programme.

Table 1. DHB location and name of shared care programme

<table>
<thead>
<tr>
<th>Name used in report</th>
<th>Location (DHB)</th>
<th>Full name of programme</th>
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<td>Hawkes Bay Shared Care Pilot</td>
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<td>MidCentral</td>
<td>MidCentral</td>
<td>MidCentral Mental Health/Primary Care Liaison Programme</td>
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<td>Nelson</td>
<td>Nelson &amp; Marlborough</td>
<td>Nelson Primary Care Liaison Service</td>
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<td>Newtown</td>
<td>Capital &amp; Coast</td>
<td>Newtown Union Health Services Primary Mental Health Programme</td>
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<td>Wanganui CPN/Primary Care Integration Initiative</td>
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<td>Wellington</td>
<td>Capital &amp; Coast</td>
<td>Wellington Independent Practice Association Primary and Secondary Care Mental Health Liaison Programme</td>
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</table>

History of shared care programmes in New Zealand

Shared care programmes between mental health services and general practice in New Zealand first became evident in 1993 when the Central Regional Health Authority (CRHA) contracted...
with the Newtown Union Health Service for a service for people with mental illness who were enrolled at their surgery. Although the Department of Health’s (1993, p.6) discussion document on Primary Mental Health was released in that same year, only one other programme, that of the Hawkes Bay pilot, commenced in the mid 1990s. As Table 2 shows, the commencement of the Wellington programme in 1998 was the start of an emergence of a run of new programmes, the majority of which commenced in 1999 and 2001. Start dates provided in Table 2 are the official start dates as given by the programmes. The start date often coincided with the appointment of personnel to work in the programme. In several programmes the first people with mental illness to be accepted on the programmes did not join for several months after the start date. Some DHBs such as Taranaki and Otago went through a pilot phase before they adopted the programme as part of the services available.

Table 2. Programme commencement and discontinuation dates by year

<table>
<thead>
<tr>
<th>Year</th>
<th>Programme Commenced</th>
<th>Programme Discontinued</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>Newtown</td>
<td></td>
</tr>
<tr>
<td>1996</td>
<td>Hawkes Bay Pilot</td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>Wellington</td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>Auckland Pilot</td>
<td>Taranaki Pilot</td>
</tr>
<tr>
<td></td>
<td>Taranaki Pilot</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>Waikato Pilot</td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>Auckland Post Pilot</td>
<td>Auckland Pilot</td>
</tr>
<tr>
<td></td>
<td>MidCentral</td>
<td>Taranaki Pilot</td>
</tr>
<tr>
<td></td>
<td>Otago Pilot</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Taranaki Post Pilot</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waitemata</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Northland</td>
<td>Hawkes Bay Pilot</td>
</tr>
<tr>
<td></td>
<td>Otago Post Pilot</td>
<td>Otago Pilot</td>
</tr>
<tr>
<td></td>
<td>Southland</td>
<td>Waikato Pilot</td>
</tr>
<tr>
<td></td>
<td>Wanganui</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Nelson</td>
<td></td>
</tr>
</tbody>
</table>

Programmes had very different starting points, including the availability of new funding, and as a solution for improving existing services. The Hawkes Bay pilot emerged as a result of new funding in mental health becoming available. The Auckland pilot was one of the 10 national demonstration projects on integrated care purchased by the Health Funding Authority (HFA); the Auckland pilot was the only mental health integrated project purchased in this group of ten. Other programmes, such as Newtown, emerged in order to improve the service it provided to the large numbers of people with mental illness enrolled at Newtown Union Health Service; and Otago started in response to research findings that showed the high level of unmet physical health needs (Lee et al., 2000). The reason for starting does not necessarily reflect the focus of the programme, many of which had multiple aims and purposes such as relieving pressure on secondary mental health services, increasing consumer choice and reducing the number of “unnecessary” referrals to the mental health service. For example, while the Otago programme’s origins were about improving the physical health of people who utilised mental health services, the aims developed by the programme were much broader, being about reducing disparities and facilitating access by people with mental illness to primary health care.
The history of individual programmes has also seen some pilot programmes (e.g. Hawkes Bay, Waikato) being discontinued. The Hawkes Bay pilot was discontinued because the DHB considered that the pilot’s ongoing existence led to “inequitable access” to general practice for a limited number of people in the mental health service. The pilot was originally established to run from 1996 to 1998, however neither the CRHA nor the HFA made decisions about the future direction of the pilot service. The DHB made the decision to discontinue the pilot once it became a DHB responsibility. The Hawkes Bay team has indicated that it hopes to develop a new a programme based on shared care that is more equitable. The Waikato pilot ran for two years ending in 2002. The key stakeholders involved in Waikato are currently reviewing the evaluation with a view to finding a way forward. Auckland has continued providing shared care services to their pilot group beyond the trial period. Other programmes, such as Otago and Taranaki, built on the experience of their pilots to further develop the programmes offered in their region.

Many programmes used the experience of other programmes as models for their service. For example, Newtown influenced the development of the Hawkes Bay pilot and in turn, Waikato and Wellington both built on the experience of the Hawkes Bay pilot; MidCentral adapted the Wellington programme, while Southland and Nelson adopted many features of the Otago GP link programme. A request repeated by many of those interviewed was the need to learn more about other programmes operating within New Zealand.

While Hawkes Bay started as a regionally initiated pilot service, other areas did not follow this pattern. More recently, the South Island has been taking a co-ordinated approach, led by Otago, to shared care developments. Apart from the Auckland programme purchased to demonstrate integrated care, no other programme had a national focus.

**Defining shared care in New Zealand**

In approaching the DHBs, the research team chose not define what constituted a shared care programme. We considered that so little was known about the area in New Zealand that it was up to the DHBs to decide whether or not their DHB purchased a primary mental health shared care programme. The initial letter of enquiry to each DHB and the accompanying information sheet provided a basis for the DHBs to work with. The responses by the DHBs indicate there is a lack of consensus as to what a shared care programme is. This lack of consensus stems from the fact that all DHB mental health services had working relationships with primary care, some of which were described as programmes, while other relationships were seen as “routine care”. Although the Māori Mental Health Service of Wanganui considered the closer working relationships between themselves and local providers and the use of a documented care plan was shared care, their service has not been included as a programme in this report as they considered their approach was the way they worked, rather than a programme as such.

Programmes varied from structured formalised services (e.g. Wellington), through to less formalised ways of working (e.g. Waitemata). Some programmes, most notably pilots, were stand alone (e.g. Hawkes Bay, Waikato, Northland), while others (e.g. Otago) were being developed as part of routine service delivery. Differences in the type of programmes extend to funding arrangements. Some programmes (e.g. Waikato) had very formal funding arrangements, while others (e.g. Wanganui) did not receive specific funding, but were instead, set up by changes to the role and work of existing staff.
Of the seven DHBs with no formal programme, some had arrangements with primary care providers that the service describes as “normal” arrangements, but did not consider that these arrangements constitute a shared care programme.

**Models of shared care operating in New Zealand**

There was a wide range of models of shared care in operation, many of which were variations of the models described in the literature. No one model of shared care dominated service arrangements within New Zealand and no programmes were found that did not involve general practice. The programmes were often a mix of the key features of the consultant-liaison and shared care models plus a few included elements of shifted outpatients. The names of most programmes did not necessarily reflect the model of service provided.

The consultant-liaison model was the main feature of the Wanganui programme. In Wanganui a community psychiatric nurse was based for two half days a week in a group general practice. An aspect of the Newtown programme involved a psychiatrist providing a consultant-liaison service. As consultant-liaison workers, the nurse and psychiatrist saw individual patients in joint or sole consultations in the general practice setting and advised general practice staff about how to manage individual patients. People whose health care was reviewed as part of the consultant-liaison service included people newly presenting with mental illness and people with pre-existing mental illnesses. The role of the review was to advise general practice staff on how best to manage current needs or to review a person’s mental health care plan. The Newtown programme incorporated elements of the shifted-outpatients model in that the psychiatrist sometimes saw people regularly at the general practice as an outpatient service. Shifted-outpatients involves planned, rather than one-off review of care that takes place under consultant–liaison services when people’s health status changes. The community psychiatric nurse in the Wanganui programme followed up people who had recently been discharged from the mental health service as well as assessing people with mental illness whom the GP wanted some advice about how to manage care.

Unlike other services, Hawkes Bay and Northland developed their programmes based on shared care; that is, primary and mental health services providing complementary and co-ordinated care. In shared care, a jointly developed care plan is the basis on which the roles and responsibilities of different practitioners and services are specified. The shared care programmes were designed to work with people who had existing mental illnesses. Many programmes included elements of shared care, such as care plans, in their programme. The Waikato programme offered two options, shared care and GP total care. In the GP total care option, the responsibility of mental health care is transferred from the mental health services to general practice. Total care was also an early feature of the Wellington programme, but was later changed to include elements of shared care.

Liaison was a key feature in many programmes. Some programmes (e.g. MidCentral, Wellington, Taranaki) created new liaison worker roles. These roles were usually filled by community psychiatric nurses who were based in the mental health service. In the pilot phase of the Taranaki programme the liaison worker was based at the GP network offices. More recently, the newly appointed Taranaki liaison worker (who has a social work background) is based within mental health services. The primary focus of the liaison role was to facilitate the transfer of people from the mental health service to general practice. In this facilitation the liaison worker established the shared care arrangement for individual people and acted as the link between patients, general practice, and the mental health service. The liaison workers usually attended the person’s first GP consultation on the programme to discuss the transfer process and develop or share any care plans used. After this initial visit the liaison worker
continued to provide support and advice to general practice and the people in the programme as required.

The Waitemata programme incorporated a transitional approach in which people were transferred from the Continuing Care Team to GP care for a trial period of six months. In this trial period the liaison nurse followed up with the consumer and GP to ensure all was working well. At the end of the period the consumer and the GP had a choice as to whether they wanted the arrangement to continue.

Another model of service operating in New Zealand is that of the GP Link model developed in Otago. Here, the emphasis is on improving access for people in the mental health services to general practice. The responsibility for mental health care remains largely with the mental health service, with the role of general practice focussing on general health.

Several programme (e.g. Newtown, Waikato) had elements of the primary practitioner model in that some people’s mental health care was the responsibility of general practice.

Location of shared care programmes in New Zealand

There are 15 DHBs in the North Island. Of these, seven DHBs have programmes in operation (Capital & Coast has two programmes), two DHBs have programmes that have been discontinued, and six DHBs have no formal shared care programme. Figure 1 shows the status of shared care programmes in the North Island by DHB.

Figure 1. Location of shared care services in the North Island

<table>
<thead>
<tr>
<th>North Island DHBs programmes in operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northland</td>
</tr>
<tr>
<td>Auckland</td>
</tr>
<tr>
<td>Waitemata</td>
</tr>
<tr>
<td>Taranaki</td>
</tr>
<tr>
<td>Whanganui</td>
</tr>
<tr>
<td>MidCentral</td>
</tr>
<tr>
<td>Capital &amp; Coast x 2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>North Island DHBs programmes discontinued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waikato</td>
</tr>
<tr>
<td>Hawkes Bay</td>
</tr>
</tbody>
</table>

Map source: Ministry of Health website: www.moh.govt.nz

The status of shared care in New Zealand 13
There are six DHBs in the South Island. Of these, three DHBs have programmes in operation, one DHB has a programme in planning and two DHBs have no formal shared care programme. Figure 2 shows the status of shared care programmes in the South Island by DHB.

**Figure 2. Location of shared care services in the South Island**

![Map of South Island DHBs](https://example.com/map.png)

**Issues raised regarding the status of shared care programmes**

Although there are a number of issues about the status of shared care that were raised in the documentation and by those who were interviewed for this research, there was a general consensus that shared care was a good idea and efforts need to continue to ensure future developments. This expression of support was not only evident from those who had experience in shared care but was also expressed by many DHBs who did not have a programme as such. A common request was the need for more information regarding other programmes. While some interviewees reported their programmes were developed based on other programmes and that there was some regular contact with staff on other programmes, others expressed surprise that shared care programmes were still in existence in New Zealand. Several of the DHBs that did not have a programme or were at the very earlier phase of programme planning, advised the research team that they intend to make use of the findings of this research to inform their programme development so that they did not “re-invent the wheel”. There was a general consensus about the need for a national forum on mental/primary health shared care development to learn about the experiences of others who were developing or running programmes.
Many interviewees stated it was imperative for New Zealand to adopt a national approach/framework for the future development of shared care services. Some interviewees said that there should be no more pilots of shared care, that enough lessons had been learnt, and that New Zealand should now be looking at sustainable ways of providing shared care.
The status of shared care in New Zealand
The organisation and management of shared care

Governance of shared care

The governance of the programmes varied. Some programmes (e.g. Wellington) involved a large governance group that included consumer representatives, mental health and general practice management and practitioners, and programme staff, while other programmes (e.g. Waitemata) had no formal governance structures, rather the programmes were managed by the mental health services. These two examples cover the extremes of governance arrangements. The Wellington programme used a formalised approach with organised meetings to plan, monitor, and review the programme. In contrast the Waitemata programme was planned and developed during regular Continuing Care Team (CCT) meetings and used the same forum to discuss progress and raise issues. The majority of programmes had a specific governance group responsible for overseeing the programme’s development. Primary and mental health service personnel were well represented in these groups, however the level of Māori and consumer representation was variable.

Māori input at governance level

The programmes that had Māori representation included Auckland, who invited a Māori social worker to sit on the steering group with a view to “providing guidance with handling Māori clients”, Wellington, where Māori perspectives were provided by the service leaders from Capital and Coast Health’s Māori Mental Health Service, Waikato, where the stakeholder group Te Rūnanga o Kirikiriroa sat on the programme’s steering group and Newtown where Māori were represented on the Policy Board. However, more often than not, Māori input at the governance level was in an advisory role rather than direct representation, with advice being given from Māori advisory personnel or Māori Mental Health Services. Such participation by Māori seems at odds with the requirements of current health sector practice, for example the requirements on DHB Board membership for two Māori members.

Consumer input at governance level

All those programmes that had a formalised steering group (as opposed to a governance group) had consumer representation. Sometimes these representatives were people on the programme (e.g. Hawkes Bay), while at other times (e.g. Wellington) representation was provided through the local consumer organisations. Where programmes did not have an identified consumer representative (e.g. Northland), they generally relied upon general consumer feedback regarding services needed and provided.

Aims of shared care

Each programme developed aims tailored to meet their local needs. While all programmes were essentially consumer-oriented they differed in their service focus. The consumer orientation was about maintaining and improving health status and providing more choice. The service-oriented aims were focused on integrated care, general practice, and mental health. All programmes aimed for some form of integrated care, with most seeing this being achieved through improving communication and working relationships between secondary and primary services. Exactly how this improvement in communication and working relationships was to be achieved resulted in a different emphasis between a general practice
and a mental health focus. Those with a general practice focus aimed to increase the skills, knowledge and role of the GP in providing mental health care to people with existing mental illness as well as those newly presenting. Those programmes with a mental health focus aimed to reduce the demand for mental health services by having some care for existing clients being provided by general practice, and by reducing the number of new referrals from general practice.

Underpinning many of the programmes aims was the philosophy of recovery. Programmes considered that moving people with mental illness from secondary to primary care embraced the recovery model.

**Funding of shared care programmes**

There was no one way that the programmes were funded. Funding differed in terms of the source, the amount, its availability over time, and the components of service being purchased. Table 3 provides a summary of this funding variation.

**Table 3. Summary of funding features by programme**

<table>
<thead>
<tr>
<th>Programme</th>
<th>Funding Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>Pilot funded through Health Funding Authority (HFA); Auckland mental health service (MHS) found funding to continue service for those on the pilot.</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>Pilot funded by CRHA through four contracts. GPs paid fee-for-service plus GMS. Now use Disability Allowance if applicable – DHB is covering two special cases.</td>
</tr>
<tr>
<td>MidCentral</td>
<td>Manawatu IPA hold a two year contract with MidCentral – fee-for-service (max of 100 clients)</td>
</tr>
<tr>
<td>Nelson</td>
<td>MHS employs project co-ordinator (30 hours per week) GP services are funded by DWI through Disability Allowance</td>
</tr>
<tr>
<td>Newtown</td>
<td>Capitated funding for 300 consumers to Newtown Union Health Service from Capital &amp; Coast DHB whose mental health service also supplies the psychiatrist for a fortnightly consultant-liaison service.</td>
</tr>
<tr>
<td>Northland</td>
<td>Pilot funded through DHB to Whangarei Healthcare IPA for 12 months (20 clients) capped fee</td>
</tr>
<tr>
<td>Otago</td>
<td>MHS employs project co-ordinator full-time; GP services funded by DWI either through Disability Allowance or DWI special fund</td>
</tr>
<tr>
<td>Southland</td>
<td>MHS employs project co-ordinator full-time; GP services funded by DWI through Disability Allowance</td>
</tr>
<tr>
<td>Taranaki</td>
<td>Pilot funded by HFA when it ended the MHS found more funds to continue; fee-for-service based</td>
</tr>
<tr>
<td>Waikato</td>
<td>Pilot funded by HFA &amp; DWI benefit – managed by Linkage – MHS now looking at ways to start again.</td>
</tr>
<tr>
<td>Waitemata</td>
<td>No specific funding – Continuing Care Team helps the client to claim Disability Allowance to cover GP costs but this not available to all.</td>
</tr>
<tr>
<td>Wanganui</td>
<td>MHS fund a two half day CPN clinic at GP surgery – GP surgery supplies the room and use of computer</td>
</tr>
<tr>
<td>Wellington</td>
<td>Capitated funding to Wellington IPA from Capital &amp; Coast DHB (exc. GMS). In addition GPs claim GMS each time the consumer visits the surgery for a consultation.</td>
</tr>
</tbody>
</table>
Few programmes had only the one source of funding. The earlier programmes, such as Newtown and the Hawkes Bay Pilot, were initially funded by the CRHA. Hawkes Bay was purchased by the Mental Health Group and Newtown by the Primary Health Group of the CRHA. The Auckland programme was purchased by the HFA using funding specifically targeted at trialling models of integrated care. Funding for these three programmes later became the responsibility of their respective DHBs.

The mental health services of some DHBs were a main source of funding for several programmes. Some of the funding was under the direct control of the mental health services for staff salaries (e.g. Wanganui), while other funding was transferred from mental health to a tagged funding contract (e.g. Wellington). In some programmes DHBs provided the only source of funding (e.g. MidCentral), while other programmes (e.g. Otago, Waikato) were funded from multiple sources.

Several of the programmes that started as pilots during the 1990s have had to address the issue of ongoing funding in order to continue. Taranaki used funding left over from an HFA-purchased pilot together with money from a local trust to continue providing shared care beyond the pilot phase. At the end of the Hawkes Bay pilot, arrangements were made for people’s Disability Allowance to be increased to enable them to offset the cost of GP visits where possible.

The Disability Allowance is an income-tested discretionary benefit available through the Department of Work and Income (DWI) for people with costs associated with an ongoing health need or disability. All programmes in the South Island and some in the North Island have worked with DWI to enable individuals on programmes to utilise the Disability Allowance as part of the shared care programme. In several DWI offices, specific DWI employees have the responsibility to work with consumers, mental health services, and programme staff, to find ways to fund general practice health care costs. These arrangements included pooling funding (e.g. Waikato); ensuring an individual receives their entitlement (e.g. Otago); and arranging for some or all of a person’s Disability Allowance to paid directly to the GP (e.g. Nelson).

**Amount and availability of funding**

There is no easy way to summarise the exact amount of funding for each programme as some programmes funded staff, while others funded general practice visits. Where general practice visits were funded, the funding provided was targeted to offset the consumer co-payment cost for seeing the GP. In some cases the GPs were also able to claim for the General Medical Subsidy (GMS). Where funding was specified, the amount made available was sometimes tagged to an individual using a capitated formula (e.g. Wellington) or on a fee-for-service basis (e.g. Hawkes Bay), while in other cases some funding was pooled, such as some of the DWI funding in Otago. Education and administration costs were not always incorporated into the reported total budget of the programmes.

Most programmes, especially those that had commenced as a pilot were time limited, primarily because the funding attached to them was for a fixed period. Lack of sustainable funding and the subsequent ending of programmes have raised a number ethical and equity issues which programmes have had to respond to. Although some programmes that have recently started are to operate for a time period defined by contract (e.g. Northland), they all state that they expect to continue providing the service beyond the initial trial phase.
Number of participants

As Table 4 shows, the number of participants on the programmes varied greatly. Often it was the funding of the programme that dictated the number of participants. Some programmes were funded for very few people, for example the Northland pilot which is funded for a maximum of 20 people, while others such as Newtown, are funded for 300 people. On many occasions the targeted number of people expected to participate in a programme was not reached. Reasons for this were the unforeseen length of time it took for programmes to become operational and restrictive entry criteria.

The majority of programmes were able to provide demographic and clinical details for participants such as gender, ethnicity, and diagnosis. Those that could not provide this data were usually in the process of collecting it.

Table 4: Target vs. actual number of programme participants

<table>
<thead>
<tr>
<th>Programme</th>
<th>Target number of participants</th>
<th>Actual number reached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland Pilot</td>
<td>200</td>
<td>116</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>No set target</td>
<td>212 (as at May 1999)</td>
</tr>
<tr>
<td>MidCentral</td>
<td>100</td>
<td>27 (as at October 2002)</td>
</tr>
<tr>
<td>Nelson</td>
<td>No set target</td>
<td>Just commenced, no details to date</td>
</tr>
<tr>
<td>Newtown</td>
<td>300</td>
<td>297 (as at December 2002)</td>
</tr>
<tr>
<td>Northland</td>
<td>20</td>
<td>17 (as at March 2003)</td>
</tr>
<tr>
<td>Otago</td>
<td>No set target</td>
<td>22 on pilot</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-pilot - unknown</td>
</tr>
<tr>
<td>Southland</td>
<td>No details to date</td>
<td>Just commenced, no details to date</td>
</tr>
<tr>
<td>Taranaki</td>
<td>No set target</td>
<td>31</td>
</tr>
<tr>
<td>Waikato</td>
<td>100</td>
<td>35</td>
</tr>
<tr>
<td>Waitemata</td>
<td>No set target</td>
<td>20 (as at December 2002)</td>
</tr>
<tr>
<td>Wanganui</td>
<td>No set target</td>
<td>50 referrals during pilot phase</td>
</tr>
<tr>
<td>Wellington</td>
<td>No set target</td>
<td>215 (as at May 2002)</td>
</tr>
</tbody>
</table>

Funded components of shared care programmes

The source of funding had an influence on what was purchased as part of the programmes. Some funding paid for general practice services and time while others paid for mental health services and time; some also funded programme administration costs and for evaluations to be carried out. Administration costs sometimes included payment for attendance at governance or advisory meetings. Funded components of general practice included routine and extended consultations, liaison and education. Funded components of mental health services included providing dedicated liaison staff and contributions to general practice staff education sessions. The Disability Allowance fully or partially covered the co-payment cost of GP consultations and was also available to cover medication, travel and telephone costs associated with attending a general practice appointment.
Issues raised regarding the organisation and management of shared care

Two recurring issues, sustainable funding and the infrastructure support required in establishing programmes, were raised about the organisation and management of programmes. Some of the programmes’ documentation and many of the interviewees expressed concerns about the sustainability of funding for their programme. Even some of those programmes that had obtained what they considered was long-term funding, expressed concerns about the viability of their programme over time. This concern was because there were many hidden costs to running shared care programmes that both general practice and mental health services said they had had to absorb. For general practice, the hidden costs included the staff time required for liaison and follow-up, and the costs of providing facilities for consultant-liaison services. The mental health services often had to carry the cost of salaries of mental health workers involved in the programmes and staff time spent in identifying and preparing people for entry into shared care.

A further concern was about the infrastructure required for running shared care programmes. This infrastructure included the need for project management and co-ordination that was often not specifically funded. In addition, the transfer process of moving people’s care from mental health to general practice was often found to be more complex and time consuming than programmes had foreseen. A consequence of this was that programmes often did not reach their projected numbers within the desired timeframes. Reaching projected numbers was not only about infrastructure difficulties, but was also a consequence of how some programmes were designed (e.g. eligibility).

A further issue regarding the management and organisation of shared care programmes related to discontinuation. When programmes provided free GP care for a pilot period, some felt that there was an ethical issue when this free service was withdrawn. Some programmes reported taking steps to find solutions for individuals to continue to have easy access to the GP following the discontinuation of the pilot programmes. These steps included working with DWI to re-instate people’s access to the Disability Allowance for general practice services and for those people ineligible for the Disability Allowance, mental health services sometimes made individual arrangements whereby the service was prepared to pay the GP co-payment.
The organisation and management of shared care
Shared care at an operational level

In discussing the operations of shared care, the focus was on how services worked on a day-to-day basis, including establishing who was eligible to participate in programmes, how care was organised, what the various roles of health practitioners were, and what shared care-oriented training was available for those involved.

Eligibility for shared care programmes

Most programmes had a set list of entry criteria for consumers to join the programmes and some had restrictions on which GPs could participate. Although criteria for consumers varied between the programmes, most had criteria based upon recent (as in the preceding six months) involvement with the mental health services and having a mental illness of ongoing duration. Some programmes were open to all people with an ongoing mental illness who attended mental health services, while others were restricted to people whose mental health status was considered stable. Most, but not all programmes, restricted the access of people on clozapine to join programmes because of prescribing restrictions. In several programmes people who had been admitted to hospital in the preceding six months or who were under the Mental Health (Compulsory Assessment and Treatment) Act (MHA) were automatically excluded from joining. Many programmes were limited to people who had a Community Services Cards (CSC).

As programmes varied as to whether they were open to all GPs in an area or a limited number of GPs, some consumers had restricted access because of who they had as their GP. In the case of Taranaki, restrictions on consumer numbers was due to the shared care contract being with a specific GP group. In the case of MidCentral, restrictions were based upon GP education; the only GPs allowed to participate in the programme were those who had completed the locally developed shared care training programme.

Programmes varied slightly in how they determined an individual’s eligibility. Most decisions involved mental health service staff and liaison workers identifying those who they considered were suitable to join. In many programmes general practice staff could recommend people to the programme, but in general mental health staff made the decision as to whether the people could join. In Newtown all people with a mental illness who registered at the Newtown Union Health Service were potentially eligible for the programme but access was only granted to those whose illness and health status was considered to put them into the 3% of the population targeted by mental health services because of serious mental illness (Wilson, 1997).

In almost all programmes consumers had to formally consent to participate in the programme. Some eligible consumers are known to have declined to participate. Reasons for declining have included not wanting general practice to be involved in their mental health care, not wanting to change to a GP on a programme, wanting to remain with mental health services, not wanting to pay for GP visits (when there were no free GP visits offered on the programme), and not wanting to risk carrying GP costs in the future if the programme ends.

Programmes differed in whether eligibility to a programme was ever reviewed. Some programmes (e.g. Newtown) had an ongoing review process, while others had no set clinical or eligibility review procedures. Some people’s eligibility to a programme was removed if they required intensive mental health service interventions such as being admitted to hospital, while others lost access to the programme if they left the district where the programme was
located. With pilot programmes, eligibility often ceased at the end of the pilot phase. In some situations transitional arrangements were made for these people prior to the commencement of new programmes.

**Services provided for people in the shared care programmes**

Programmes differed in the focus of the services provided to people. Some programmes focused on moving the total management and responsibility of people’s mental health care from the mental health services to general practice, while others focused on sharing the management and responsibility of people’s mental health care. Yet other programmes were principally focused on having people’s general health needs well met. Roles pertaining to mental health varied and included the assessment and management of mental illness, managing treatment side-effects, supporting and advising people on mental health matters, prescribing medication, completing welfare benefit documentation, and liaison. Liaison involved one-off assessments following consultations as well as regular contact. Many programmes also had assertive follow-up procedures. Sometimes follow-up was the responsibility of the liaison worker, while on other occasions it was the responsibility of the general practice.

Table 5 provides a summary of how services were organised by programme. From this table it is evident that some programmes worked with formalised care-plans while others were primarily based on liaison.

**Table 5: Summary of service provided**

<table>
<thead>
<tr>
<th>Location</th>
<th>Service Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>Liaison programme with transfer to GP with Clinical Nurse Specialist support</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>Shared care – GP with Community Mental Health Team and Other providers</td>
</tr>
<tr>
<td>MidCentral</td>
<td>Liaison programme with transfer to GP care – care plan and primary care liaison worker support</td>
</tr>
<tr>
<td>Nelson</td>
<td>Liaison programme with transfer to GP care (goal) – liaison worker oversees transfer process and works with GP and DWI.</td>
</tr>
<tr>
<td>Newtown</td>
<td>GP and Practice nurse deliver mental health service based on Shared Care (with MHS and other providers) and GP-Total care, plus psychiatrist consultant liaison service.</td>
</tr>
<tr>
<td>Northland</td>
<td>Liaison programme with transfer to GP care – care plan and MHS support.</td>
</tr>
<tr>
<td>Otago</td>
<td>GP link service – still on MHS caseload with regular GP visits for physical health needs – MHS liaison co-ordinator works with GP and DWI</td>
</tr>
<tr>
<td>Southland</td>
<td>GP link service – still on MHS caseload with regular GP visits for physical health needs – MHS liaison co-ordinator works with GP and DWI</td>
</tr>
<tr>
<td>Taranaki</td>
<td>Liaison programme with transfer to GP care – care plan and primary care liaison worker support for transfer and MHS backup</td>
</tr>
<tr>
<td>Waikato</td>
<td>Shared Care: GP main provider of care but MHS also involved GP-Total care: exit from MHS to total GP care</td>
</tr>
<tr>
<td>Waitemata</td>
<td>Transfer to GP care – 6 months transition period supported by liaison nurse from Continuing Care Team</td>
</tr>
<tr>
<td>Wanganui</td>
<td>Clinical Nurse Specialist liaison service – two half day clinics in GP surgery.</td>
</tr>
<tr>
<td>Wellington</td>
<td>Liaison programme with transfer to GP care – care plan and primary care liaison worker support; some shared care with MHS and other providers</td>
</tr>
</tbody>
</table>
Shared care plans were either specifically developed for the programme or were based on those already in use. In most, but not all cases, individual’s shared care-plans were developed with the consumer present and were intended to be updated throughout the programme. In other cases, care plans informed the GP in the form of discharge summaries. Programmes that aimed to expand the role of general practice in peoples’ mental health often involved an initial consultation attended by the consumer, liaison or mental health staff worker, and the GP.

Waikato was unique by incorporating pharmaceutical services into its programme. A pharmacy group had a defined role and was funded as part of the programme to oversee how individuals’ medication was managed.

Māori involvement in shared care programmes

Whether looking at the number of Māori participants, the role of Māori providers and practitioners, or the level of consultation, Māori involvement in shared care programmes was found to vary greatly. For all programmes that furnished ethnicity data it can be seen that Māori consumers participated in every programme. The level of participation ranged from 9% to 50% of the total number of consumers. In the Waitemata programme run by the Continuing Care Team (CCT), only three of the 27 consumers were Māori; the programme reported that the number of Māori clients in the care of the CCT overall was low as Māori people were mostly referred to the Māori Mental Health Services Team, therefore this liaison transfer service was predominantly for non-Māori. In contrast, Northland’s pilot specified that half the participants were to be selected from the Māori Mental Health Service caseload.

The involvement of Māori providers in shared care either took the form of providing services and support as part of the programme or as a consulting role by reviewing programme documents and training material to ensure that issues for Māori were appropriately covered. In Otago a Memorandum of Understanding between Te Oranga Tonu Tanga Hinengaro Hauora Services and other Otago Mental Health Services stated that Kaioranga Hauora Māori Workers of Te Oranga Tonu Tanga would regularly interface with other Mental Health Services to ensure that ongoing quality assistance in cultural matters was provided to clients who require care. Many programmes reported the ongoing involvement of Māori Mental Health Services in providing cultural input; liaising with and supporting both programme staff and consumers. Health practitioners who identified as Māori were also involved in a minority of programmes (e.g. MidCentral).

Roles of practitioners in shared care programmes

General practice roles

The majority of programmes focused on increasing the provision of mental health care in a general practice setting. Programmes varied in whether this focus was for the GP to provide services for patients’ mental health needs, or physical health needs, or both. For many programmes a primary objective was to transfer the responsibility of an individual’s mental health care to the GP. This transitional process was usually supported by a liaison worker, and once complete, the GP received varying levels of support from mental health services and liaison workers depending on the programme.

Not all GPs in a programme’s geographical boundary necessarily had a role in the programme. In some situations (e.g. MidCentral, Waikato), restrictions in the form of
requiring compulsory attendance at education sessions and contracting were placed on which GPs could participate in a programme.

The role of the practice nurse also varied between programmes. Newtown differed from all other programmes in regards to the nursing role. At Newtown, the practice nurse was a key player in the mental health programme. Their role included seeing people for joint or solo mental health consultations, running outreach clinics, and following up people even when in hospital. Other programmes had no specific plans for involving practice nurses and relied on more informal arrangements; for example, many liaison workers would make a point of introducing themselves and the programme to the practice nurse. MidCentral supported the involvement of practice nurses in providing care to individuals on the programme by making their attendance to the GP education sessions compulsory.

**Mental health service roles**

Mental health services staff carried out a number of different roles on the programmes. These roles included identifying who was eligible for programmes, working with these individuals to complete any discharge/consent forms, address concerns that people had, and supporting them, clinically and personally in the transition and new service arrangements. Nurses and psychiatrists also provided support and advice to GPs and practice nurses, both in person and by telephone. In some areas this role was carried out principally by community psychiatric nurses. Mental health staff also contributed extensively to the training of the general practice staff by holding both formal and informal sessions.

In several programmes mental health staff took up new consultant-liaison or liaison worker positions as part of the programme. These new positions were funded by and accountable to the mental health service. A key component of the liaison worker role was to work with individuals whose care was being transferred or discharged to general practice. This involved arranging for shared care documentation to be completed, setting up and attending initial GP appointments under the shared care programme, and following up with individuals to ensure that the arrangement was working well. In Wanganui a community psychiatric nurse ran clinics for two half days at a general practice surgery on a weekly basis. This role was funded by the mental health service. In these clinics the nurse followed-up people recently discharged from the mental health service to the general practice and carried out a mental health assessment on people referred by the GPs. Newtown’s consultant-liaison service was provided by a psychiatrist who held joint or sole consultations fortnightly at the surgery. The psychiatrist also held meetings with the GP and nurse involved in the programme to review and advise them on care management.

In Otago a psychiatric nurse was employed as a project co-ordinator to oversee the local programme. Once people were identified as eligible for assistance the project co-ordinator worked with the individual to find a way of increasing the contribution of general practice in their care. This involved the project co-ordinator working with individuals and DWI to ensure that a person is receiving their full entitlement of the Disability Allowance and developing alternative approaches to the payment system of the Disability Allowance where possible. Alternative arrangements include supporting people to pay off a lump sum (up to $300) of GP debt, and assisting people with setting up automatic payments to the GP. The Otago project co-ordinator has also assisted other DHBs in the South Island (e.g. Nelson and Southland) to establish similar programmes. This assistance often involved the project co-ordinator travelling to these regions to provide advice and guidance.
Training requirements

Several programmes provided specially developed training sessions for general practice staff. In the main these training sessions were targeted at the GP. The content of the education sessions included clinical sessions such as: pharmaceuticals, the AIMS test (a test for monitoring the long-term side effects of anti-psychotic medication), the management of specific disorders, acute illness, the Mental Health Act, and the recovery process. Attendance at training sessions was usually voluntary, but in some instances (e.g. MidCentral) attendance was mandatory for programme participation. As part of the development of these sessions efforts were made to ensure GPs were able to get Continuing Medical Education (CME) credits for their participation. In some programmes GP training in mental health was obtained via the usual CME channels. Sometimes training sessions were partially supported by pharmaceutical companies. In some programmes (e.g. Wellington) general practice non-clinical staff, such as the receptionist, also attended training sessions.

Consumers also played a key role in some training sessions. Generally this consumer role was in a consulting capacity advising training organisers about content. There were however some sessions where consumers were part of the teaching team.

Informal unplanned training occurred in most programmes through the closer and regular contact between mental health and general practice staff. General practitioners in the Hawkes Bay pilot also reported learning by doing. They found that increasing their contact with people with mental illness increased there skills and knowledge. Some GPs also attended meetings organised by NGO providers such as the Schizophrenia Fellowship.

Unmet training needs raised by the programmes included more emphasis needing to be placed on training for the practice nurse role and other general practice staff (e.g. receptionists) and on the management of particular health problems regularly presenting to general practice (e.g. the assessment and management of anxiety).

Issues raised regarding service delivery

A number of operational issues were raised by interviewees, including: the time it took to get people on to a programme, workload, attitudes towards the programme, and the level of support provided to GPs.

As mentioned earlier, many programmes did not reach their intended target number of participants. Often the entry criteria proved very restrictive, and this was especially the case when a programme worked with only one GP group, or if a particular person’s current GP was not interested in participating in the programme. These restrictions were reported as being particularly frustrating for liaison workers as they were usually the main person involved in instigating the transfer process. Several programmes experienced reluctance, and very occasionally refusal, by some GPs to be involved in shared care. Other GPs were reported to have embraced the programmes, with evidence of some GPs having “large” case loads of people who were enrolled in the programmes. While the definition of large was not explored, one GP in the Hawkes Bay pilot was reported as having 35 people enrolled in the programme, and the Newtown Union Health Service had 297 people on its programme.

Issues regarding increased workload were raised by many groups. Workload was discussed in relation to the start up process and the amount of extra paperwork that programmes often created. Some mental health workers said that because of this increase in paperwork they felt...
there was little incentive for them to get involved in shared care. Some liaison workers reported already feeling stretched dealing with the current numbers on the programme and were concerned about how they were to manage if a programme reached its intended number of participants. Liaison worker’s workload was also increased at times when GPs wanted nothing to do with shared care resulting in liaison workers having to establish whether the person would change GPs, and then having to set up new relationships. The programme staff tended to refer people to GPs who had “good” reputations and were considered to have an interest in mental health. A consequence of these referrals was an increase in workloads of these particular GPs. The staff at DWI directly associated with programmes reported a big increase in their workload. However, some DWI staff reported that spending more time working with people involved in the programmes resulted in enhanced working relationships.

On the whole, GPs expressed satisfaction with the level of support they received as part of shared care arrangements. However, nearly all of the GPs involved in the GP Total Care option of the Waikato programme reported feeling isolated because there was no arrangement for mental health services support. These GPs recommended only the shared care option should continue beyond the pilot phase.

There was wide support for the need for training. Some programme staff considered the training focused on clinical knowledge at the expense of process issues. It was also expressed that at times there was not a good understanding between the mental health and primary care sector about the work each other did, and the skills each group already had.
Evaluations of shared care programmes

Just over half the programmes included a formal evaluation as part of the programme’s development. Many of these evaluations were carried out at the end of a pilot phase, the results of which were made available for this evaluation. Other programmes had more informal arrangements to evaluate their service, usually based on feedback from GPs and consumers. Consumers and GPs were consulted or were surveyed in all evaluations and mental health staff in only some. In addition to drawing on the formal evaluations, this section also presents some opinions and experiences of those interviewed regarding the perceived effectiveness of programmes. Many of the programme evaluations have been carried out with the intention that their findings will be used to shape existing or future programmes or to provide the basis for expanding shared care services.

Types of evaluation

There was no one type of evaluation carried out. Some evaluations were very detailed such as the quasi-experimental design carried out with the Hawkes Bay pilot, and the impact evaluations carried out by Wellington. Programmes with more complex evaluations were usually those that sought to increase the role of general practice in the mental health care of people who were enrolled in the mental health services. Other programmes had a simple evaluation design based on questionnaires and interviews with consumers and GPs. The more formal evaluations were sometimes carried out by external evaluators. These evaluations usually contained some statistical analysis of health outcomes and costs. The more informal evaluations were usually carried out by programme staff and were based on short and simple questionnaires obtaining subjective feedback.

Types of data used in evaluation

While no one method was used by all evaluations, most had elements that drew on qualitative and quantitative methods. Most formal evaluations used a mixed method approach. Methods used included:

- Chronological record of programme development
- Document reviews and analysis
- Interviews with consumers, GPs and in some cases liaison workers and mental health staff
- Questionnaires with consumers, GPs and in some cases mental health staff
- Satisfaction surveys
- Focus groups with programme stakeholders
- Hui
- Health services utilisation data (GP and practice nurse consults including telephone calls and mental health service contacts e.g. inpatient stay, outpatient visits, CMHT and crisis team contact)
- Health status outcome measures – general health:
  - European Quality of Life Scale (EuroQoL), Short-Form Health Survey (SF-36)
- Health status outcome measures – mental health:
  - Brief Psychiatric Rating Scale (BPRS), Hamilton Depression and Anxiety Scales, Health of Nations Outcome Scale (HoNOS), Life Skills Profile (LSP), Positive and Negative Symptom Scale (PANSS).
- Expenditure evaluation.
Findings of evaluations

Given the variation in the type of shared care programmes in existence in New Zealand it is not possible to always make direct comparisons and collate results from the programme evaluations. In addition, the type of evaluation and methods used varied considerably. Formal evaluation reports were obtained for the Newtown programme, the Hawkes Bay pilot, the Auckland programme, the Waikato pilot, the Otago pilot, the Wellington programme, and the Taranaki pilot. Copies of these evaluations may be available through the programme contact listed at the end of each programme appendix.

Peoples' experiences of shared care

Most programmes found that consumers had a generally positive experience with shared care services. In particular, consumers liked the removal of the cost barrier to see the GP. Most evaluations reported that consumers generally found the knowledge, skills and attitudes of the general practice staff appropriate. There were conflicting messages regarding the amount of information provided to consumers on programmes; some reported that there was too much, especially on entry to the programme, while others said there was insufficient information especially as programmes were drawing to an end. While many consumers liked receiving mental health care in the general practice setting, many reported concerns about the management of their mental health transferring to GP total care. Their concerns were that they would have problems accessing mental health services in the future as some felt that perhaps the GP was not the best person to be reviewing their mental health over a long period of time. Some consumers did not want to lose the contact with mental health services, having built a rapport with their case worker. There were also many issues surrounding the ending of programmes, with consumers feeling confused about why a pilot had ended resulting in the funding for free GP care discontinuing.

General practice staff also reported positive experiences with their involvement in the programmes. They appreciated being paid for providing a service to people with mental health needs that previously they had not always received payment for; many had carried a debt for providing this service. Most GPs also liked programmes that included training sessions that enabled them to increase their skills and knowledge in mental health. They found that increased skills and knowledge were not only useful when seeing people in programmes, but also beneficial when serving others in their practice. General practitioners also appreciated improved working relationships with the mental health services and the easier ways to obtain advice and support, particularly when liaison workers were involved. Some concerns expressed by GPs included: the delays obtaining information about individuals for whom they were providing a service, difficulties accessing the mental health staff in times of crisis, and the acuity of some people who were being recommended for GP total care. The uncertainty of the ongoing programme funding was another major concern and worked against the involvement of some GPs. Practice nurses were rarely consulted as part of an evaluation.

In the evaluations that sought opinions of mental health service staff, the findings showed mixed experiences with shared care. For some mental health staff, programmes resulted in them having to complete considerable amounts of additional paperwork. Because of this they felt that there was little incentive to refer their clients to the programme. Concerns amongst mental health staff have been expressed about the impact these programmes may have on the acuity of the CMHT case load by transferring people whose health was stable from mental health service care to the GP. Another concern was the adequacy of general practice to follow-up people with ongoing mental health needs. Mental health staff did however,
frequently report their own or consumers’ positive experiences of people receiving mental health care in a general practice setting.

Other stakeholders who were sometimes consulted as part of the evaluations included supported housing staff and DWI staff. Supported housing staff were generally favourable about these programmes. While favourable about the concept of the programme, the DWI staff involved in programmes all reported a major increase in their workload.

**Service utilisation**

Few evaluations presented comprehensive service utilisation data. From the limited information available, the average GP utilisation for those in the shared care programmes varied from 10 to 15 consultations per year. However, these figures are difficult to extrapolate from as some included telephone and nursing consultations while others included only consultations with the GP. Most programmes reported a range of high and low users of GP services. The Hawkes Bay pilot found that people who were high users one year were not necessarily high users the next year. Waikato considered their average utilisation rate of 15 was skewed by one particularly high user. Given that some programmes were funded on a fee-for-service basis while others were funded using a capitated formula it is unclear if service utilisation was based on need or influenced by the funding mechanism.

Of the evaluations that systematically reviewed mental health service utilisation most reported that the programmes had not been running long enough to draw any conclusions about change over time. This difficulty was compounded because some people who required further assistance from MHS were no longer eligible to remain on the programme. The Hawkes Bay pilot reported a statistically significant finding in the reduction of outpatient visits from two visits per year to one visit, but there was no change in inpatient or CMHT use. Wellington reported that the use of specialist services had reduced, but the evaluation report did not include exact figures.

**Outcome measurement**

Most programmes have not yet presented outcome measurements over time. Of those who have, such as the Hawkes Bay pilot, which utilised the SF-36 and the HoNOS, the only statistically significant results reporting improvements were found in the first nine months of the pilot. The Wellington programme found (in a small sample group) in their first evaluation that health status outcome measures indicated that people’s health status was maintained and in some cases improved.

**Economic evaluations**

While some programmes have incorporated an evaluation of the cost of providing programmes, none have yet completed a comprehensive economic evaluation. The evaluations that have included an economic component (e.g. Waikato) have largely concentrated on the upfront costs of providing such programmes. These upfront costs include management, some administration costs, and the itemised cost of some programme components, such as payments to general practice.

**Issues raised regarding the evaluations**

A number of programmes had no allocated funding to carry out an evaluation and asked for further information on how to conduct ‘in-house’ evaluations. Others wanted more
information on specific outcome measurements such as the HoNOS. Some people reported the timing of evaluations was problematic, the evaluations often taking place before the programme had been running for sufficient time to measure impact on health status and service use.

Timing was an issue for two evaluations. In the case of Auckland, the project team felt that the timing of their evaluation was inappropriate. The programme had encountered delays at the start however, both the project team and the evaluation team were contractually obliged to carry out the evaluation regardless of these delays. In the Hawkes Bay pilot, the evaluators considered a longer time period was needed to measure the impact of shared care.

**Recommendations for further evaluations**

While evaluation plans will need to be tailored to the specific programme objectives, a quick and easy template for planning an evaluation of shared care has been developed and is presented in Appendix N. Ideally, planning for evaluations should commence prior to a programme starting, as it is only when accurate baseline data are obtained, and compared to changes over time, that the impact of a programme can be measured. Detailed evaluations incur a cost in time and money, and programmes need to incorporate this into their workload and budget. In line with government policy (Ministry of Health, 1995) and the mental health standards (Ministry of Health, 1997), it is important to fully involve consumers in planning any evaluation. This is particularly important to ensure the outcome measures are acceptable and appropriate to all stakeholders.

Given that many programmes are still developing and changing there is a need for evaluations to include a detailed process component. Process evaluations will differ depending on the type of programme, but need to include details about inclusion and exclusion criteria, detailed roles of workers, and describe the patterns of care received by those on the programme. Process evaluations also need to indicate problems encountered in establishing and operating programmes, and report on the steps taken to remedy these. Emphasis in process evaluation does not have to be on how often something happens, but that it actually happens; the role of the evaluation being to improve the services provided in the existing programme.

It is important that evaluations first and foremost focus on the consumer experience in any programme. Understanding consumer experience requires three kinds of outcome measures: health services, health status, and consumer measures. Health service measures include utilisation review and patterns of care. A good evaluation will obtain service use data for at least 12 months prior to consumers joining a programme. Measuring patterns of care requires information on the role of practitioners in an individual’s care, in order to establish whether programmes are providing a co-ordinated and complementary service. Service use needs to incorporate general practice, all mental health services, and where possible other hospital utilisation such as accident and emergency. General practice data must be clear about what is defined as a consultation. This involves making decisions about telephone contact and the role of the practice nurse.

In selecting the health status measures to use, services should plan on using the outcome measures used by the local mental health service or those specifically utilised by other researchers evaluating similar programmes. Both general health measures (e.g. SF-36, EuroQol) and mental health status measures (e.g. HoNOS, BPRS, Camberwell) are required. Health status outcome measures need to be completed on entry to a programme and periodically thereafter. Those planning evaluations need to be aware that permission from
measurement designers is required for some outcome measures. Obtaining this permission can involve a cost, and some measures require specific staff training before their use. Health status data also needs to include information on the implementation and efficacy of prevention strategies.

While consumer outcome measures may focus on satisfaction with a service they also need to include how successful programmes are at contributing to the person’s road to recovery. Researchers (Nocon & Qureshi, 1996) argue that programmes need to be evaluated on whether they provide consumer choice and independence. The role of any consumer input in evaluating programmes should always be designed to ensure a programme is managing each individual’s needs effectively.
Discussion

In line with international trends, the development of mental/primary health shared care services in New Zealand has been based upon a fundamental principle that general practice has an important role in assessing and treating people newly presenting with mental illness, and in providing a service to those with ongoing needs from mental illness. How regions of New Zealand engaged in this development differs; some regions have set up programmes emphasising and supporting liaison, while others have focused more on the actual role of the GP and to a lesser extent practice nurses in providing mental health care. These differences have occurred because programmes have developed in response to local needs and the availability of resources. Only one programme, the Auckland pilot at St Lukes, was developed as part of a national drive to better understand how to improve integration. The majority of programmes were developed locally by the mental health service and general practice.

Given the diversity in programme aims, types, size and funding, the issues raised in this research are a useful starting point from which New Zealand can discuss how best to develop mental health/primary care shared services. These issues have relevance regarding policy and service delivery nationally, regionally and locally.

Complexity of programmes

One of the issues that stood out in this research was the difficulty many programmes had in getting established, another was the complexity of many programmes. What was apparent was that shared care programmes required a new and different relationship between mental health services and general practice. In developing this new and different relationship it would appear that both general practice and mental health services put in safeguards to manage the change. These safeguards included: determining eligibility criteria, the development of information and payment systems and training programmes, developing assertive follow-up systems and in some programmes creating new shared care plans. Many programmes have developed a follow-up system to ensure that people are not lost to general practice or mental health services. Assertive follow-up in mental health is sometimes necessary because of the nature of mental illness; some people will not access services when they become unwell. Consumers should be involved in decisions about their follow-up arrangements (Ministry of Health, 1997). The need for these safeguards raises questions about the relationship between mental and primary health services in the absence of shared care.

The setting up of safeguards often resulted in significant one off costs. Given that many programmes did not reach their targeted numbers of people to join, these establishment costs appear to be unexpectedly high. Some of these costs are a consequence of taking a targeted approach to these programmes rather than accepting shared care to be an essential component of service provision for all people with mental illness.

Consumer consent

The practice of gaining written informed consent to join a shared care programme raises an interesting debate as to whether people with mental illness should have to consent to being referred from mental health services back to general practice. It is the norm with other specialist services that people are referred back to general practice once specialist care is no
longer required. A question exists as to why consent is required? Given the consent process what are the consequences if a person declines to participate? Will they remain in mental health services longer than they need to, or will they be confronted with discharge from the mental health service?

Reaching Māori

People who identify as Māori often choose to receive mental health services through Māori providers and Māori mental health teams. As many programmes have been developed by the general adult mental health services it would appear that many Māori consumers have had less opportunity to become involved in shared care. Given the over-representation of Māori in mental health services (Dyall, 1997), future programmes need to consult with Māori consumers, Māori providers, and Māori mental health teams to ascertain whether their involvement in shared care would be both beneficial and desirable. With the emergence of PHOs, consideration also needs to be given as to how shared care between adult mental health services and Māori providers might work. Given that the largest Māori clinical occupational group is nurses (Ropiha, 1993), consideration should be given to nurse-led shared care programmes as a priority.

Eligibility

Targeting has required programmes to establish eligibility criteria. Eligibility to access programmes raises equity issues nationally and locally. On a national level shared care programmes are not available in all DHBs and consequently a large number of people are excluded from the chance to be involved in such programmes. The sporadic availability of programmes also means that service continuity is lost when someone on a programme moves to an area without a programme. At a local level many programmes used entry criteria that also created inequitable service provision; often programmes excluded people who did not have a Community Services Card. General practitioner involvement was sometimes restricted by the parameters of the programme or by a GP’s decision not to be involved.

Having eligibility criteria based upon a standard of illness raises the question, is there a group of people who can be defined as seriously mentally ill, and if so, who decides? Slade, Powell and Strathdee (1997) reported a lack of consensus in the UK on who were the people with serious mental illness. A lack of consensus on this issue in New Zealand appears confirmed by the Hawkes Bay pilot where different understanding among GPs as to what was a serious and ongoing mental illness were reported (Nelson et al., 1997). People with mental illness are often presented as if they belong to one of two groups, those with minor mental illness, and those with serious mental illness. In reality no one person is necessarily permanently in either of these groups. Both groups of people can have periods of severe illness and long periods of wellness, and both groups can have their mental health needs met through individually planned arrangements involving general practice and mental health services. Using diagnosis, or contact with mental health services, as criteria for entry to shared care programmes is also problematic, especially if there is no clinical review process in place. By adopting fixed criteria for eligibility there is an implication that there are a group of people who have serious and ongoing mental illness for life. While this may be the case for a few people, it works against the recovery approach.

Having mental health practitioners determine who is eligible for a programme may result in gate-keeping, the mental health services not allowing some people to join programmes. Gate-keeping is unsurprising given the intense media scrutiny of mental health services following
adverse events involving people who may be mentally ill. A cautionary approach is therefore likely to be taken until confidence in communication and working relationships is established, and systems are in place to assure adequate follow-up and review arrangements, should they be needed.

**Recovery Model**

While there was an awareness of the recovery model in many programmes, this was often conceived as being about service use rather than embedded in an individual’s care plan. As “recovery is a journey as much as destination” (Mental Health Commission, 1998, p.1) what must be emphasised is that the journey may not constantly move in the same direction. For a fully integrated approach the future development of shared services should look to ensure that people with mental illness, minor or serious, can access the most appropriate service for their needs at any one time and ideally any transition between the two services should be seamless. Several of the programmes are very close to achieving this integration. However, the finding that some people’s eligibility to programmes was discontinued if they required a return to the mental health service, appears to be in contradiction to the underlying notion of shared care, and makes the concept of recovery difficult to incorporate into the programme.

**Practitioner Roles**

The finding that the development of many programmes has been service, rather than need driven, is important. A consequence of this is that often people with mental illness indicate their voice is not always heard. Although keen to be part of general practice-based care, people with mental illness often emphasised the role that mental health providers had in their care and were concerned about ongoing access to these services. This raises the issue to what extent should the mental health services be involved in the care of people with serious and ongoing mental illness whose care is transferred to general practice? UK guidelines provide a number of recommendations for GPs caring for people with serious mental illness to involve specialist services (Cohen & Singh, 2001). These recommendations include the specialist services role in regular medication review, the management of relapse, and reducing the risk of relapse. A further issue requiring consideration is how to include people on specialist-prescribed medication (e.g. clozapine) in the programmes.

The programmes in New Zealand were all based around general practice, in particular the GP, and highlighted the relationship between an individual’s physical and mental health. Yet most evaluations did not actually seek to measure physical health improvement as a programme outcome. Those that did mainly used general health outcome measurement tools (e.g. SF-36, EuroQol) and unilateral measures of impact, such as people’s perception of health change over a period of time. Even fewer evaluations reported on health promotion and prevention interventions. Overseas research by Burns and Cohen (1998) highlights the high level of co-morbidity between physical and mental health and how people with “severe” mental illness often have lower recorded rates of health screening, such as cervical smears, mammography, and cholesterol tests. It is unclear how effective shared care programmes are in improving general/physical health.

With the exception of Newtown, no programme had a strong practice nurse component. This is perhaps a consequence of how primary care has developed in New Zealand. However, given the limited availability of GPs in many rural areas, nurses clearly have an important role in primary mental health, and this role needs to be explored. **Primary Solutions** (Cohen, 2003), a UK report on primary care mental health services, also identifies the need for more
nurse-led developments. The role of the community mental health nurse (CMHN) also needs to be better understood. It is the CMHN who is generally the main health supporter of many people with mental illness who live in the community (White, Roy, & Hamilton, 1997). While the CMHN carries out this role as a member of a multi-disciplinary team, many people see other team members infrequently. Programmes that are based on GP Total care, and even some on shared care, have effectively replaced the CMHN role with that of GP. Given the success of the Newtown programme which was built around a nurse and doctor, such collaborative disciplinary arrangements need further exploration.

**New roles**

In addition to staff taking on new roles, several programmes created new positions. These positions have largely been liaison workers, who have a critical role in preparing and supporting people who move into shared care or GP Total care. Limited information concerning the work and workloads of the staff in these positions is available. Given that several of these workers reported that they felt they were already working to capacity, research is necessary to understand the detail of their role and how their role with an individual changes over time. Unlike the UK, where some new positions are employed in general practice and others in mental health (Neary, 2003), all new roles in New Zealand have been employed by mental health services.

**Knowledge, skills and training**

The shared care training programmes that have been established were found to serve several purposes; not the least of which was to provide consumers a basis to have confidence in the GP’s skills and knowledge. While several programmes had start-up training programmes, formal ongoing training was not always evident. Most training was geared towards general practice and the GP. Mental health practitioners provided many of the training sessions, mirroring the traditional way medicine is taught with the specialist being the teacher. In that the goal for many programmes was shared care, consideration needs to be given to joint training sessions that also covers working relationships as well as clinical skills.

**Funding**

New Zealand, unlike Australia and the UK, who are also developing mental/primary health shared care services, has had to focus on funding issues to enable people to access general practice. Funding issues have led to New Zealand developing a programme approach in which individuals are targeted using specific criteria for eligibility to programmes. Variations were reported in the source of funding (mental health services, Disability Allowance, other contract); the form of funding (capitated, fee-for-service, opened-ended, limited availability); and what the funding purchased (consultations, injections, training programmes, liaison). Most programmes were not fully funded; general practice and mental health services both meeting many “hidden” costs as a result of their involvement in a programme.

A consistent funding mechanism is a key national issue that needs to be addressed. Using mental health services funding to pay for a group of consumers to access general practice-based services is potentially problematic. A long-term implication of paying the GP co-payment using mental health services funding is that mental health funds will be inadvertently transferred from specialist services to primary services; that is, away from those people with most serious mental illness. The likelihood of this happening is increased given the absence
in many programmes of exit criteria or eligibility review. This transfer of funds away from specialist services would occur because people do recover from mental illness, and yet when recovered still need to use general practice for health care. In addition, those programmes that have funded the GP co-payment required by general practice from health funds have effectively transferred the cost from welfare to health. Welfare funding, in the form of the income-tested Disability Allowance, is available for people to offset the costs of ongoing illness or disability.
Conclusion

Since 1993 New Zealand has developed a number of different responses aimed at increasing the role and responsibility of general practice in mental health. These responses have been about increasing the services provided in a primary setting to those newly presenting with mental illness and about increasing the role of general practice with those already diagnosed with mental illness. While there has been a mushrooming of new programmes in recent years, this has been paralleled by the discontinuation of some pilot programmes. Even though many of the programmes have similar features; no two programmes were identical. The differences were largely a reflection of mental/primary health development responding to local need with limited national direction. It is significant that many parts of the South Island have recently adopted a similar approach, led by the Otago DHB, to the development of services.

In addressing the implications of this research for the future development of shared care, shared care needs to be placed into the context of the current primary health reforms that include the establishment of Primary Health Care Organisations (PHOs). It is expected that soon, most people will not have to pay for general practice based services thereby removing one of the hurdles to the development of shared care. Not only does New Zealand have to consider how these programmes may sit with PHOs, but also whether their future development should rest with the DHBs as part of their response to community need, or whether some national direction is needed.

Although there is limited knowledge about the effectiveness of shared care programmes in improving health outcomes, all programmes that had undertaken any form of evaluation reported positively on the benefits of their programme. These benefits included people with mental illness finding the increased role of general practice in their health care as being a “good thing”; practitioners reporting improved communication and working relationships between the primary and secondary sectors; and all stakeholders report having a sense that although developmental, mental/primary health shared care services, appears to be an excellent way to progress New Zealand’s health services. Given this endorsement, it is disheartening that so few people with ongoing needs for mental illness have been able to access such programmes. The low numbers involved in some shared care programmes are more troubling when one considers the costs incurred in setting up the programmes. While acknowledging that as a pilot, services are often more costly, a more detailed review of current infrastructure and set-up costs would be useful. Nonetheless, some programmes did manage on very limited budgets and appear to have developed as an effective service as those with larger budgets.

Given the support for shared care by consumers who have been on programmes, and the expected increase in the incidence of mental illness, more needs to be done to ensure that shared care can be extended. National direction is needed regarding funding, targeting and eligibility to achieve consistency and efficiency of shared care services, and to provide some clarity around who is accountable legally and clinically for shared care decisions. Local decisions are required about what is the best form of shared care to meet local needs.

A sustainable way of funding future mental/primary health shared care is fundamental to ensure that the full potential of shared care can be achieved. The efforts made to address funding matters have consumed considerable time and resources; time and resources that could have been used in working at the service delivery aspect of shared care. Targeting of programmes has resulted in some programmes being potentially open to everyone with mental illness whiles others have many restrictions as to who can join. The restrictions
mainly limit eligibility to those people who have a serious mental illness of some duration that is considered to be stable. The restrictions allow some people access to programmes, while others who may benefit from shared care are deemed ineligible. While most programmes provide for consent to join, this process is only after mental health practitioners are satisfied that a person is “suitable” for shared care. In this regard consumers are not given a full choice about whether they will join shared care.

A way forward

Tremendous efforts have been made to develop mental health shared care services in New Zealand. To continue this development it will be important to look at the different strengths of each programme so that all districts of New Zealand can improve services to people newly presenting with mental illness and for those with ongoing needs from mental illness. Given the limited number of people on some programmes and the cost and complexity of programmes, it is difficult to support the extension of shared care programmes unless some changes are made. Yet it is extremely important that general practice has a role in the health care of people with mental illness. Consideration needs to be given to whether a programme approach to shared care has made shared care unnecessarily complex. The difficulties of establishing programmes have not just been about structures, it has also been about the attitudes of health practitioners towards each other, and about working through boundary issues.

A clearer perspective on what consumers consider to be the issues for shared care services should be sought. There is also an urgent need for more information about the experience of Māori consumers and providers with shared care. Māori participation at governance level in shared care also needs to be strengthened, consistent with the governance arrangements at DHB level. While many consumers in the programmes were reported as supporting the development and continuation of shared care, little information was obtained about people choosing not to join. Many people expressed concern about the ongoing access to mental health services whilst on a programme, in light of this DHBs, professional organisations and mental health consumer groups should consider developing guidelines to enable people transferred to GP care, to have ongoing specialist mental health review.

While undertaking this research there was an almost unanimous call throughout New Zealand for a national approach to mental/primary health service development. All programmes were keen to know more about other programmes, with a view to improving the services provided to people with mental illness by advancing their own programme. By appending summary details of the programmes identified as part of this research, this report will meet some of this need for information. However, more needs to be done, and to this end we suggest that the Mental Health Research and Development Strategy hold a national forum on primary mental health services. This forum should be open to all existing and potential shared care programme stakeholder groups to enable a sharing of experience and discussion of what needs to happen at a national, regional and local levels in order to advance the quality and the availability of shared care services throughout New Zealand.

If a national approach to future shared care development is adopted, it will also require a local focus for its implementation. In addition, local input will always be needed to address local needs or problems specific to their area. While many people spoke of the need to stop having pilot services, until there is a consensus on the best ways for providing shared care services, New Zealand should continue with a developmental approach. While targeting may be the only way that New Zealand is able to develop shared care services in the short term, it will be
important to take steps so that implementation does not work against the recovery model. Programmes will need to develop ways to work with people whose mental health deteriorates while on the programme, without them losing access to the programme. This could take the form of a review of general practice and mental health services’ roles. In addition, if people are to lose free access to general practice if their mental health improves and they are moved off the programme this could well act as a disincentive to recovery.

Funding is a key issue to be worked through. Increased understanding within the primary and mental health system of existing funding mechanisms such as the Disability Allowance is required, as it would appear to be one way to fund the co-payment of GP consultations. What the role of the Disability Allowance in the PHO is, in relation to primary care costs has, to our knowledge, yet to be decided. Consumer groups, the Department of Work and Income (DWI), and the Ministry of Health need to consider if more needs to be done to ensure consumers have access to the Disability Allowance to offset primary care and medication costs. Funding solutions are also needed for people who do not hold a Community Services Card or are ineligible for the Disability Allowance so that they are still able to access shared care programmes. Future shared care service development must also consider the “hidden” costs, which to date have been met by general practice and mental health services. Importantly, whatever funding solutions are found, they need to be sustainable.

Given that it is the work of the nurse in the mental health service who has the most contact with people with mental illness, and that there are many areas within New Zealand where GPs availability is limited, consideration of a nursing focus to shared care would be worthwhile. Any discussion on the nursing role would need to involve mental health consumer groups and Colleges of Mental Health Nurses and Practice Nurses. A greater understanding of the mental health training and educational needs of primary practitioners is also required. It is important to tailor education programmes more effectively, as there are many primary practitioners who are extremely skilled and knowledgeable in primary mental health care, while there are others who are reported to have minimal skills and knowledge. Training and education should look differently at the medical and nursing educational needs and involve the respective professional organisations. In addition to clinical aspects of providing primary mental health services, education programmes should also focus on building the relationships necessary for effective shared care services and given that there are still reports of some practitioners not wanting to work with mental illness, general strategies are still needed to help facilitate a shift in attitude. Focus also needs to be given to the education needs of the workers in the newly developed positions.

New Zealand is now at a crossroads where decisions need to be made as to what should happen nationally, regionally and locally for the future development of mental/primary care services. Mental health consumer groups, Māori, policy staff (MoH, MHC, DWI, MHRDS), provider groups (DHBs, IPAs, NGOs), and professional bodies (Colleges of General Practitioners, Psychiatrists, Practice Nurses and Mental Health Nurses) should work together to provide a national approach regarding funding, workforce development, training, and guidelines for follow-up and review protocols. Although shared care in New Zealand is still at the stage where programmes are necessary, plans need to be made for the day when mental health and primary services deliver integrated care as the norm.
Appendices

Appendix A – Auckland Liaison Attachment Shared Care

Profile
Location  Central Auckland
       The service is still operating on a limited basis.

General description
The pilot involved shared care between GPs and St Lukes Community Mental Health Centre (CMHC), with patient care provided by a GP and supported by a clinical nurse specialist (CNS) with other specialist backup available.

History
The pilot was part of the Mental Health Integration Task Force, which was a group of projects working within the Community and Mental Health Services (CMHS) section of Auckland Healthcare Services Ltd. The decision to focus on shared care was influenced by i) the arrival from the UK of a psychiatrist to Auckland Healthcare who identified a number of gaps in the services provided by primary and secondary care, ii) a lack of communication between the two services was also recognised by ProCare Health Ltd, a group of 380 GPs and similar concerns were being voiced at the time by mental health consumers.

When the Health Funding Authority (HFA) decided to focus on integrated care it called for proposals for National Demonstration Integrated Care Pilot Projects and the Mental Health Integration Task Force put forward a proposal for the liaison-attachment shared care project, this was one of 10 nationwide integration projects chosen to be separately funded and evaluated. For research purposes a Randomised Control Trial (RCT) was incorporated into the project.

Programme
A consultation-liaison model of shared care, whereby joint management is agreed between the patient, GP and the CNS with care being provided in a primary care setting.

Aim
- To bridge the gap between the services brought about by a perceived lack of resources and provide the opportunity for the secondary services to actually move the clients through.
- To improve the effectiveness of both primary and secondary carers, improved communication between the two services should prevent duplication of services and therefore wastage of resources.
- To pilot a model that might provide improved use of resources.

Size - The RCT was to enrol 200 patients, 100 patients for the shared care group and 100 for the control group, however at the time of the evaluation there was only a total of 115 patients enrolled, 58 in the shared care group and 57 in the control.

Demographic - Of the 58 patients participating in shared care, 51 identified as NZ European, 4 Māori, 8 Pacific Island, 1 Asian, 4 other non-European, approximately 52% were female.

Diagnosis - The diagnostic grouping were as follows:
Psychosis 25, Bipolar 19, Unipolar Depression 12, Anxiety 2.
Criteria

*Entry* - The criteria for recruitment were:
- Clients aged 18 years or over
- Current clients of CMHC and who have been so for at least six months
- Able to give informed consent
- CMHC staff assess that shared care is appropriate
- GP agrees to shared care and the research project

*Exit* - There were no exit criteria; the pilot was for a set period of time.

*Who applied criteria* - As a RCT was being used, the selection into the groups (shared care or control) was to be random.

Project management

*General oversight/Reference Groups* - A steering group consisting of members of the project and evaluation teams, ProCare project management, GP representatives, the Integration Task Force and the Community Mental Health Team (CMHT) at St Lukes was responsible for the oversight and planning of the project.

*Day-to-day* - The project team were responsible for the operations side of project; it consisted of 6 members, the head of which was the lead investigator (a psychiatrist) and included a part-time researcher who was responsible for data collection for the RCT. An evaluation team, based at the Health Services Research Centre (HSRC), Victoria University of Wellington, was responsible for evaluating the project.

Roles and responsibilities – clinical

*GP* - During the initial appointment with the client and CNS they would discuss the management plan, the shared care contract and establish the client file. They would agree on the regularity of client appointments (e.g. at least 3-monthly) and that the GP will care for the client’s physical and mental health needs in liaison with the CNS. The research component of the project meant that GPs also had to keep records of attendance.

*CMHT* - Involved in the planning and project management but also provided specialist support and advise to the CNS. St Lukes produced a *Shared Care Pathway for GPs*, booklet which described the model and how it would work for GPs; it also provides a framework for a general shared care service.

*New Roles* - The CNS nurse provided support to the client, communicated regularly with the GP’s practice and liaised with the specialist services of the CMHT. They also helped prepare the client’s management plan. In addition to their clinical duties they had administrative duties related to the ‘in-house’ research arm of the project.

Clinical arrangements

*Service profile* - Once clients were selected for the project they signed a consent form before entry. The shared care clients’ initial visit to the GP was with the CNS, they would all discuss and agree upon a management plan. The client is then expected to visit the GP at least 3-monthly. For the duration of their involvement in the project, clients did not have to pay to visit their GP. The GP would then be responsible for the physical and mental health needs of the clients, but would have close contact with the CNS who would also liaise regularly with the client and CMHT.
Consultation time - Standard appointment time applied except for the first session, which was double in length.

Care plans - A clients' individual management plan was agreed upon between the client, GP and CNS. The project team developed the template for recording the clients’ concerns, goals for addressing those concerns and planned interventions by the GP and nurse. The management plan also included early warning signs.

Referrals - If a client experienced problems or their condition worsened the GP or client could contact the CNS for additional support or advice. The CNS was also able to access other services from the CMHC or inpatient unit and these were recorded as one measure of outcome.

Reviews - There were no clinical reviews

Concept of recovery - One of the motives for the project was to enable clients to progress out of specialist care and access primary care more easily on their path to recovery. A significant complaint from consumers was the difficulty in doing this. Although recovery was not highlighted, the whole project was very much seen as part of a recovery focus within the service. This was confirmed by the focus group feedback, which commented on the more normal form of care and a greater sense of involvement in decision-making.

Training
For whom/By whom - There were formalised training sessions for GPs in the form of a series of evening seminars and discussions, plus a handbook of mental health care. This training was evaluated separately as part of a university based project. GPs were also up-skilled through increased involvement with mental health patients and the CNS.

Funding
Programme/Services - The National Demonstration Project contract negotiated for the project was for $282,626 for the two-year period from January 1999 to December 2000. It was intended that the GP would bill the project and be reimbursed from this, however, this only happened for those clients who weren’t entitled to Disability Allowance (DA). For those receiving the DA it was found that this could be increased to cover medical expenses including the consultation, medication, transport and telephone, if the CNS advocated for them at DWI. The GP would sign for the expenses on the DA review form, this would be presented to DWI and the client would pay the GP from their increased allowance.

Medication - See above for comment regarding Disability Allowance.

Communication and Liaison
Consumers - During the development of the project, consumers were not formally approached until a relatively late stage, when the model, methodology and procedure had been decided. However, the project was done in response to requests from consumers to have better access to GPs and informal input from consumers was sought during development.

Māori and Pacific - A Māori social worker from St Lukes CMHC was invited to sit on the steering group with a view to “providing guidance with handling Māori clients”. They remained with the project for only eight months (until May 2000) when they left St Lukes.

GPs - Communication with the GPs was mostly through the CNS and in the context of ProCare GP cell groups. Two GPs were on the project steering group.
Information systems - The following documents were prepared for the project:

- Information sheet for the GPs
- Contract for Shared Care Participation
- Shared Care Project Management Plan
- Record for GP Appointments
- Billing information for GPs
- St Lukes Shared Care Pathway for GPs
- Information sheet for clients of the CMHC
- Consent Form

Summary of evaluation

Undertaken by - The HSRC evaluation team carried out the evaluation using:

- Document reviews and analysis
- Interviews
- Questionnaires
- Focus groups
- Hui

Findings

The evaluation focused on the following – the noteworthy points can be summarised as:

The Integration Process

- There were some delays with the contract and funding from the HFA.
- Reports on the relationship between the Project Team and other key stakeholders were mixed. Communication had improved overall with the main criticism being directed at the project team management.

The project team felt that the delay unfortunately resulted in the contracted evaluation team doing their evaluation when the project had only just started which was seen by the lead investigator as quite inappropriate.

Integration and the Project

- Guideline and Procedure documents were reviewed most favourably however, some GPs did express a wish for some more training.
- The question about how clients will receive care at the end of the research pilot had not been satisfactorily explained.

Health Outcomes

- Clients reported that the project was going well; their families were also strongly in favour of the shared care approach. The only concerns expressed were with regard to the transition period and wanting more information.
- GPs were all relatively satisfied with the project. The only concerns were to do with the communication and management of the project.

The evaluation team expressed concerns about the:

- allocation of clients to the shared care or control groups
- ethical implications of not having a definite strategy for post-project funding for GP visits
- lack of information made available by the project management for the evaluation team.

The project team felt that this was due to the inappropriate timing of the evaluation and the evaluation team not respecting normal scientific process in a randomised controlled trial.
Economic Analysis

- The project design and available data precluded a full cost-effectiveness analysis.

Implementation of the Principles of the Treaty of Waitangi
- Part of the contract was to establish and implement a Māori health policy that reflected Māori health priority areas:
  - there were no Māori strategies or policies in place within this project
  - the Māori representative left the steering group after eight months and was not replaced
  - no Māori staff were employed as providers in the service delivery level of the project

The project team said that this was due to a major limitation in central Auckland at the time of the project development was the lack of Māori and Pacific Island primary care organisations or GP’s with whom to form partnerships.

The Randomised Control Trial
The RCT was the responsibility of the project team. Research assessments were carried out at entry with, 6 month and 12 month follow-up. Outcome measures used included:
- HoNOS
- SF-36
- Positive and Negative Symptom Scale (PANSS)
- Hamilton Depression and Anxiety Scales
- Quality of Life
- Service utilisation
- Satisfaction scores

Findings of RCT (to date)
The model of shared care was demonstrated to be practical, well liked by clients and GPs and to have a range of positive outcomes including:
  - the clients views that this was a less stigmatising form of care
  - clinical outcome was as good as for routine care
  - more physical health care provided

Documents and Outputs

St Lukes Community Mental Health Centre - Shared Care Pathway for GPs - booklet

Update
Shared care services have continued beyond the pilot period for those clients involved in the pilot programme this is organised through St Lukes CMHC and it is hoped to extend this service in the near future.

Contact for further information
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Appendix B – Hawkes Bay Shared Care Pilot

Profile
Location: Napier and Wairoa (Hastings - Comparison Group)
Dates: 1996 to 2002

General description
Shared care that involved the development of care plans and a collaborative working relationship between consumers, GPs and the Community Mental Health Team (CMHT).

History
In 1994 the Central Regional Health Authority (CRHA) announced its intention to purchase additional mental health services throughout the central region. GPs in the Hawkes Bay responded to this announcement by approaching the CRHA to see why they - the GPs - had not been consulted about which additional services might be purchased. In response to this the CRHA called together an Advisory Group consisting of community-based mental health services, GPs and health researchers to meet to plan a primary psychiatric care project. In June 1996 the pilot was purchased by the CRHA. This pilot targeted a group of people with ongoing needs for mental health care. It began with the Napier CMHT, seven GPs and consumers from the Napier CMHT. It was extended after three months to include three more GPs from Napier, two GPs from Wairoa, the Wairoa CMHT and consumers based in Wairoa.

Programme
Shared care involving:
- Provision of GP consultations at no charge to consumers enrolled on project
- Free extended consultations for mental health for patients seeing GPs in the pilot
- A training programme for GPs
- Care plans and collaborative working relationships
- Documentation and evaluation of the pilot by researchers

Aim - The primary aim of the pilot was to develop shared care services that would improve the mental health status of a group of people who had ongoing needs for mental health care. The objectives to meet this aim were i) to improve the ability and capacity of primary practitioners to effectively assess and treat mental illness; and ii) to improve the support, liaison, referral and linkages between primary and secondary services and other mental health services.

Size - As at May 1999 177 consumers from Napier and 35 from Wairoa had been enrolled.

Demographic – Only clinical and demographic details were collected from the Napier participants from the onset until December 1998. Of the 177 there were males (87) and females (88). The mean age was 37 years (range 16-88 years). Ethnicity was recorded as Māori (30), European (116), Other (5), Unknown (26).

Diagnosis – Schizophrenia or Other psychoses (67), Mood disorders (31), Other diagnoses (56), Unknown (23).

Criteria
Entry - Criteria for entry into the pilot were that a consumer:
- had a mental illness (defined as DSM IV Axis 1 diagnosis) which had involved an assessment by the CMHT and was considered to be of a serious nature
• had needs for mental health services (in primary or secondary settings) for a minimum of six months
• had a community services card (CSC)
• had a GP who was participating in the pilot, or did not have a GP

**Changes to criteria** - In response to what were seen as initial limitations, some modifications were made to the pilot entry criteria:

• Relaxation of the criteria requiring consumers to be in contact with the mental health service for a minimum of six months. This was to allow GPs to identify people who met the other criterion but were not using the mental health service.
• Targeting only those with CSC was seen as excluding people who could benefit from the study, so the criteria was widened to include those with financial hardship. Following the interim report, new entry was largely limited to those in supported housing

**Exit** - There were no exit criteria.

**Who applied criteria** - Entry criteria were initially applied by the either the GPs or the CMHT. The interim evaluation showed that GPs and the CMHT had different interpretations of the meaning of ongoing and serious mental illness, this prompted the decision that the CMHT would then apply the criteria.

**Project management**

**General oversight** - Initially it was intended that the pilot would be organised locally in Napier with support from the CRHA. However, following a visit to Napier by the Health Services Research Centre (HSRC), Victoria University of Wellington in 1996, concern was expressed that insufficient progress had been made towards getting the pilot developed. The HSRC was then given the responsibility of assisting the CRHA and the Napier providers with running the pilot.

**Day-to-day** - Management of the pilot on a day-to-day basis was divided, with the HSRC coordinating the administrative side of things and the CMHT responsible for clinical.

**Reference Group** - An Advisory Group was created to oversee the pilot. It consisted of community-based mental health services, GP representatives and health researchers from the HSRC and was expanded to include consumer representatives from Napier. Two GPs were also GP co-ordinators who worked with the project management, they were also members of the Pilot Advisory Group. The purpose of the group was to shape the pilot and address issues that arose once the pilot began. The group met several times prior to the pilot starting and on three occasions after the pilot commenced.

**Roles, responsibilities and accountabilities**

**GP** - All GPs were expected to participate in the training programme, become involved in the mental health care of consumers enrolled in the pilot, and meet and liaise with the consumers and CMHT in developing and implementing shared care with the use of care plans and regular communication.

**CMHT** - The CMHT were responsible for introducing the pilot to the consumers, obtaining consumer consent and meeting and liasing with the consumers and GPs in developing shared care.
Agencies - The role of the supported housing was not specified but they did participate in care plans as necessary.

Clinical arrangements
Service profile - There were three patterns of how care was organised:
- Separate care – consumers used only the GP or CMHT
- Parallel care – consumers used both the GP and CMHT, but these providers worked in isolation, thereby potentially duplicating care.
- Complementary care – consumers used both the GP and the CMHT, and these providers worked together, providing care and treatment.

Consultation time - For the extended consultations GPs could claim for reimbursement at a rate of $30 per consultation (plus GMS) for an average of four consultations a month for any patient they saw with a mental health need. These consultations had to last 20 minutes or longer. They were given at the discretion of the GP and were expected to be free of charge to the patient.

Care plans - At the commencement of the pilot, neither Healthcare Hawkes Bay nor the GPs were using a formalised system of care planning that the pilot could build upon. As a result, the format, content and process of care planning had evolved over the time of the pilot. When the plans were fully developed they had the following five key elements:
1. Information about the consumer – focusing on who the person is socially, as a family member, what their hobbies and interests are, and how they spend their time.
2. Information about the consumer’s health history – both mental and physical. This should include past medication history.
3. Information of a consumer’s current goals and needs with a plan of action for how these will be met by the consumer and others involved. It includes stating who is responsible for medication, the expected frequency of contact that the person will have with their family, the GP, the CMHT and other providers.
4. Identification of a consumer’s early warning signs of worsening mental health and a plan of action in response to recognition of these. The plan of action should provide steps that the consumer can initially take; that the family or friends can take; and steps providers can take.
5. Details on who wrote the plan, who has a copy, and a date for review.

Referrals - 25% of the consultations involved the GP referring to or liaising with other providers, usually the CMHT. Only one percent of these were referrals seeking admission.

Reviews - The interim report recommended that the CMHT regularly review (6-monthly) with consumers that the mental health services were meeting their needs and that they have a good working relationship with providers, such as GPs, nurses, social workers etc, and that this review took place within two months of someone new moving to Napier.

Training
For whom - Training was provided to all GPs involved in the pilot, some other GPs and a few members of the CMHT were also able to attend the sessions.

By whom - A training programme facilitated by the Wellington School of Medicine consisting of formal training sessions covering the following topics:
- Clinical syndromes
- Mental Health Act and Mental state exam
- Drink, dope and the demand for drugs
Appendix B – Hawkes Bay Shared Care Pilot

- Treatment of schizophrenia
- Difficult people
- Chronic depression
- Cultural issues and anxiety disorders
- Sexual abuse
- Mania

A locally-based training programme covering:
- Developing shared care
- Content and process of shared care planning
- Working in teams

Training could also take place through self-directed learning, reading and informal liaison.

**Funding**

*Programme* - The pilot was funded by the CRHA through four contracts:
- Contract 1 was with each GP in the pilot for providing shared care, attending training and meeting research requirements.
- Contract 2 was with the Healthcare Hawkes Bay Ltd for providing shared care, coordinating the pilot in Napier and Wairoa and meeting research requirements.
- Contract 3 was with the Postgraduate Department at the Wellington School of Medicine for developing and implementing a training programme.
- Contract 4 was with the HSRC, for the evaluation of the pilot.

*Services* - For the pilot the CRHA paid the GP co-payments associated with the consumers seeing a GP. GPs could claim for such visits on a fee-for-service basis. The payment rate was $20 plus the general medical subsidy (GMS). This was a little higher than the existing co-payment rate to cover generally longer consultations. For extended consultations GPs could claim for reimbursement at a rate of $30 per consultation plus GMS for an average of four consultations a month for any patient they saw with a mental health need.

*Changes* - Limits were initially set at 15 claims per month per GP; this limit was later removed. In 1998 GP payment rates changed from $56.15 an hour to $67.50 in total for attendance at a two hour training session.

*Medication* - No extra funding towards the cost of medication to consumers.

*Training* - Funding for initial training was made available by accumulating tagged training money for each GP. This totalled $12,000 which was divided in the following way: $5,000 to establish and deliver the training, $4,000 for part payment to GPs to attend and $3,000 for the development of a resource folder from the training.

**Communication and Liaison**

*Consumers* - Consumers were asked to join the pilot, and consented to participate in the evaluation. They were invited to raise any issues or concerns they had regarding the pilot with the consumer representatives. During the pilot development consumer representatives expressed concern that they were not hearing from consumers. The representatives also believed that they should be involved in all aspects of the pilot and offered to expand their role to include participation in the ongoing training programme and to be a resource for consumers to contact if they had any concerns about their care plan.

*Families/whanau* - It is noted that some family/personal supports were involved in consultations and the final report states that it is intended for them to be involved in the care planning process.
Māori and Pacific - Māori had mixed responses to the pilot. There was a higher rate of Māori who declined to participate in the pilot. Some viewed the GP becoming involved in their mental health as a natural development because of the GP’s role in their whanau and in their birth.

Information systems - GP utilisation data have been provided in a monthly return sheet specifically designed for the study; reimbursement to GPs was linked to provision of these sheets. Data on mental health service utilisation was collected using a computer programme that records contact data already gathered by Healthcare Hawkes Bay.

Summary of programme’s evaluation
Undertaken by - The HSRC at Victoria University of Wellington. An interim report was produced in 1997, a final report in December 1998 and a Health Research Council of New Zealand Grant in 1999 enabled further analysis. The research tools used included:

- Chronological record
- Consumer interviews
- Provider interviews and questionnaires
- Health services utilisation data (GP visits and mental health service contact data)
- Health status outcome measures (HoNOS, SF-36, and self assessment)
- Consumer outcome measure (regarding choice)

Findings
Achievements – Included: developing consumer-orientated care plans; developing and delivering a training programme; establishing entry criteria for shared care; developing and implementing a payment system for GPs; and contributing to a significantly improved working relationship between GPs and the CMHT.

Changes in staff – A high turnover of psychiatrists, CMHT nurses and social workers was reported as being detrimental to the pilot becoming established and reaching its full potential.

Health status - The health status of the study group changed in the short term, but not in the long term.

Utilisation - Average utilisation was 12 consults a year. Female utilisation rates showed a statistically significant increase from 12 to 14 consults over two years as did non-Māori. A statistically significant reduction in outpatients appointments was found, but not with inpatient stays and CMHT visits.

Consumers - Consumers were generally positive about shared care. They reported three main benefits: their involvement in the development of a care plan; the increased number of health providers now available to them to access for mental health; and improved access to the GP because they no longer needed to make a financial decision before seeing them.

GPs - GPs reported that shared care required them to work with consumers in a new way. Many liked their increased involvement in the mental health care of consumers. They reported unanimously that their overall skills and knowledge in the care and treatment of people with mental health needs had improved.

CMHT - Initially disliked the pilot because of the amount of paperwork involved at the early stages but as that decreased they considered the pilot as a positive development, but considered that more refinement was necessary.

Supported Housing - It was generally felt amongst the supported housing managers that the pilot enabled their residents to make a decision about seeing the GP without having to
consider either the house’s or their own personal financial position. Also the care plans provided clarity in the roles and functions of the different providers involved in care.

Benefits for Māori - On the recommendation of the interim report a Māori researcher was contracted to undertake this work, but the evaluation was not delivered.

Limitations of the evaluation - The evaluation team felt that the evaluation was carried out too early. Family feedback was not sought because of time and financial constraints. Insufficient data was made available to undertake the planned economic evaluation.

Documents and Outputs


Update
It is hoped that shared care services will resume in a revised form during 2003.

Contact for further information
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Appendix C – MidCentral Mental Health/Primary Care Liaison Programme

Profile
Location  Palmerston North
Dates  2001 – present

General description
A Primary Care Liaison programme whereby eligible consumers are transferred from mental health services to the care of a specially trained GP. A Primary Care Liaison Worker (PCLW) assists with this transfer process and helps develop an Integrated Care Plan with the GP and consumer, the PCLW is then available to assist and advise both the GP and consumer if required.

History
This Primary Care Liaison programme was set up to assist some people who were using mental health services (MHS) to transfer their mental health care to a GP. With increasing the role of general practice in community mental health, it is hoped the MHS will meet the needs of more people who require specialist mental health services. It is a services partnership between MidCentral DHB and Manawatu Independent Practice Association (MIPA). It has been influenced by a similar initiative in Wellington.

Programme
Primary Care Liaison Programme with the following key features:
- Removal of cost barrier, which prevents some people who use MHS from going to a GP.
- Consumers choose which GP they want to go to.
- The care and treatment consumers receive from their GP and the Mental Health Service (MHS) is agreed and written up as an individual Integrated Care Plan. This is so consumers know who is doing what and when.
- The development of a new position in the Community Mental Health Team (CMHT), called the PCLW, who will assist with your transfer to a GP.
- The development of GP Mental Health training to improve the skills of the GP in relation to mental health
- The development of a GP Resource Manual to support general practice in the provision of care
- The programme will be evaluated to see whether it is working. The opinions of people using the programme are a central feature of the evaluation

Aims
- To increase the eligible persons access to primary care services
- To enhance the mental and physical health services that mental health consumers receive from their GP
- To provide the opportunity for the eligible person currently receiving services from a secondary mental health provider to be discharged into the care of their GP.
- To increase the capability of GPs to access, treat and support people who have DSM IV Axis I diagnosis
- To increase GP access to consultation and liaison services provided by the secondary MHS

Size - Contracted for 100 but as at October 2002 there were 27 on the programme with numbers growing weekly.
Demographic - Male (12), Female (15) - 3 identify themselves as Māori and 24 as European.

Diagnosis - Schizophrenia (12), Bipolar Affective disorder (4), Anxiety (3), Depression (8).

Criteria

Entry - Consumers residing in the MidCentral geographical location and who:
- Currently access MidCentral Health mental health services and
- Have been assessed by a Psychiatrist as having a DSM IV Axis I Diagnosis and
- The Psychiatrist, GP and Consumer agree that ongoing treatment can be safely and appropriately met within a general practice, and
- Are current holders of a ‘community services card’ (CSC)*
- Need regular GP or practice nurse input

* prefer clients to have a CSC, but they may still be accepted on to the programme if this does not apply as each case is judged individually.

Exit - There are no set exit criteria but 3 people have withdrawn from the programme – 2 whose health deteriorated requiring re-hospitalisation and 1 who moved from the district.

Who applies criteria - The CMHT applies the entry criteria. CMHT Key Workers identifies possible eligible consumers and the PCLW evaluates their suitability for the programme.

Project management

General oversight/Reference Groups - During the planning/set phase the PCLW was employed as a member of the project team before the first patients were transferred approximately three months later. The project team included MidCentral’s Director of Mental Health, a Consumer representative, IPA representation through GPs and managers and also a member of the CMHT. A management group still meets on occasion.

Day-to-day - The PCLW and the MIPA project co-ordinator are responsible for the day-to-day management both with regards to service provision and the administration of the programme i.e. payments etc. They meet at least once a week and both report back to their respective groups. They also report to a mental health stakeholder group and a mental health advisory group.

Roles, responsibilities and accountabilities – clinical

GP - The prescribed education course is compulsory for all GPs and Practice Nurses to become an accredited provider. All accredited providers must attend a minimum of two ongoing education courses annually. GPs are involved in the eligibility consultation and then work with the PCLW during the transfer process but even after the transfer period the GP and Practice Nurse can still call on the PCLW for support and advice and they also have access to a Psychiatrist if required.

CMHT - Once consumers are transferred from MHS to GP care they are in effect discharged from MHS and are no longer part of their key worker’s caseload. Psychiatrists are involved in determining the eligibility and are also available later to assist and advice GPs by phone or in person if required.

Agencies - Supported housing provide housing to some clients on the programme and a representative from supported housing attends programme group meetings.
New Roles - Primary Care Liaison Worker, whose role is:

- To discuss the new service with consumers and help them decide whether they want to transfer to a GP.
- To assist the transfer from the CMHT to a GP of the consumer’s choice. Can assist in finding a GP if consumer does not already have one.
- Help to develop the Integrated Care Plan.
- Confirm consumers meet the criteria for free GP visits.
- Go along with consumers on their first GP visit.
- Assist consumers in working out any problems or issues that arise during the transfer to their GP.
- Assist the GP and practice nurse with the transfer back to the CMHT should a consumers mental health deteriorate.

The PCLW is also responsible for follow-up, a GP can report to them if there seems to be a problem with non-attendance.

Clinical arrangements

Service profile - Patients are transferred from MHS to GP care with the PCLW involved in the transfer process. Consumers and families (if the consumer requires) are consulted about discharging from MHS to GP care, the PCLW also helps with all the transfer paperwork and goes through the treatment plan with the consumer and GP.

Consultation time - The standard consultation time of 15 minutes applies with regards to payment, however, extended consultations are still given.

Care plans - The important features of the Integrated Care Plan are:

- Consumers will be involved in the development of the plan
- It is a communication and action plan which outlines who does what, when for the consumer
- It is about the consumer so will reflect their circumstances and needs – physical and mental health, cultural, spiritual, disability and other support needs.
- It will include a focus on wellness, looking at things that consumers can do to improve their well-being.
- It needs to be agreed and signed by the consumer, their GP, and PCLW.
- It prepares for the possibility of a decline in mental health, by including early warning signs and a plan of action.
- A review date is set for each Integrated Care Plan to make sure the information continues to be relevant and up-to-date.
- A copy is given to the consumer, their GP and PCLW. If consumers wish, a copy can be given to other people involved in their care.

Referrals - A Psychiatrist is available to provide advice and support to GPs. The PCLW is also a Duly Authorised Officer under the Mental Health Act (MHA), if a consumer relapses then they will automatically go back to MHS; there have been two who have relapsed and have had to come back on to the ward under the MHA. The intention is however, that when they become suitable to re-join the programme they can do so later.

Reviews - The Integrated Care Plans are to be reviewed on a regular basis, the exact time frame is still being discussed but needs to be realistic. Consumer’s eligibility for the programme is also reviewed every 6-months; this is to take into account that consumer’s personal circumstances may change.
**Concept of recovery** - The PCLW emphasises to clients that they are in effect being discharged from Adult MHS and that the move to having their mental health care in a primary care setting is a progressive step. It is also stressed that they may not always be on this programme that it’s just necessary at this time as part of their ongoing care for mental health needs.

**Training**

*For whom* - Training is compulsory for all GPs and Practice Nurses, there are four initial sessions that must be completed before they can see a client as part of the programme – the GPs get continuing medical education (CME) accreditation. The training programme is carried out locally and run regularly, even offering weekend and evening sessions for convenience. All GPs and Practice Nurses joining the programme are also given a resource manual for reference use. There are plans to extend the ‘hearing voices’ training to include other practice staff i.e. administrative staff and receptionist.

*By whom* - The PCLW and the MIPA project co-ordinator organise the sessions and are responsible for providing copies of the pilot’s resource manual.

**Funding**

*Programme/Services* - MIPA holds a contract with the Ministry of Health for the provision of free management of selected mental health clients in general practice. It is based on fee-for-service funded on 12 visits per year. The service is contracted to provide Practice Nurse and GP consultations.

- Payment will only be made after completion of the ‘Patient Consultation Claim Form’
- Payment will only be made on the 20th of the month following receipt of a valid claim
- Consultations will be reimbursed at the rate of $23.00 exc. GST.
- GMS may be claimed for any appropriate consultation for which payment is made under this service

MIPA out of hours (the City Doctors) is not free to those on the programme, if consumers visit a GP other than their own out of hours then they will be charged as there is no agreement to cover this cost, hence most consumers usually use the CMHT for out of hours crisis.

*Medication* - There is no funding for medication, there are a few exceptions for some depot medications but this is the exception rather than the rule.

*Training* - The training programme for GPs and Practice Nurses is also provided as part of the contract.

**Communication and Liaison**

*Providers* - The PCLW and MIPA Project Co-ordinator meet regularly and communicate a lot by phone, they both also have a lot of contact with GPs and Practice Nurses. The PCLW often acts as a “first port of call” for GPs if they need to contact a Psychiatrist.

*Consumers* - A consumer representative has always been informed of and invited to attend the planning and management meetings. The MIPA Project Co-ordinator attends regular meetings of two local mental health groups.

*Māori and Pacific* - The training programme was open to all GPs not just for MIPA staff from one of the Māori providers (a GP and Practice Nurse) had completed the training and were part of the programme.
Families/whanau - are involved/consulted if the consumer allows it. Families are also offered the chance to attend education sessions; the PCLW tries to involve them as much as possible.

Information systems - There are a number of forms that require completion as part of the transfer process including risk assessment forms but the Integrated Care Plan is the main source of shared information and is regularly updated and reviewed.

Summary of programme’s evaluation
The programme is currently undergoing an evaluation; this is part of the contract. The main purpose of the evaluation is to improve the care consumers receive and to provide a structure to collect information about consumers (and others) experience in this programme. It is up to the consumer whether they want to take part or not.

Undertaken by - The PCLW and the MIPA Project Co-ordinator will carry out the evaluation, which consists of primarily qualitative questions to consumers, GPs and Practice Nurses. The areas of interest to the evaluation are:

- Health outcomes
- Resource manual
- Training

Documents and Outputs
MidCentral Health & MIPA - GP Resource Manual

MidCentral Health & MIPA - Mental Health and General Practice, Consumer Information for the Mental Health Liaison Programme (Booklet)

Contact for further information
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Palmerston North
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Appendix D – Nelson Primary Care Liaison Service

Profile
Location  Nelson
Dates    Started January 2003

General description
A community based programme supporting mental health consumers in the transition from specialist to primary care.

History
National and International evidence shows a high prevalence of mortality and morbidity amongst major mental illness consumers living in the community. Physical health needs have not been adequately addressed and a number of barriers to primary care have been identified. There is potential for improvement by supporting GPs to undertake caring for the mental health needs of consumers who have been assessed and treated by Community Mental Health (CMH), but no longer require ongoing input from a consultant psychiatrist. Having read about other shared care projects in Auckland and Wellington and having consulted closely with the GP Link Project Co-ordinator in Otago this Primary Care Liaison Service has been introduced to provide a link between the GP, Community Mental Health Services (CMHS) along with Consumers, whilst negotiating with DWI and family/whanau.

Programme
A Primary Care Liaison Shared Care service that supports GPs in caring for the mental health needs of those persons managed by CMHT and the Psychiatric Outpatients Clinic who are considered to no longer require this ongoing input from specialist mental health services.

Aim - To provide the following benefits:
For Consumers
- Removing the cost barrier
- Removing the focus on ‘illness’ and promoting ‘recovery’
- Better use of funding
- Holistic approach to care that meets identified needs
- Choice, particularly to ‘move on’ from the specialist service
- Removal of bottlenecks for consumers coming in to specialist services
- Improving the communication between GPs and specialist staff

For General practice
- Easier access to specialist services
- Increased continuity of care
- Sustainable funding for consultations
- Training for GPs and general practice staff
- Clearer lines of accountability
- After-hours problem management
- Co-ordination in general practice, especially for consumers who miss appointments
- Better communication between primary and specialist/education re. mental illness

For Specialist Services
- Resolving bottlenecks
- Better matching of need with response to support optimal use of scarce resources
- Cost-effective solutions
- Support to general practice
- Decrease scripting for physical complaints
Size - To date there have been no completed transfers to the service.

Demographic - No details to date

Diagnosis - No details to date

Criteria

Entry - Eligibility requirements are as follows:
- Service users will consent to participate
- Be mentally stable
- Be eligible for the Disability Allowance
- Have an Axis I diagnosis
- Currently receiving specialist mental health services (i.e. psychiatrist outpatient or community team care management)
- Agreement can be reached between Mental Health Services (MHS), GP, DWI, service user and family/whanau
- Have been reviewed by a Psychiatrist over the last six months

Exit - There are no exit criteria.

Who applied criteria - Case managers make the initial selection but there has to be agreement by all the key stakeholders.

Project management

General oversight/Reference Groups - A steering group comprising of MHS Managers, the Consumer and Family Advisors and GP representatives was formed to plan and oversee the service – they meet on a regular basis.

Day-to-day - The Primary Care Liaison Nurse (PCLN) is responsible for the day-to-day management of the service and reports to the Mobile Community Team Unit Manager.

Roles, responsibilities and accountabilities – clinical

GP - The PCLN will attend the first GP appointment during which they will all discuss the shared care plan. GPs will be expected to attend the education programme when it is up and running. During the early transition period the PCLN will be following up GPs and Consumers on a monthly basis this will then be extended to every three months. The PCLN will also act as a liaison between GPs and Psychiatrists if advice or support is required.

CMHT - Case Managers will primarily be responsible for choosing eligible consumers to participate in the programme, they will also provide the PCLN with the current care plan for those consumers. Psychiatrists are still available to review treatment and provide advice to the GPs via the PCLN.

Agencies - DWI is actively involved in this programme and plays a fundamental role in processing client’s Disability Allowance.

New Roles - The PCLN will assist in the liaison between the GP and the CMH teams; provide direct support to the Consumer and their GP; relay advice from the psychiatrist to the GP if needed and arrange appointments to review treatment.

Clinical arrangements

Service profile - The case managers check eligibility and refer consumers to the programme via the PCLN who will then discuss their suitability with all the key stakeholders. The PCLN will then attend the initial GP appointment and provide a link between the GP and the CMHT
during the transition period. They will also negotiate with DWI and as necessary consumers’ family or whanau. Liaison will continue until a shared care plan is well established.

**Consultation time** - The first visit to the GP for shared care can take up to 30 minutes (and can be claimed for), other than this there are no special arrangements for extended consultations; the standard 15 minute appointment applies.

**Care plans** - A shared care plan is completed by the PCLN and the consumer. This is then given to the GP and discussed at the first shared care appointment.

**Referrals** - Referrals to the primary care liaison shared care service are made by the case managers, completed referral forms for the programme are then sent to the PCLN.

**Reviews** - Intend to start with monthly reviews to check that Consumers, GPs and Family are all happy with the new way of working, will then move to 3-monthly reviews. As for mental health reviews these can be arranged if necessary via the PCLN. HoNOS rating scale is completed monthly for the first 6 months, then 3-monthly.

**Concept of recovery** - The intended benefits to the consumer highlight how the service is focused with the use of terms such as: moving on and recovery: “Consumer choice, particularly to ‘move on’ from the specialist service” and “Removing the focus on ‘illness’ and promoting ‘recovery’”.

**Training**

*For whom* - A training package for GPs and Practice Staff is currently being designed in Otago with input from staff from other DHBs such as Christchurch. This regional approach is preferred, although other projects have been accessed for ideas.

*By whom* - Once the regional education package is designed its delivery can then be considered. In the meantime the PCLN will provide support and advice.

**Funding**

*Programme/Services* - Funding for the service is by maximising consumers’ Disability Allowance to include medical costs; this can be paid directly to the consumer or with the consumer’s permission directly to the GP. It is anticipated that a consumer will visit the GP between 4-7 times a year replacing the visits to the psychiatrist and care managers support.

There is a small amount of funding from MHS, which covers the salary of the PCLN who is employed for four days a week.

*Medication* - Medication costs can also be covered by the Disability Allowance and DWI is also offering to pay that directly to pharmacies if the consumer wishes it.

*Training* - There is no extra funding available for training.

**Communication and Liaison**

*Consumers* - The consumer advisor is a member of the steering group and is invited to attend all project meetings to ensure a consumer perspective is voiced.

*Information systems* - Paperwork is to be kept to a minimum but there are consent forms, referral forms and the shared care plan that have to be completed, along with a discharge summary from the case manager.
Programme Evaluation
An evaluation is planned but at this stage exactly how and by whom has yet to be decided. It is intended to use the HoNOS and to record utilisation data to compare with future measurements. In addition qualitative questionnaires for consumers/families/GPs and CMHT staff will also be used. Statistics will be recorded and a database set up.

Documents and Outputs
Nelson & Marlborough Mental Health Services - Primary Care Liaison Service (Information Pamphlet)

Contact for further information
Chris King
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C/- Mobile Community Team
Nelson Marlborough Health Services
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Appendix E – Newtown Union Health Service Primary Mental Health Programme

Profile
Location Wellington (South)
Dates Started 1993

General description
The Newtown Union Health Service (NUHS) is a community owned and governed primary health care service. People from the Wellington South electorate who are on low incomes are eligible to join. The services provided in the primary mental health programme are mainly delivered by a GP and a Primary Mental Health Nurse (PMHN) based at NUHS, these mental health consultations are provided at no cost to the patient. Another feature of the programme is a fortnightly consultant-liaison service provided by a psychiatrist.

History
In 1992 the region’s largest psychiatric hospital discharged long stay residents into the community, many moved into the southern suburbs of Wellington and as they had to register with a GP, many registered at NUHS. In response to this community need NUHS decided to target mental health using a community development approach. Working with consumers, Non-Government Organisations (NGOs), supported accommodation providers, Community Mental Health Teams (CMHTs) and churches, a wide group had input to the service development. This involved extensive networking, liaison and cooperation, building up a team approach to care. This multi-disciplinary team approach to care means that NUHS liaise and network widely. The programme started small and gradually grew, by 1994 demand was so great that NUHS had to look for additional funding. In addition to receiving a special contract for the mental health programme, Capital and Coast Health allocated a staff member to NUHS to provide a part-time consultant psychiatrist–liaison service. In 1998 NUHS was awarded a TheMHS silver medal for primary mental health care in recognition of innovation and success of the programme.

Programme
The programme has a shared care, wellness and recovery focus that addresses physical, mental and social health needs. Mental health services are primarily provided by a GP and PMHN team. Because of demand for the programme other GPs within NUHS are involved in mental health. A psychiatrist consultant also provides a liaison service every fortnight. NUHS uses a definition of shared care that requires participation of the patient, family and caregivers where appropriate; depends on trusting relationships between all involved; implies a collaborative agreement and relies on team work; and requires a management plan for the patient and clearly defined responsibilities for individual health workers.

Aim - The programme’s goals are:
- To provide a high quality, affordable, easily accessible, acceptable and appropriate primary health care service for people with on-going needs from major mental illness.
- To develop a service in which members have a voice, are involved in determining the needs to be addressed, the type of service required to meet these needs and the formulation of the policy for the service; consumer input and community involvement at all levels of policy, planning and delivery.
- To develop a service that maintains people in good health, that responds early in crisis and initiates care which may maintain that person in the community.
• To develop and promote a model of Primary Health Care delivery which is based on
team work (involving a range of primary health care providers) and team decision-
making - a multi-disciplinary approach to care.
• To develop a working relationship with psychiatric secondary services and other
primary health care services including supporting hostels in psychiatric area with the
aim of providing a shared care service for people with a major mental illness.
• To ensure extensive liaison and networking with NGO, other mental health service
providers, church and community groups.
• To ensure a healthy working environment for staff of the service and to maximise the
opportunity for them to use their skills.
• To develop and model shared care arrangements.
• To provide a recovery based approach to care.

Size - Contracted to provide primary mental health care for up to 300 people, as at December
2002 there were 297 people within the programme. Of these, 70% were in a shared care
arrangement and 30% exited out to GP total care (of those exited out of CMHT, 4% will
relapse and go back to CMHT follow-up). The main reasons for relapse of mental illness
have been, substance abuse, changes in accommodation (i.e. being asked to leave a flat or
becoming homeless) and stopping medication.

Demographic - As at December 2002: Māori (48), Pacific (12), Middle Eastern (16), Asian
(16), African (30), European (172), Other (3).

Diagnosis - The mental ailment profile was as follows: Schizophrenia (137), Bi-polar (31),
Depression severe (90), Personality disorder (13), Post traumatic stress disorder (26).

Note: there are several people, especially those with the personality disorder ailment code
who also have other mental health diagnosis. Over 63% of patients have significant co-
morbidity, asthma, diabetes, hypertension, obesity, smoking.

Criteria
Entry - People become part of the specially funded mental health group on the basis of their
diagnosis and history. They need to have been seen at least once by the secondary or
specialist mental health service and have an on-going DSM IV diagnosis. Eligibility for the
programme is assessed when people first join NUHS, if they have had contact with the mental
health service they are given a mental health ailment code, NUHS use five mental ailment
codes Bi-polar disorder, Psychosis, Depression, Personality disorders, Post traumatic stress
disorder. Anyone who is already registered with NUHS who develops a mental illness and
meets the criteria can join the programme.

Exit - Reviews of eligibility for the programme are carried out on a regular basis.

Who applied criteria - People’s initial consultation after enrolling at NUHS is a well-health
check carried out by a nurse and a follow up appointment with the doctor. The nurse and
doctor team enrol the patients on the mental health programme.

Project management
General oversight/Reference Groups - NUHS has a Policy Board, which oversees the
service’s direction, sets policy and advises staff. It is involved in approving all new initiatives
and in working through any complaints. It is made up of community and staff members,
community members are elected at an annual general meeting open to all people registered at
NUHS. Two of the community representatives specifically represent the primary mental health programme. The Policy Board is chaired by a community person and meets monthly.

Day to Day - The GP and PMHN assigned to the programme have the biggest input, they meet once a month with the liaison psychiatrist to discuss patients. There is also a confidential formal complaints system that allows people to present their concerns about the service verbally or in writing.

Roles, responsibilities and accountabilities – clinical

GP - provides medical oversight to the programme in addition to:

- Ongoing medical care and prescribing
- Regular review of medication and alteration of doses
- Initiation of new medication including atypical anti-psychotics (excluding clozapine) for patients and close follow up when this occurs
- Attending consultant-liaison clinic with psychiatrist
- Attending 2 weekly meetings with NP and monthly multi-disciplinary team meetings with psychiatrist.

When not holding clinics the GP visits supported housing and hostels and attends case conferences as required. Both the GP and the PMHN spend considerable time following up issues that arise from consultations. The GP is also responsible for completing all documentation required by Income Support.

Primary Mental Health Nurse - The PMHN will see all new mental health clients for a well-check. There are some clients who predominantly see the PMHN who discusses their care with the GP and Psychiatrist. The PMHN also holds clinics at the mental health consumers drop-in service. The PMHN does more phone work than the GP so is often the first point of contact in acute situations, the PMHN will see the person, carry out an assessment and either manage the situation themselves, consult or refer on as needed. The PMHN is also a resource person for other NUHS staff who may also have clients with mental health needs. The PMHN is involved in extensive liaison with other agencies e.g. Inner City Liaison Group, and Inner City Project.

MHS - The psychiatrist liaison service is not limited to those people on the primary mental health programme, it is open to all people registered at NUHS.

Agencies and CMHT - In addition to NUHS only care, there are some people whose care is shared with other mental health services such as supported houses or the CMHT.

Clinical arrangements

Service profile - The clients move between the PMHN and GP depending on their health needs, six weeks with the GP then six weeks with the PMHN etc. The GP and PMHN hold regular clinics and see people alone or jointly. People can either make an appointment or drop in and wait. People can also phone the service for advice. Consultation activities include providing acute and on-going management of general and mental health problems, managing medication, providing supportive counselling and health promotion.

The purpose of the liaison clinic is to provide a review (for either acute or routine purposes) of the care and treatment of patient in the targeted mental health group; and to provide advice and assessments for the ‘GP only’ patients. The clinic works is based on a multi-disciplinary team approach and has provision for extended appointments to enable the nurse, GP and psychiatrist to jointly plan care.
The health receptionist is a key member of the team, welcoming patients to the clinic, having an awareness when people may be stressed and managing this, and often seeing patients in the community.

**Consultation time** - Since 2000 the funding has allowed for 30 minute appointments for mental health consults.

**Care plans** - Clients are encouraged to be involved in all aspects of their care and are consulted with regard to treatment plans, medication changes and follow-up arrangements.

**Referrals** - Those requiring on-going specialist care for an acute problem are referred to outpatients, day hospital or admitted as an inpatient. To date the few (2 or 3) who have been re-admitted to Mental Health Services, were admitted due to stopping medication. Referrals to the programme can be self-referral or from other NUHS staff, but also from a number of other sources, e.g. NUHS is often the primary care provider of choice of the consumer groups, Schizophrenia Fellowship, Court Forensic Liaison Nurse and Income Support.

**Reviews** - All mental health clients are on a 3-monthly recall system. The GP and nurse review the recalls together. There is assertive follow-up of people if there has been no contact.

**Concept of recovery** - Basis of the mental health programme, fully embraces a recovery based approach to care.

**Training**

*For whom* / *By whom* - When the programme first started there was no formal training given to the GP and PMHN; they learnt on the job. In 1997 a comprehensive trained mental health nurse was employed. Now that there is more demand for the service, other NUHS staff have had to up-skill. Formal and informal training is offered both on and off site and to all NUHS staff, including:

- GP training days
- Use of Psychiatrist visits for informal training approach.
- Postgraduate certificate in mental health nursing
- Workshops for all staff including reception management e.g. Hearing Voices Workshop

NUHS has developed its own orientation manual for use by all new medical and nursing staff.

**Funding**

*Programme/Services* - via two sources:

1) Capitation
2) Co-payment by CCDHB for 8/10 of nurses salary.

CCDHB provide funding on a capitated basis for up to 300 patients. The high user visit rate is used as a benchmark; this is the health subsidy payable to GPs on behalf of service users who have attended a GP more than 12 times in 12 months. CCDHB also supply the consultant for the fortnightly consultant-liaison service.

**Medication** - Not covered by the funding.

**Training** - Not covered by the funding.
Communication and Liaison

Consumers - In depth networking and liaising with community groups, non-government organisations, CMHT, carers and supported accommodation providers have resulted in good consumer and community input to the services in an ongoing developmental way. The membership of the Policy Board consists of at least ten community representatives with representatives from Mental Health Consumers.

Māori and Pacific - NUHS link and meet regularly with Māori Mental Health services, Te Whare Marie, and Māori accommodation providers in the area, Blossoms and Te Whare Ahuru.

Evaluation

NUHS actively reviews its own practice, and also opens itself up to be evaluated by others. To date there have been three studies carried out on the NUHS service as a whole. In addition to these the NUHS mental health programme is currently being used as a case study in a doctoral thesis which is looking at the role of general practice in the care and treatment of people with on-going needs for mental health.

A ‘snap shot’ of a months work – 1999

- 66 mental health patients seen
- 20% of those consults were acute and almost all managed by GP/nurse team
- 2% required referral to CMHT
- 50% of consults required active management e.g. medication changes, changes of accommodation
- 1/3 of consultations required liaison with other mental health providers, this often occurred outside of the consultation and consequently added to the time taken to look after one patient e.g. seeking advice regarding further management, sharing information about medication changes.

Findings

Utilisation - The average utilisation rate for all people in the mental health programme in 2002 was 12.3 visits per year.

Funding - The outreach work, management support and research are all still inadequately funded

Documents and Documents and Outputs


Contact for further information

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Appendix F – Northland Shared Care Programme

Profile
Location Whangarei
Dates Started November 2002

General description
A community mental health shared care and transition pilot project that provides for adult mental health patients with physical health needs. Ongoing care provided by general practice teams with the support of specialist hospital team and community mental health teams including Norton House and Te Roopu Whitiorea.

History
Many people with long-term mental illness have lost contact with a regular general practice team because of their complex needs and the cost of visits. This initiative aims to be an example of integration between primary and secondary services. The project has been in planning for approximately two years and builds on initiatives of similar projects in Wellington, Hamilton and West Auckland.

Programme
A co-ordinated shared care model whereby the consumer is managed in a general practice setting, but the GP and consumer both have continuing support and access to secondary services if required.

Aim - To identify Mental Health Consumers in secondary care who could be transferred to accessible GP services in a co-ordinated shared care model.

Size - A pilot planned and funded for 20 people in total, 10 from adult Community Mental Health Services (CMHS) and 10 from adult Māori Mental Health services. All 20 consumers have been identified, as at March 2003 17 clients had been transferred to the pilot.

Demographic - No details available to date.

Diagnosis - No details available to date.

Criteria
Entry
• Patients currently under CMHS with a stabilised condition
• The patient is considered suitable to be transferred from Secondary Care
• A clear need for ongoing mental health support which may include a health condition
• Reviewed by a psychiatrist before entering the programme
• Holder of a community services card
• Consumers’ agreement with informed consent to join the project
• An agreed process between both parties to initiate follow-up and the method of contacting
• Includes patients on a Community Treatment Order

Exit - The project is currently contracted to run for a year but hopefully this pilot will help to justify a longer term arrangement for providing shared care services to a wider group beyond this twelve month period.
Who applies criteria - Northland District Health Board (DHB) Mental Health Services (MHS) have selected 20 consumers they feel are suitable to participate in the project.

Project management
General oversight/Reference Groups - An Integration Committee consisting of the MHS General Manager, the Director of Clinical Services and representatives from Whangarei Healthcare IPA (WHIPA) met on a regular monthly basis, this forum was where the project was first discussed and considered, and this group in effect became the steering group for the project. A working group was formed from this original committee, the Project Co-ordinator for WHIPA, a Psychiatrist and a member of DHB management and they were responsible for actually getting the project up and running.

Day-to-day - The Project Co-ordinator of WHIPA is primarily responsible for the day-to-day management of the pilot.

Roles, responsibilities and accountabilities – clinical
GP - There are set criteria for GPs involvement in the project:
- An interest in Mental Health Issues
- Knowledge of diagnosis, treatment and ongoing maintenance of psychiatric illness
- Relates and communicates with Mental Health consumers
- No surcharge for patients in the project for regular consultations
- Take part in regular Continuing Medical Education (CME)
- Provide a culturally appropriate service

After transfer GPs are responsible for the consumer’s mental and physical health needs; however, they have access to a consultant psychiatrist or registrar and access to the crisis team if needed.

CMHT - The CMHT assesses the suitability of the consumers to be transferred into the project. The team, in consultation with a psychiatrist prior to transfer to General practice prepares a care and crisis action plan that includes early warning signs. It is intended that a Community Mental Health Nurse (CMHN) attends the introductory appointment with the GP and client. The GP is also given a contact name from within the CMHT if they need advice or support.

Clinical arrangements
Service profile - Once a patient is considered suitable by the CMHT for transfer to the GP team the care and crisis action plan is prepared by CMHT. Clients can remain with their regular GP or nominate a GP who is prepared to take part in the programme. An appointment is then made with the GP to introduce the Client and an a agreed process of contact and follow-up procedure is decided upon between the Client, GP, Caregiver, Family and CMHN.

Consultation time - The standard consultation time of 15 minutes applies, but most GPs can be flexible according to patient needs.

Care plans - Co-ordinated Treatment Plans are prepared during the transition period and includes: Action and crisis plan, early warning signs, list of contacts including Psychiatrist, Community Nurse (PCN), Caregivers and Family

Referrals - Ensure that there are clear pathways for referral to consultants for specialist advice if needs or condition changes and fast track re-admission if there is severe deterioration of a consumer’s condition.
Reviews - GPs are responsible for monitoring a consumer’s mental and physical health, however, as part of the interface between primary and secondary care it is intended to develop and implement a clinical pathway for evaluating care.

Training
For whom - The following education modules will be covered by Continuing Medical Education (CME) for GPs:
- Māori Mental Health Promotion
- Case Planning
- AIMS Testing
- Acute Phase Management
- Management of Schizophrenia and Bi-polar in general practic

By whom - Whangarei Healthcare has a full-time professional development co-ordinator facilitating CME for GPs and is envisioned as being part of Whangarei Healthcare and MHS’ joint role.

Funding
Programme/Services - Capped funding arrangement with GPs so that target population receives free consultations for mental and physical health needs.
- A fixed capped fee of $350 + GST per patient per year
- Paid quarterly in advance by the DHB to the IPA who will then pay the GPs
- GP claims GMS for consumer
- Reviewed for each consumer on a six monthly basis
- Based on 12-15 GP visits per year

Medication - The funding does not cover medication at this stage.

Training - The funding of regular CME for GPs is part of Whangarei HealthCare’s role so this cost has not been identified in the project. If specialised sessions are to be provided for a minority of GPs in addition to CME that involve extra costs prior approval must be obtained from Northland DHB or sponsorship obtained.

Communication and Liaison
Clients - Clients have to give informed written consent to join the project, this is completed with the client’s key worker. In addition to documenting current contact information the consent form makes a statement that the client is agreeing to be registered for the shared community care of their community mental health requirements and that that will include the following:
- Primary follow up for treatment care with the nominated GP service
- To attend regular appointments and programmes as negotiated and arranged
- That as part of the treatment the GP service may contact Northland Health for additional support, guidance and advice – which will include sharing of information
- If required Northland Health will assist the GP service should they become unwell

Service Providers - One of the visions of the pilot is to improve communication between primary and secondary care. As part of the interface between primary and secondary care providers there is a need to establish a clear chain of communication to enable GPs to access areas that fall outside the community care guidelines. There needs to be an agreed process between parties to initiate follow-up and the method of contacting and to ensure co-ordination with secondary care providers at all times.
**Information systems** - Client consent forms, client co-ordinated treatment plans and transfer checklists help to provide and share contact details and client information between parties.

**Monitoring and Reporting**

*Care Plan Monitoring* - Agreed assessment tools are to be adopted for both parties to effectively determine the benefit and identify modification to the project.

**Monitoring** - Ongoing monitoring with providers to cover:
- Number of consumer consultations
- Duration of consultations
- Type of service provided - after 6 months
- Consumer satisfaction or benefit
- GP satisfaction survey
- GP satisfaction of patient/doctor relationships
- GP satisfaction with relationships with Mental Health Service

**Reporting** - The reporting requirements of the contract are for six monthly reports of consumer utilisation rates of service to assess if the consumer is still accessing GP services.

**Start up issues**

*Entry Criteria* - The CMH units had difficulty identifying clients. Clients that were often suitable for entry into the programme were often discharged from CMHS back to their GP by-passing the programme. Several problems have been identified:
- Attempts were made to pass patients with a history of forensic or a history of difficult management (not meeting the entry criteria) to GPs.
- The programme was aimed at providing a co-operative management programme between primary and secondary care providers to reduce the need for readmission. Some of the recommended clients had been in secondary community care so long they had become institutionalised in their expectations.
- Some clients were transferred to GPs without the co-ordinators knowledge and the GP had no background on the programme.
- General practice front desk staff did not understand how the capitated system worked and sent an account to a client.

GPs feel there is a need for more consultation on the selection of suitable patients. GPs consider they have some patients they have identified that may benefit from ongoing mental health and medical care but because of the workload of the CMHT and the time taken to assess the suitability many suitable clients have been discharged from CMH care, back into the community before they could be placed in the programme. They would need to be readmitted before they were considered for the pilot.

*Initial consultation* - It was intended that a CMHN attends the introductory appointment with the GP and client but this has proved difficult to arrange with both GP and CMHN.

*Training* - CME for GPs is seen as being part of Whangarei HealthCare’s and the MHS’ joint role - this has been initiated with a sponsored launch meeting for GPs and the MHT.

**Contact for further information**

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Appendix G – Otago GP Link Project

Profile

Location: Dunedin
Dates: Pilot link project 2001 – 2002
Full Programme commenced July 2002

General description
A pilot programme was run to see the effect of removing the cost barrier, for mental health clients, for visiting their GP; this was achieved by ensuring that clients were claiming for their costs appropriately from their Disability Allowance. Having proved successful the programme was extended and also acquired a separate funding pool in order to assist those clients who experience difficulty with managing their finances. The programme offers two stages for clients: stage one where clients receive their Disability Allowance directly to be used to pay for GP visits and stage two where the funding pool is used to pay for GP visits, this is claimed directly by the GP on either a fee-for-service basis or as a capitated yearly amount to cover 10-12 visits per annum.

History
In 2000 the Otago District Health Board (ODHB) Mental Health Service (MHS) seconded a Consultant Psychiatrist (half-time) and a Registered Psychiatric Nurse (full-time) to develop effective linkages between the mental health service, GPs, Government and Non-Government Organisations (NGOs). These staff undertook a survey to examine the views of Otago GPs about local mental health services and their role in providing such health care. They identified that there were physical needs of the seriously mentally ill community that were not being adequately addressed. They also identified that GPs were prepared to do more mental health work if barriers of cost and time could be overcome and if they were provided with adequate education and backup from specialist services. The project also supported a Trainee Intern Health Care Evaluation Project, which researched the current physical health of a group of clients of the mental health service. This showed that there was unmet need in regards the physical health of this group of clients. A pilot was established in 2001 involving ODHB MHS and DWI. These agencies worked together with 22 mutual clients who had participated in the research project and who were either not regularly visiting their GP, had ongoing health needs and identified cost as a barrier to attending their GP. The pilot was considered successful and at the end of its term the decision was made to extend the project to all current clients of the mental health services.

Programme
A shared care model that promotes closer working relationships between Primary and Secondary Health Services and other agencies such as DWI, it also promotes a brokerage role for the Project Co-ordinator and Community Mental Health Team (CMHT) Case Manager. The programme focuses on enabling clients to visit their GP for physical health needs that aren’t being addressed because of the financial barrier to accessing primary care, that barrier is removed by ensuring clients’ claim appropriately from their Disability Allowance to cover the cost of GP visits. Specialist mental health services are still responsible for the mental health of the clients but GP involvement is increased and communication improved between the services.

Aim - To reduce disparities for seriously mentally ill clients by assisting them in having their primary health assessed regularly and empowering and educating clients as to accessing and providing the documentation required for Disability Allowance application and renewal.
Size - Twenty two clients participated in the pilot, the continuance of the programme saw it open up to all clients of MHS, this is a client base of between 2,500 and 3,000 and due to its size demographic and diagnosis data are not readily available.

Criteria
Entry - The programme is open to all clients of the MHS who are eligible for a Disability Allowance from the DWI; there are three types of Disability Allowance:

- The Disability Allowance is for people who have a disability and need on going medical care and help with every day tasks.
- The Child Disability allowance is to help with the costs of caring for a disabled child at home
- The Special Disability Allowance is payable if the client’s partner is in hospital (for at least 13 weeks) or in residential care. This allowance will assist with the cost of visiting the partner but clients must be on income support to receive this allowance.

If clients are not receiving Income Support they may still be eligible if their income is under a certain limit. Clients receiving Superannuation are also eligible. For those clients with extensive medical costs, there are special benefits over and above the Disability Allowance, which can be granted at the discretion of DWI.

Clients residing in supported accommodation are not currently eligible as the accommodation provider usually claims the maximum allowance on behalf of the client and therefore pays for the clients GP visits and prescriptions. Clients attending supported Vocational Centres may not be eligible (depending on the number of days they attend). These Vocational Services claim the entire Disability Allowance and pay the clients a “wage”, which can be used to pay for GP attendance.

Exit - There are no exit criteria applicable to this programme.

Who applied criteria - Eligibility is directly linked to benefit eligibility but referrals for the programme can come from, MHS, GPs, Families, DWI and self-referral. Clients with independent income are encouraged to allow for the cost of GP visits in their budgets.

Project management
General oversight/Reference Groups - The establishment and implementation of both elements of the project, stage one and stage two clients, is by way of a partnership between ODHB, DWI (Dunedin, Alexandra and Oamaru Service Centres) and South Link Health. This partnership is managed and co-ordinated by the Chief Executive, Otago District Health Board, Dunedin, the Regional Commissioner, Work and Income (Southern) Dunedin, and the Executive Director, South Link Health Inc, Dunedin.

The Partnership Management Team meet at least quarterly to review progress and explore opportunities within the relationship.

Day-to-day - The Project Co-ordinator is responsible for the Day-to-day running of the programme and providing education/assistance to CMHT staff on implementation aspects of the project.

Roles, responsibilities and accountabilities – clinical
GP - All GPs in Otago can participate in the programme. GPs can get advice and support for those clients on the programme from the CMHT staff case managing the client or from the Project Co-ordinator.
**CMHT** - Case managers refer clients to stage 2 of the project via the Project Co-ordinator.

**Agencies** - DWI are actively involved in this programme and play a fundamental role in assisting clients to claim for primary care costs from their Disability Allowance. There is a designated DWI case manager for all clients on stage 2 of the project and they and the Project Co-ordinator liaise at least weekly.

**New Roles** - The Project Co-ordinator role has been developed to assist, support and advise CMHT staff, GPs and clients and also to work much more closely with agencies such as the DWI.

**Clinical arrangements**

*Service profile* - When a client is referred to the GP Link project the Project Co-ordinator will meet with them and their case manager to discuss how the project works. They establish if the client has a GP, if not then the client can choose a GP. If a client has any existing debts with their GP then the Project Co-ordinator can help the client make a claim of up to $300 from DWI towards clearing this. DWI has a designated case manager for those clients on stage 2 of the programme so they then meet with the client and make all the necessary arrangements to claim for primary health care needs from their Disability Allowance and to also set up any automatic payments to GPs or pharmacies if required. Clients are encouraged to set up an automatic payment to the GP. Because of a new funding agreement (Stage 2) there is now another option for clients and that is to have the payment made directly to their GP. Stage one clients are those who successfully manage their finances and pay the GP as and when they visit, they then have to provide all the necessary paperwork to DWI proving that they have attended the GP appointments and collected prescriptions claimed for, the stage two option is offered to those clients who experience difficulty in managing their finances and the GP either claims for each visit or is paid a capitated amount per annum This fund pool is managed by Southlink Health.

*Consultation time* - There is no special arrangement for extended consultations; the standard fifteen-minute appointment applies.

*Care plans* - Care plans are made available to GPs and these include the clients:
- Current diagnosis and management plan
- Early warning signs
- Current medication and prescribing responsibility
- Readmission protocols
- Who and how to contact the case manager, MHS or other community supporters involved in the clients care

*Referrals* - Referrals back to MHS can be made by the GP if necessary, they use a standard mental health referral form.

*Reviews* - Because the project is part of normal clinical practice the normal reviews apply and these are carried out by the case managers. As for eligibility, Disability Allowance is reassessed annually by DWI.

*Concept of recovery* - The concept of managing your illness, not your illness managing you, is what the GP link project is all about; the maintenance of health and health promotion and getting as many supports as the client needs involved in recovery plans.
**Training**

*For whom* - Continuing Medical Education (CME) for GPs and Practice Nurses is being developed. Project Co-ordinator provides training and assistance with process, to the Community staff.

*By whom* - South Link Health will be responsible for organising the CME.

**Funding**

*Programme/Services* - General practice services are funded in one of two ways, firstly via a client’s Disability Allowance whereby the client can claim the following:

- GP attendance.
- Transport assistance to attend MHS outpatient appointments, GP visits and to collect prescription medication
- Prescription medication costs
- Practice nurse visits for administration of Depot medication
- If deemed appropriate for health, heating subsidy.

Secondly, by using the capitated funding arrangement between South Link Health, ODHB and the DWI (Southern), this forms the basis of stage two of the programme and enables clients to access their primary healthcare provider without the financial constraints, it has a budget of just under $30,000 and is limited to 102 places.

So there are three options for GP payment:

1. If a client has managed their finances well in the past then they can continue to pay the GP at each visit – stage one
2. A weekly automatic payment can be set up via the client’s bank to cover the cost of the regular visits.
3. This option involves the capitated funding arrangement and is also used when a client has considerable existing debt with their GP – stage two

*Medication* - Prescription medication costs can be claimed. Automatic payments can be set up to pay prescription costs directly to the Pharmacy.

**Communication and Liaison**

*Consumers* - The consumer advisor, ODHB was consulted regarding the pilot and ongoing expansion of the project and the Consumer Advisory Network, which consists of consumer representation from all mental health services in ODHB, supported the project with many of their members participating in the pilot study. The consumer advisor attends monthly meetings, with mental health services management and quality groups, to express views of the local Consumer Advisory Network.

*Family* - A family advisor also attends these monthly meetings. A MHS information booklet introducing the programme was designed and is given to family members.

*Māori and Pacific* - There is a Memorandum of Understanding between Te Oranga Tonu Tanga Hinengaro Hauora Services and other Otago MHS that states that Kaioranga Hauora Māori Workers of Te Oranga Tonu Tanga will have regular interface with other MHS to ensure ongoing quality assistance in cultural matters is provided to clients who require care.

*Information systems* - A simple consent form was developed to facilitate case manager liaison with the GP practice and the client’s case manager at DWI. The GP should be provided with all the necessary documentation in line with Discharge Planning, Std 18 National Mental
Health Standards and Service Continuum Standard, Accreditation Standards for Health and Disability Services. A shared care plan is also available but is only usually completed when a client is new to a GP.

**Summary of programme’s evaluation**

*Undertaken by* - Feedback from the pilot was very positive from both the GPs via South Link and staff at the DWI. The project staff carried out a qualitative survey of client participation, this also provided positive feedback.

Plan to carry out an evaluation later in 2003 this will use some HoNOS data collected last year as a baseline and other data on medical cost per inpatient bed day to make comparisons, but will still use client feedback

**Documents and Outputs**


Curtis, D. (2000) The brokerage role of the psychiatric nurse: ensuring the physical needs of the mentally ill are met in primary care sector (Presentation)

Healthcare Otago, Mental Health Clinical Practice Group, Community Liaison Project (Report)

Healthcare Otago – Introduction to Mental Health Services (Information Pamphlet)

Recreation Dunedin - Free and under $5 (Booklet)

**Contact for further information**

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Appendix H – Southland GP Link Project

Southland DHB are currently in the very early stages of their GP link project, as at the end of February 2003 no clients had been ‘enrolled’ on to programme, however, its start was imminent. Southland have based their programme entirely on the GP Link project currently in operation in Otago and have been in close liaison with the Project Co-ordinator based in Dunedin. Southland DHB employs a GP Link Liaison Worker on a full-time basis; they are attached to the Community Mental Health Team (CMHT) based in Invercargill.

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Appendix I – First Health and Taranaki Health Integration Pilot Project
Primary/Secondary Relationships

Profile
Location New Plymouth
Dates Pilot 1999 – 2001
Programme currently operational.

General description
The project initially focused on the points of transfer of care and targeted the key times both providers needed to communicate in the most effective manner. It developed a structure of ongoing consultation to a sample of consenting consumers/Tangata Whai Ora. In July 2000 it was agreed to shift the focus of the project to removing barriers to primary care access with the emphasis on financial barriers as the project acknowledged that whilst relationships had improved significantly there were a considerable number of mental health service consumers not able to access primary care.

History
The primary/secondary integration project between Taranaki Healthcare and First Health was first considered in April 1997. It had been suggested at a Mental Health Networkers forum responding to the invitation from the then Midland Regional Health Authority (MRHA). It was agreed that Taranaki Health and First Health would submit an integration proposal focusing on improving relationships between primary and secondary providers in mental health. In November 1998 a contract was agreed and the pilot began in February 1999.

Programme
Based on research into integrated care whereby a combination of the consultant-liaison model and that of shared care is used, the approach to integration taken by First Health and Taranaki Health reflected both these shared principles in addition to the particular issues facing primary and secondary care providers in Taranaki.

Aim - The overall aim of the project was to improve the provider relationships between all parts of the mental health sector and to develop communication and protocols that would assist with the provision of a seamless service for consumers/Tangata Whai Ora. More specifically the project objectives were:

- To facilitate those aspects of Midland Health Strategic Plan and the document “Making a difference through Integrated Mental Health Services” that relate to the mix of health services.
- To link relevant (i.e. First Health GP Practices and Taranaki Health Mental Health Services) and the community, within the defined region, in the development of focused co-ordinated mental health services.
- To implement a framework of service delivery around Primary/Secondary relationships that could be replicated more widely in other regions as one strategy to improve the way in which mental health services are delivered to Consumers/Tangata Whai Ora.

Size - As of the end of August 2001 there had been 43 referrals to the project, of these referrals:
31 Clients were accepted on to and completed the pilot
5 Declined to join
4 Were not accepted as had complex physical and mental health needs
2 Died prior to being transferred to the pilot (neither deaths were related to mental illness)
1 Left the project

Demographic - Of the 31 clients who completed the pilot there were 12 Female & 19 Male, 25 NZ European and 6 Māori.

Diagnosis - Of the 31 clients 22 were diagnosed with Schizophrenia & other psychotic disorders and 9 with mood disorders.

Criteria
Entry - Selection criteria for Consumers/Tangata Whai Ora joining the project were:
• Eligible for or have a Community Services Card (CSC)
• Their primary provider must be within First Health Taranaki GP network
• Presently in Taranaki Health Mental Health Services
• Accepts and understands funding limitations
• Their GP must consent to transfer of care
• Must have impaired perception of their own health needs due to their psychiatric illness
• Must demonstrate a willingness to work and establish a relationship with their GPs
• Should have co-existing health needs
• Have little support network (i.e. not in supported accommodation)
• Should have a history of at least six months with the Mental Health Service (MHS)
• Have an Axis I diagnosis of schizophrenia or a mood disorder.

Exit - Participation on the pilot was for a fixed term of 12 months. The evaluation report mentions that one client left the project but gives no further details as to why.

Who applied criteria - After the initial referral was made by either the Psychiatrist or Community Mental Health Nurse (CMHN) a decision was made by the Primary Liaison Worker (PLW) whether the proposed client be accepted for the project.

Project management
General oversight/Reference Groups - There were a number of people and agencies involved in the development and implementation of the project, they were primarily representatives from Taranaki Health, the Health Funding Authority (HFA), First Health and there was also input from a PLW from Capital and Coast Health in Wellington. First Health and Taranaki Health formulated guidelines, standards and assessment protocols (in consultation with key team members). Key performance goals and improvement strategies were established for each quality indicator. The project management team would continuously monitor project milestones.

Day-to-day - The PLW was the key contact person and dealt with most of the day-to-day running of the project.

Roles, responsibilities and accountabilities – clinical
GP - Attaining names of potential participants was done in conjunction with the Taranaki Health MHS staff and potential participants were then discussed with their GPs. GPs were also involved in the transfer process if the family or whanau wanted to discuss any issues regarding the transfer. During the first GP appointment the client would attend with the PLW and the care and crisis plan would be discussed. It was expected that the GP see the consumer every three months for a Mental State Assessment. The general practice was responsible for
initially contacting consumers in the event of non-attendance; if these attempts failed then they would notify the PLW.

**CMHT** - CMHT staff were involved in the initial referral of a potential participant on to project. Either the Psychiatrist or the CMHN would introduce the client to the PLW. Psychiatrists were available to advise GPs if required by telephone and the clinical education sessions were also delivered by Consultant Psychiatrists.

**Consumer Adviser** - Their role ranges from advocacy and support for an individual through to having input into policy and decision-making around the service. The Consumer Adviser supported consumers transferring to their GPs and accompanied consumers on their first couple of visits to the GP or if consumers felt they were having problems with their GP. They worked closely with the PLW and also had a role in the evaluation by providing feedback from consumers.

**New Roles** - In October 2000 a PLW was appointed 0.5 FTE to facilitate the transfer of care. The identified goals for this role were:
- Familiarisation with the project and acquisition of relevant resources
- Establishment of an office base at First Health
- Development of protocols and practices promoting best practice
- Educational and promotional activities e.g. GPs, Practice Nurse, Community and Mental Health sector teams, Crisis Service and numerous community groups.
- Attaining names of potential participants for transfer to general practice
- Assessment and transitioning of people through this process
- Evaluation of the project

The role involved:
- Contacting the primary care practice to discuss and confirm client transfer
- Facilitating the development of the Individual Care Plan
- Resolving barriers to discharge e.g. liaise with the consumer, family/whanau
- Attending the first visit to the GP with the client to provide support to the client and hand-over to the GP
- Providing clinical consultancy on the management of consumers with mental health needs to GP and Practice staff

**Clinical arrangements**

**Service profile** - Once accepted on the project the formal transition progress began, this usually involved an introduction by either the Psychiatrist or CMHN if the consumer was unknown to the PLW and a consent form would have to be signed. The families or whanau were always involved in the transition process and encouraged to meet the PLW and GP to discuss any issues that were pertinent to the transfer.

Once the formal documentation was completed an appointment with the GP was arranged. The PLW (if requested by the consumer) transported the consumer to the initial appointment. An introduction to the Practice Nurse at the initial appointment was also considered beneficial for the consumer. The first appointment was seen as informal with a brief history given and the care and crisis plans discussed. After this appointment it was then the consumer’s responsibility to make further appointments. Each consumer’s details were inputted on to the Practice computer database and put on a 3-month recall system, more frequently if receiving ‘depo’ medication. It was envisaged that this would only be back up as the consumer would be taking responsibility for their appointment schedule.
It was decided in the planning stage of the project that the practice would oversee the notification of consumers should they not attend or failed to make appointments. After reasonable attempts to contact the consumer the practice staff was to liaise with the PLW regarding further attempts to contact them. This usually resulted in a home visit with a reminder and offer of transport and always a resolution home visit.

**Consultation time** - It was clearly defined that consumers would fit into the normal appointment schedule, this time varied from 10-20 minutes. There was no limit placed upon the number of visits within the year.

**Care plans** - At the time of transfer the PLW and Consumer went through the process of documenting details of psychiatric illness, health issues, social background and a crisis plan. This took the form of the care plan.

**Referrals** - As part of the project regime, it was expected that if any of the consumers required input from the Mental Health Crisis Team during the day, there was the expectation that the GP would see them urgently at the GP surgery for a brief assessment.

**Reviews** - It was expected that the GP see the consumer every three months for a Mental State assessment.

**Training**

*For whom* - An education and training package on the care of mental health disorders was an integral part of the operational plan. At the launch of the project a Mental Health Focus Group was arranged in which a variety of speakers and topics were covered including an introduction to the project and a discussions regarding consumer and family/caregiver perspectives of mental health. In addition to these there were more formal education sessions for the GPs, which covered psychiatric topics and medication. Three Practice Nurse forums covered a range of topics including:

- An introduction to the project
- Information on mental illnesses, mental health terminology
- Community based services available to mental health consumers
- Hospital based services available to mental health consumers

*By whom* - The PLW was responsible for organising all the focus group meetings and education sessions and participated in the introductory session. First Health has the services of a Practice Nurse Development Officer who implements and monitors the educational needs of the Practice Nurses. The Clinical sessions to the GPs were given by a Consultant Psychiatrist and included the following topics:

- Psychiatric Disorders
- Depression
- Anxiety Disorders

**Funding**

*Programme/Services* - There were three partners to the pilot contract Midland Region Health Authority, First Health Taranaki and Taranaki Health. The Midland Region HFA was the funder/purchaser for the project.

When the focus of the project shifted to removing financial barriers to primary care one of the strategies used to achieve this was to establish a fund that enabled free primary care for those on the pilot. It was a fee-for-service arrangement whereby GPs invoiced First Health for reimbursement at the end of each quarter. The total to be invoiced was $98.44 ($87.50 +
$10.94 GST) per consumer per quarter, which equates to $393.76 per year per. There would be additional payments of:

- $135 (GST inclusive) for Consumers having monthly Intra-muscular injection (IMI) Depot
- $270 (GST inclusive) for Consumers having fortnightly IMI Depot
- Practice to invoice for a ‘giving fee’ of $11.25 ($10 + $1.25 GST) when administering IMI Depots.

All consumers were seen at the surgery with the exception of one client where GP home visits were negotiated for a fee of $118.44 (GST inclusive) per quarter. All invoices were sent to the PLW to sign in preparation for payment.

Medication - Funding for medication and pharmacy charges were not covered only the payment to GPs for administering depot.

Training - It is part of the PLW role to organise and participate in the education session. The Psychiatrist’s time is paid for out of the budget for the project.

Communication and Liaison
Providers - In consultation with Psychiatrists, CMHNs and the Consumer Adviser a comprehensive range of policies and protocols were developed.

To update the Psychiatrists and CMHNs regarding the project and the client selection process the liaison worker attended their weekly meetings to present information and answer any questions. The selection of the consumers and the referral process was defined at these meetings. Update meetings were also held with the Mental Health Crisis Team, the Crisis team also held copies of the care-plans for their reference.

Consumers - The Taranaki Consumer Advisory Group were introduced to the project early in its conception and were also introduced to the PLW upon their appointment.

The newsletter ‘Korero Mai’ published by Taranaki MHS for the mental health sector in the area was sometimes used as an avenue to keep the sector as a whole informed of developments in the project.

Information systems - The Individual Care Plans recorded all the up to date contact details and crisis procedures for each consumer. The general practice computer database was used, as a back-up recall system should the consumer fail to make an appointment. All GPs were notified by the First Health e-mail system with information regarding the PLW hours and contact details. All were informed of the protocol regarding contacting the Mental Health Crisis Team at the introduction to the project.

Summary of programme’s evaluation
From the onset of the Project it was deemed vital to conduct an evaluation. This was to gauge the level of effectiveness and satisfaction of all participants. The Consumer Advisor and PLW designed an evaluation questionnaire for both GPs and consumers. This data was to be collected every three months. The evaluation was carried out by a person employed specifically for this purpose.

The questionnaires included sections on each stage of the process:
Consumer questionnaire & GP questionnaire covering:

- Introduction to the Project
• Transition from secondary to primary care
• Care by the GP (Consumer)
• Perspective and understanding of mental illness and related issues (GP)
• Role of the PLW

At each 3-monthly appointment the GP was obliged to complete a brief psychiatric rating scale and return it to the PLW for collation. Initially an AIMS test (Abnormal Voluntary Movement Scale) was also enclosed but due to ongoing concerns by the GPs regarding this form it was later removed on the understanding that the GP should record any perceived (by the GP and or the Consumer) abnormal movement and or side effects.

Two people were employed to interview the consumers over a two-week period.

**Findings**

**Health status** - No details provided regarding mental health status. With regards to physical health consumer feedback stated that they all felt that their physical health had improved since being in the care of their GP and in many cases physical conditions had been diagnosed.

**Utilisation** - No utilisation data was recorded

**Clients** - Twenty of the 31 consumers were interviewed. The following was reported:
- All 20 consumers stated that they felt comfortable being in the care of their GP and they were all confident in the GPs ability to care for them.
- There were no problems identified with the appointment process or length of appointment with the GP.
- They all expressed satisfaction with the normality of visiting a GP rather than attending the Psychiatrist’s appointment at the hospital.
- All expressed satisfaction with the PLW and being aware of how to contact them.
- All thought that the project was valuable and would like it to continue.
- They had financial concerns if the project should terminate.
- Many felt sad about leaving long-term relationships they had formed with MHS staff.

**GPs** - Fifteen GPs were interviewed and given evaluation forms to complete. They gave the following feedback:
- All GPs felt confident in treating their mental health consumers and all believed they had adequate support. Three felt that the administrative processes of the project were difficult to follow and thought that there should be more formal structure.
- When questioned about how they thought the project worked 13 said that they thought the project worked well, the other two thought that there was no difference between the project and the normal transfer procedure from primary to secondary.
- Ten GPs were satisfied with the structure of PLW role with five stating that they felt that they didn’t have enough face-to-face contact with them.

**CMHT** - Generally the feedback was supportive of the project. They were comfortable with the transition process. They had input into the client’s care plans and offered up to date relapse prevention plans. The Community Nurse’s acknowledged that with the project consumers moving out of the system they were able to accept more acute consumers in to their workloads.

Former Consultant Psychiatrist and Clinical Director who was involved at the very beginning offered positive feedback and further support for the project and highlighted that the professionals involved did not create anticipated barriers as both groups could see that the
Appendix I – First Health and Taranaki Health Integration Pilot Project Primary/Secondary Relationships

The project was based on sound clinical principles and common sense, so “buy-in” was easy. They highlighted the advantage of reducing the caseloads of psychiatrists and went on to say that all the psychiatrists know of other patients who would benefit greatly from a similar transfer of care to a General practice but who did not meet the criteria.

Primary Liaison Worker - At the initial presentation of the project by the PLW, some GPs expressed reservations over their ability to meet the needs of the intended clientele and the adequacy of the proposed funding regime. There were also concerns raised about the level of support for the consumers in the event of a crisis. Only two GPs made contact with the PLW when there were problems.

Initially some prompting was needed by the PLW to the GPs to ensure that the mental state examination was completed. In four cases the care plan was handed over to the Practice Nurse.

The consumers appreciated being asked to contribute their thoughts to the project, their main concern was the termination of the project and its affect on them.

Advantages

- Increased contact with the GP resulted in awareness of consumer’s physical conditions.
- Consumers were empowered to participate in their care
- The GP was the main provider and as a consequence there was clarity in the care and consumers had a sense of normality visiting the GP
- There was a collective sharing of information between primary and secondary care providers
- There were increased opportunities for GPs and Practice Nurses for ongoing education regarding mental health illness and related issues
- The Māori Mental Health Team was available for their consumers on an ongoing basis to provide cultural input. This was a direct development between the primary liaison worker and the Māori Mental Health Team
- The transfer of these consumers from the MHS enabled more acute consumers to be followed up by the MHS
- There was ongoing access and support from the referring Psychiatrist should problems arise with the client’s care.

Achievements

- Agreed guidelines of standards of communication, particularly for reporting and discharge planning between Psychiatrist and GPs. First Health GPs expressed their pleasure at the significant improvement in communication and referral processes from Taranaki Health MHS.
- The development of a ‘hotline’ for GPs to access a Taranaki Health Psychiatrist
- The development of a Taranaki DHB (TDHB) MHS newsletter to keep GPs informed of TDHB Adult MHS developments has been well received by GPs.
- The development of a process whereby selected GPs of the East and West sector are invited to present referrals at TDHB MHS multi-disciplinary team meetings
- The establishment of training/education sessions for primary care providers on mental health themes.
- The removal of financial barriers to primary health care and thus enabling 31 long-term consumers of secondary specialist care to be successfully transitioned to their GP.
- The development of more consumer orientated care plans.
• Establishment of an email consultation service between GPs and Consultant Psychiatrists.
• Improved working relationships between secondary and primary providers
• The project at all times kept within allocated budget

Disadvantages
• The project was unavailable to consumers outside the First Health Network
• The consumers expressed feelings of vulnerability in regard to the termination of the project and their future mental health.
• It took several months to develop a clear knowledge of the primary liaison role, as it was a totally new concept to the region. Because of the location of the PLW office, there was also a sense of distance from the MHS. It took some time to develop a cohesive relationship with all partners in the project.
• Within the project management team there were three changes to the psychiatrists designated to the pilot. The changes were unrelated to the project but affected the clinical continuity and support to the PLW.

Update
Early in 2002 the pilot was due to end, funding was to be withdrawn, however, the DHB MHS Manager and the Community Mental Health Manager (CMHM) decided to pool the remaining funds from the project together with a grant from a Community Trust in New Plymouth to ensure that the primary integration programme would continue. There was a period when the programme continued without adequate management this period coincided with a gap in the involvement of a PLW. The new PLW now has an additional task of investigating the current status of those people initially on the programme as there had been a breakdown in communication and some people were in effect receiving dual care where they were back under the care of CMHT whilst still being on the programme.

How the new programme differs from the pilot:
• There is no longer a management team as such, the PLW is responsible for the day-to-day running of the programme and reports directly back to the CMHM.

There is an expectation that the people who commenced GP follow up under the initial pilot will transition to self-funded GP care, creating opportunities for others to benefit from integrated GP care. DWI are aware of the programme, and the people who exit off the programme to resume self funded GP care. Consumers are encouraged to check that they have their full DWI entitlements through contact with their DWI Case Manager.
• First Health no longer administers the new programme; this is now the responsibility of the CMHT (PLW).
• The programme is now no longer limited to First Health GP’s only. Other IPAs have joined the programme, thus extending the options for consumers and GP’s.
• The first GP consultation is a double session, the standard 15 minutes applies to all further consultations.
• More emphasis on the care plan as an ongoing communication tool, the new programme’s consumer information brochure highlights that it is a unique plan that ‘outlines who does what and when so that everybody is clear and working together as a team’. It also emphasises the consumer’s involvement in the development of the care plan, that it will be reviewed to ensure that information remains relevant and lists who will keep a copy of the plan.
• The brochure explicitly states that any after hours GP appointments will have to be paid for by the consumer, the programme does not cover funding for these.
• Liaison with the Mental Health Crisis Team with respect to those consumers on the programme and those exiting is established. Crisis Team contacts with programme consumers are now being collected to contribute data to assist measurement of efficacy.
• There is no formal evaluation process, however, the brochure states that feedback is requested and welcomed at all times.
• The entry criteria:
  
  **General criteria:**
  o Person must have or be eligible for a CSC – DWI
  o Person must currently receive follow up from Taranaki MHS
  o Taranaki MHS Psychiatrist supports the referral for transfer to GP follow up
  o Person’s GP accepts and consents to the transfer
  o Person understands and accepts that free GP care is time limited to 12 months
  
  **Psychiatric criteria:**
  o Person has a psychiatric illness that impacts significantly on their life
  o Person demonstrates a willingness to work with this transition programme and to establish a rapport with their GP.
  o Person must have co-existing medical health needs
  o Person is not residing within contracted residential rehabilitation care
  o Person has at least a 6 months history of contact and stable mental health
  o Person has a diagnosed psychiatric illness. Those people with a diagnosis of Personality Disorder or Substance/Alcohol abuse will not be eligible for this programme.

**Additional comments**

Firstly, as people are now exiting off the programme for the first time in this region it highlights the need for some form of monitoring of those consumer’s health progress, contact with GP etc, to see whether or not, if having had the benefit of free GP care for 2 years, people will continue to attend their GP when the need arises, when they have to pay for the care. It would also be good to have a measure of the quality of continuing GP care with respect to specific interventions provided relating to presentations to GP’s. The PLW has been promoting this idea and hopes to be successful in securing support / funding to enable this to occur.

Secondly, it is now apparent to the PLW that approximately 1/3 of the consumers have had crisis team contacts, some admissions and some returning to the care of the MHS. It is hard to know whether these contacts would have occurred irrespective of other factors, however it is suspected, at least in some instances, that the lapse with the administration and profile of the programme, may have contributed to the extent to which consumer’s ended up in crisis etc. Now that crisis contacts are being collected the PLW hopes to be in a better position to know a bit more about this.

**Documents and Outputs**


Taranaki Health – GP Integration Programme (Information Sheets)

**Contact for further information**

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Appendix J – Linkage Shared Care Pilot

Profile

Location  Hamilton
Dates  September 2000 – August 2002

General description
The Linkage Shared Care Pilot was set up to increase the range of psychiatric services for consumers, to provide a model of care which would enable up to 100 Waikato Mental Health Service (MHS) users to transfer all or part of their care to a GP.

History
In September 2000 the Linkage Shared Care Pilot was purchased by Midland Region HFA and the Department of Work and Income (DWI). The pilot came about as a result of a collaborative effort between Health Waikato Adult Mental Health Services (AMHS), Pinnacle IPA, Pharmacy 547, Centre 401, Schizophrenia Fellowship Waikato, Linkage, Te Rūnanga o Kirikiriroa, and Hamilton East Medical Centre (HEMC).

Programme
Shared Care with Psychiatrist Liaison/Consult. Consumers were offered the option of receiving all their psychiatric care from a specially trained and supported GP, or receiving part of their care from the GP, in conjunction with the AMHS and the pharmacy.

Aims
- To develop and implement a model of service that involves GPs providing high quality, no cost psychiatric care for up to 100 mental health consumers with long term mental health problems who choose to receive their care from the GP, or the GP in conjunction with the AMHS
- To develop a medication monitoring system that assists service users to optimise their knowledge of their medication, increase compliance, and provide all medications, education and monitoring services and no cost.
- To identify barriers that prevent these consumers from choosing to receive part or all of their care from a GP in the pilot, or a GP in conjunction with the AMHS
- To use information gained from the pilot to develop a larger project that will provide consumer-responsive, clinically effective and financially viable psychiatric care from GPs or GPs in conjunction with a specialist MHS, and pharmacies, for ‘choosing’ consumers in Hamilton.

Size - It was anticipated that 100 service users would be enrolled on the pilot but only 35 were.

Demographic - The majority (74%) were aged between 35-50 years of age, 57% were male, and 35% were Māori.

Diagnosis - Schizophrenia (54%); mood disorders (17%).

Criteria
Entry - Entry criteria at the commencement of the pilot were:
- The individual had to have been a service user of AMHS for the past 6 months
- The individual had to be in possession of a valid Community Services Card (CSC)
- The individual had to reside within the Hamilton city limits

Service users must be willing to receive services from a GP at HEMC and use Pharmacy 547 for dispensing of medication.
Changes - Part way through the pilot additional guidelines were introduced. This was partly in response to GPs predicament of managing service users with high needs, and partly a response to the demand by all concerned for clearer criteria. These criteria were added by the Consult Liaison Psychiatrist and included:

- Must not be on a Community Treatment Order
-Must be stable:
  - At least 6 months since last admission
  - Stable on current medication regime for 6 months
  - Monthly or less contact with Community Mental Health Nurse (CMHN)
  - Two monthly or less contact with Psychiatrist
- Clozapine and MITT service users were not eligible

Who applied criteria - AMHS at Health Waikato referred service users to the pilot.

Exit - Each service user could only stay on the pilot for a maximum of 12 months after this time there was no official exit process, however, exit interviews were offered. Nine people withdrew from the pilot before completing the 12 month period; of the nine, one returned to previous GP who was not at HEMC, one commenced paid work and was no longer eligible for income support, three moved outside the Hamilton area and four required specialist intervention.

Project management
General oversight/Reference Groups - Representatives of the group of stakeholders (see History above) formed a Steering Group, which oversaw the development of the pilot. The first Steering Group meeting was in early 2000, from that point they met on a regular monthly basis but there was no dedicated project management.

Day-to-day - Linkage staff managed the pilot and carried out the administration and case management services associated with the Disability Allowance.

Roles, responsibilities and accountabilities
GP - HEMC GPs provided two types of care during the pilot, shared or total. With shared care some psychiatric care was to be provided to service users directly from AMHS, however, with total care the GPs were responsible for all of a service users mental health care and could only seek advice from AMHS or Centre 401.

AMHT - CMHNs were to continue in their role as key workers but work with GPs providing support and advice for those service users receiving shared care.

Agencies - DWI was responsible for administering payment of GP services for those service users on the Pilot and had a designated person for this role.

New Roles - A Psychiatric Consult Liaison Role was developed to provide GPs with support and advice via telephone, email or face-to-face.

Pharmacy 547 - Provide medication and advice on medication to service users on the Pilot on a pre-paid basis, during their initial visit to the Pharmacy service users can request to pick up medication in the future or to have it delivered.

Clinical arrangements
Service profile - Service users could choose between two options - Shared or Total Care.

- **Shared care**: Some psychiatric care provided by the AMHS with all other care provided by a GP of the service users’ choice from the HEMC and Pharmacy 547.
The service user and their GP would get advice and support from a Psychiatrist from the AMHS.

- **Total care**: Exit AMHS and have all care provided by a GP selected by the service user from Hamilton East Medical Centre and Pharmacy 547. The service user and their GP could still get advice and support from a Psychiatrist from the AMHS if needed.

**Consultation time** - There was some initial concern expressed that the 15-minute standard consultation would be applied to service users. However, length of appointments were spread between single (15 minute) double (30 minutes) and in a few cases triple (45 minute) appointments.

**Care plans** - Care plans were not used as part of this initiative, although comprehensive discharge plans were.

**Referrals** - Overall the contacts with Health Waikato CMHS while on the pilot compared to the previous 12 months were down by 22%.

**Reviews** - There was no formal arrangement for reviewing service users during the twelve-month pilot period.

**Concept of recovery** - An ‘Introduction to Recovery’ course was part of the training programme for both GPs and services users.

**Training**

*For whom* - An education programme for HEMC GPs and Pharmacy 547 included training in Recovery, Cultural Safety, family/Carer Perspectives, as well as Medications, Mood disorders, Psychotic disorders and Personality disorders. For service users, Recovery Training was a prerequisite for all who wanted to go on to the Shared Care Pilot.

*By whom* - The programme was co-ordinated by the Consult Liaison Psychiatrist, it was run during the GPs lunch break and each session was one hour in duration.

**Funding**

*Programme/Services, Medication & Training* - The HFA funding provided for education, consultation and liaison services to GPs and pharmacists in the pilot. This also included funding of $42,650 to Linkage for administration and workforce development.

DWI funding consisted of payment of the Disability Allowance (DA) to the contract holder for each service user enrolled in the pilot. If the service user was already paid the DA for other needs, then DWI agreed they would pay a Supplementary Benefit to cover the cost of these other needs. The DA (30$ per week per service user) was to be held by Linkage and paid on a monthly basis to GPs ($20 per week) and Pharmacy 547 ($10 per week). This was to cover medical and pharmaceutical expenses on a pre-paid basis for each service user. DWI also paid initial set up costs to Linkage of $17,410.

No funding to evaluate was secured initially, therefore, there has been no ongoing evaluation of progress.

**Communication and Liaison**

*Service Users* - Eligible service users were offered the choice of either Shared or Total Care and given an information pamphlet which described who was involved in the pilot, how it...
Appendix J – Linkage Shared Care Pilot

worked and what service they should expect to receive from the key service providers. Initially there were joint appointments between GP, key worker and service user.

GPs, AMHS & Pharmacy 547 - There was no formal process in place for regular communication between GP, CMHN and Pharmacy 547.

Summary of evaluation
While evaluation was considered by all Steering Group members as vital to the pilot, no funding to evaluate meant that there was no ongoing evaluation of progress and therefore little accurate baseline data available.

Undertaken by - John Kavanagh an independent consultant based in Hamilton.

Period of evaluation - The evaluation took approximately 4 months to complete, starting in March 2002. The period evaluated was the starting date of the pilot, September 2000 to May 2002. Because there was little baseline data the evaluation was based on the reported experience of all stakeholders involved in the pilot. The following research tools were used:
- Reviewing existing data
- Interviews
- Focus groups
- Cost benefit analysis

Findings
Start up time - The start up time for the pilot proved to be much longer than anticipated. During this delay enthusiasm for the pilot amongst both service users and AMHS started to wane especially as the pilot became more complicated and as paperwork increased.

Governance - The Steering Group was made up of a number of committed individuals who had a passion about delivering mental health services to service users in innovative ways, however, not all Steering group members shared the same understanding of shared care and there were many agendas resulting in a failure to develop a shared vision for all, which contributed to some confusion later. The pilot was managed by Linkage, but no funding was secured to project manage and facilitate the pilot. Consequently Linkage staff took on the role of project management in addition to their existing roles. For reasons that remain unexplained, there was no project plan for this pilot. This significant oversight contributed to problems such as undermining budget projections, resource allocations, data collection requirements, timely project reviews, managing risk and the steering committee’s capacity to remain focused on strategic issues.

Changes in staff - Staff changes at Linkage and in the Consult Liaison position were felt as set backs to the pilot.

Education programme - Education for HEMC and Pharmacy 547 was successful and whilst it targeted GPs other stakeholders in the pilot would also have benefited from the programme.

Access - Access to GPs and medication by mental health service users on a pre-paid system was a positive feature of the pilot, however, it was also problematic in that the free and easy access is said to have been abused by some.

Communication/Liaison - This varied between stakeholders varied and whilst communication between the participating groups was reported as improving overall there was no formalised processes in place for communication on a regular basis. GPs were sometimes unaware that a service user they were working with had been admitted to or discharged from hospital and not being aware of outcomes of visits by CMHNs, in some cases GPs found out what was
happening from the service users themselves. By contrast the CMHNs and Pharmacy 547 had an excellent relationship, having worked closely together for some time prior to the pilot. Pharmacy and GPs communicated satisfactorily but it was felt that they did not work together as a team. DWI had been very accommodating, however, there was some concern expressed that strategically the relationship with DWI could have been managed better.

- It is suggested that structured reviews should take place on a monthly basis between all those involved in the Shared Care arrangement. Key stakeholders such as GPs and AMHS staff also stated that they did not feel involved in planning for the pilot. Exit criteria was lacking for service users coming off the pilot after 12 months. Often service users expressed surprise when informed that the 12 month pilot had come to an end and found it confusing as to what was supposed to happen next, it is also worth noting that some service users found the enrolment period confusing too and expressed an “information overload”. It is suggested that for service users returning to their former or a new GP, a handover from the pilot GP to the new GP at the end of the pilot would be helpful.

- Having an agreed communication strategy may have helped to increase levels of satisfaction and participation and minimise information overload experienced by some service users.

Health status - Tools such as HoNOS or SF-36 were not utilised throughout the pilot (it was anticipated that staff at CMHS would be trained in the use of HoNOS but this did not eventuate) and therefore the only ways to measure improvements in health status are self-reporting and service utilisation patterns. Data collected for the evaluation is therefore based solely on recall.

Utilisation - At the time the evaluation was carried out recorded 22 of the 35 enrolled on the programme as having completed their 12 months, 4 were to complete over the following few months and 9 had exited from the pilot.

- Overall, there were some 509 visits to the GP. The reason service users visited their GP were split fairly evenly between General Medical and Mental Health, however it is worth noting the difficulty in separating out visits into a clear cut category as a high proportion of the visits both Psychiatric and General Medical concerns were dealt with.

- The breakdown of GP consultations over a 12-month period shows that the average number of consultations per person was 15 with a range from 2 to 72; there was one very high user whose activity accounted for 22% of all visits.

- Māori service users appear to use GP services less than non-Māori but the evaluation does not give any reason for this.

GPs - GPs did not initially understand the full ramifications of what they were getting into. They did not realise that there would be the two options of Total and Shared care – they would prefer not to continue with Total Care in the future as they lose the support of the CMHN which was of particular concern to them when service users failed to turn up for appointments as under Total Care there was no key worker to turn to for follow up. The GPs also did not appreciate how much work would be involved with 100 mental health service users, as they did not fully appreciate the time required for initial face-to-face consultations. The 5 GPs on the pilot felt that 8-10 mental health service users on each GP caseload would be the maximum to provide good care to.

AMHS - Psychiatrist’s caseloads reduced as service users were moved to the care of the GP, however, for those service users who opted for Shared Care the CMHN still had that person on their caseload so there was little incentive for them to make referral to the pilot as it just meant that they had more paperwork to do. This situation was a significant disincentive for
AMHS staff and may have been a contributing factor to lower than anticipated enrolment numbers.

Consult Liaison Psychiatrist - This role was described as pivotal to the pilot, however whilst the role was regarded by GPs as helpful it wasn’t used very much, this maybe because GPs felt quite competent or may reflect the view that psychiatrist are busy people and GPs do not like disturbing them. The role of the consult-liaison psychiatrist was unclear from the outset and the key functions of this role were in the main determined by the person fulfilling this role, there was also a change in personnel, which brought about a change in approach from a general community focus to a more specific GP focus. This staff change also coincided with a change in entry criteria this resulted in some service users who CMHT thought would benefit form the programme being excluded.

Choices - Offering service users new choices about where to get quality psychiatric assessment and treatment services was seen as a key aim of the pilot i.e. having a choice between secondary or primary, however, because the pilot only offered GP services through HEMC and Pharmacy services through Pharmacy 547 this limited the extent to which clients could exercise that choice. It is estimated that 50% of those eligible to enrol did not so because of this limitation.

Entry criteria - Changing the criteria part way through the pilot was an attempt to align perceptions and allay concerns providers had about criteria. While these changes may have addressed some provider concerns it may have fuelled concerns among potential service users ineligible to participate. There were some reports from CMHNs that those ineligible felt that their past behaviour was being held against them and that they were never going to be able to move forward. Indeed many Health Waikato CMHT felt that client choice was being eroded by these changes and this in some measure contributed to some staff becoming disillusioned with the pilot.

Exit - Many consumers did report dissatisfaction with the abruptness of the exit process but in fact letters were sent and the offer of an exit interview was made

DWI - The DWI prospectively capitated service users Disability Allowance, however, DWI administrative procedures are not configured to reconcile prospective payments. As such reconciling service user data had to be done manually and on a weekly basis a case manager was allocated to undertake this function and be the key contact for the pilot for DWI.

Māori - Māori service users and those from other cultural grouping reported similar levels of satisfaction with shared care that stemmed from the:
- holistic and respectful treatment received from GPs and the Pharmacy
- acknowledgement of the inter-relationship between mental and physical health
- lack of stigma with using GP services, which was not evident when using mental health specific services, “at the GP’s I am just visiting my GP like everyone else”.
- knowledge that the cost for accessing services had been pre-paid.

Funding - The funding allocated to the pilot did not include costs for project management or case management, or administration and operational costs. These costs were mainly absorbed by Linkage with AMHS contributing a proportion of case management through the secondment of a social worker. AMHS also absorbed additional consult liaison costs associated with extending the enrolment period for service users and the DWI the higher than anticipated administrative costs.

Update
All stakeholders attended a meeting in December 2002 and they agreed to continue with shared care and to take on board lessons from the pilot. Linkage have put in a proposal to
Waikato DHB and are presently finalising contribution details; one of the major differences between the next stage and pilot is that the DHB will contribute to GP co-payments in addition to some funding for the project team.

**Documents and Outputs**


Linkage Shared Care Pilot (Consumer Information Booklet)

**Contact for further information**

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Appendix K – Waitemata GP Liaison Scheme

Profile
Location West Auckland
Dates Started May 2001 and is ongoing

General description
A community based rehabilitation service ‘specifically tailored for Continuing Care Team West (CCT West) clients/tangata whaiora, who are seen as well on the road to recovery from mental health issues’. Through an integrated approach, and thorough ‘work up’, the objective is to support and transition these consenting clients’ clinical care from specialist mental health services to full GP care over a 6-month period.

History
With an ever increasing number of mental health clients under the care of CCT West (400+) with limited resources, it was essential to develop a scheme which could identify stable clients and a process to transition care to their GP.

Programme
A fixed period shared care model whereby clients are supported through a transition period by the CCT to full GP care.

Aim - That the scheme is client focused
- Proceeding in a timely manner, the pace determined by the client
- Support for the client in their choice of preferred GP (a resource list is provided)
- Whanau and support people involved wherever possible
- Client’s progress is acknowledged and celebrated
- Client evaluations of GP liaison process sought

That the GP and Practice Nurse are supported during the transition
- CCT West GP Liaison Nurse visits GP with clients on initial visit
- Concise summary, recovery plan (complete with early warning signs) and information handover
- Ongoing liaison and consultation with CCT staff
- One off client assessment by CCT Psychiatrist/Nurse if requested
- Direct access back to CCT services during transition period, in the unlikely event of a relapse

Size - As at December 2002: 20 clients have successfully completed the scheme, 7 are currently within the 6-month transition period, 8 are in the ‘work-up’ phase prior to entry, 6 are on hold having been identified as suitable to enter the scheme but the timing is not quite right for them personally.

Demographic - Of the 27 clients who have either completed or currently on the scheme 14 are Male, 13 Female, 3 identify as Māori, 2 Pacific Islander, 1 Ghanaian and 21 NZ European.

Diagnosis - Predominantly schizophrenia and bi-polar disorders.

Criteria
Entry - Criteria for eligibility:
- Informal client (not under the Mental Health Act)
• Have maintained 18 months of wellness with no inpatient admissions to a mental health unit or a significant intervention from crisis services
• Have maintained on medication an ‘optimal’ dose for at least 3 months and that this medication can be prescribed by the GP (currently clients on Clozapine are unable to be included due to prescribing issues)
• Have shown compliance with treatment and medication
• Have significant community support network outside of CCT West

Criteria for acceptance
• All of above
• Client is currently stable in the areas of their mental health, accommodation, employment and relationships and is managing their mental health independently
• Client is willing to enter the scheme and preferably has a reasonable relationship with the GP of their choice (If client does not have a GP – discuss with GP Liaison Nurse).

Other things to note: community social worker (CSW) input will be sought for all clients entering the GP liaison scheme to ensure financial barriers do not prevent access to GPs.

Exit - The transition period from specialist to full GP care is 6 months, however, there is some flexibility to extend this period by negotiation if required. At the end of the transition period if successfully completed the client will be discharged and subsequently a new referral to mental health services will be required.

Who applies criteria - The CCT and the GP Liaison Nurse.

Project management
General oversight/Reference Groups - The CCT (West) was responsible for “creating” the GP Liaison Nurse position. There was no project planning and no project meetings are held. This is primarily due to the fact that the Team do not see the scheme as a project but more of a way of working. The team were responsible for devising the entry criteria and made any adjustments as and where they felt necessary. The CCT hold regular team meetings and it’s during this time that they will discuss any issues regarding the liaison scheme.

Day-to-day - The GP Liaison nurse is responsible for the Day-to-day running of the scheme. She receives peer support and advice on a monthly basis from people working in similar roles in the region, including one person from a neighbouring DHB. As a member of CCT the GP Liaison nurse also participates in the routine team meetings.

Roles, responsibilities and accountabilities – clinical
GP - 21 GPs have been involved in the scheme to date. Initially GPs are contacted by the GP Liaison nurse if either an existing client or a new client is to switch from CCT care to their care. The GP is given a comprehensive discharge summary regarding the client and discusses their support network during the initial consultation attended by the client and the GP liaison nurse. During the 6 month transition period the GP can get support and advice regarding a clients well being or information regarding medication from the Liaison worker. A one off mental health assessment by CCT staff is available during the transition period if required.

CCT - CCT as a whole is involved not only in the discussions and decisions regarding the delivery of the service but also in the client selection process. There are two social workers who are part of CCT and they will ensure that clients are maximising their benefits to help pay for the GP visits.
New Roles - The GP Liaison nurse role is a 0.4 FTE and was created to oversee the transfer process and ensure support to both the client and the GP during the transition period. The GP Liaison nurse will usually attend the first GP consultation with the Client and will then follow-up with regular phone calls to the client during the 6-month transition period. They are also available to answer any queries from the GP.

Clinical arrangements
Service profile - The first step is for the CCT to identify an eligible client who would benefit from transferring to the care of their GP and discuss the scheme with them. The potential discharge is discussed at CCT review meeting. The GP Liaison nurse supports the client in finding a suitable GP if they do not have one. From there the GP Liaison Nurse and the client go through the discharge process and the GP Liaison Nurse contacts the GP to inform them of the proposed transfer. If the clients agrees, the GP Liaison Nurse attends the initial GP appointment. There then follows a 6 month “shadow period” whereby the GP Liaison nurse ensures that the client is engaging with their GP and are happy and that the GP is comfortable with the system too. During this transition phase medication is prescribed by the GP.

Consultation time - There is no special arrangement for extended consultations.

Care plans - Specific Care plans are not used for this scheme, however, the transition to the GP would be in keeping with the clients recovery plan. The GP Liaison Nurse supplies a detailed discharge summary for the GP. Contact details regarding a client’s support network are discussed during the initial GP consultation.

Referrals and Reviews - During this transition period there is a one-off client assessment by a CCT Psychiatrist available if either the client or the GP feel that there is any deterioration. If the client does become unwell then they will automatically switch back to the CCT care with no referral necessary and with immediate effect. After the client has been discharged from CCT to their GP (following the 6 month transition period) they would require a new referral to re-enter the CCT service.

Concept of recovery - The whole process of transfer from CCT to GP care is considered an essential stage of a clients’ recovery continuum.

Training
For whom - At the launch of the scheme GPs were invited to attend an induction meeting and this was combined with an education session on early warning signs and medication. Other than this there is no education programme currently offered.

Funding
Programme/Services - Currently there is no specific funding offered to clients to assist with paying for GP consultations. Where possible clients’ Disability Allowance is maximised to help cover the costs of GP visits. Some clients have been able to absorb the extra cost themselves. When benefit is maximised it is based on six visits per year if the client is on 3 month prescribing, and up to 30 visits per year if the client is receiving a fortnightly injection.

Medication - There is no funding available to assist with medication costs although prescription costs can also be claimed when maximising a benefit

Communication and Liaison
Consumers - The scheme emphasises the importance of offering client choice. Consumers can choose whether to take part in the scheme and they can choose which GP will provide their care.
Māori and Pacific - Six months into the scheme a consumer hui was held. The number of Māori clients in the care of the CCT is low however as they are mostly referred to the Māori Mental Health Services Team, as a consequence this service is predominantly for non-Māori.

Families/whanau - Families are involved where possible and can express any concerns they may have regarding the discharge process with the GP Liaison Nurse.

Information systems - The discharge summary is given to the GP at the initial appointment, at the start of the transition period, during this visit the GP Liaison Nurse provides additional information to the GP regarding the client’s support network also meets with the Practice Nurse to discuss the scheme and provide a brochure. After this initial appointment the GP Liaison Nurse follows up with regular telephone calls to both the client and the GP.

Summary of programme’s evaluation
Clients are requested to complete a 12-question feedback questionnaire. At the present time feedback from GPs is verbal.

Findings - Recommendations for the future of the scheme:
Consultations with the clients have indicated a client need for affordable GP care from supportive GPs who “know their stuff”. There is a need for:
- Development of funding initiatives to enable free GP consultations
- Ongoing training opportunities and resource material for GPs and Practice Nurses
- Lobbying for GP prescribing on ‘specialist only’ medicines in some circumstances (e.g. Clozapine)
- Continued support and communication between GPs, Clients and CCT staff
- Review of administrative procedures in GP surgeries e.g. recall and follow-ups
- Increasing resources to expand the 0.4 FTE GP Liaison nurse role, to 1.0 FTE and also the addition of some dedicated Psychiatrist hours

Documents and Outputs
Waitemata District Health Board – Continuing Care Team West (CCT West) G.P. Liaison Service (Leaflet)

Continuing Care Team – West (CCT West) GP Liaison Service – Moving On! (Information sheets)

Contact for further information
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Appendix L – Wanganui CPN/Primary Care Integration Initiative

Profile
Location  Wanganui
Dates      Started early 2002 with a 3 month pilot scheme – still providing the service as at March 2003

General description
A community based referral service whereby a community psychiatric nurse (CPN), supplied by the Community Mental Health Service (CMHS), spends two half days a week in a GP surgery providing an assessment/liaison clinic for mental health referrals. Outcome data was produced and analysed for the pilot period.

History
The Community Mental Health Team (CMHT) started discussions with Progressive Health, an IPA based in Wanganui, regarding the part-time placement of a CPN in to a general practice setting. The IPA had an appointed project officer who began to interface with the CMH (CMH) Clinical Team Leader; they worked together to get the pilot up and running.

Programme
An attachment-liaison model whereby a CPN provides a mental health clinic within a GP surgery. This scheme builds on existing ways of working but focuses on how primary and secondary services can work together to improve their service.

Aim
• To monitor past clients of CMHS, who have been discharged to GPs within that surgery.
• To assess mental health clients who were new to that particular GP service and to provide an assessment and some advice and/or ongoing referral to either CMH or other agencies.
• To provide brief psychotherapy for people who didn’t need to come into secondary services but could be handled in a GP surgery along side the GP.

Criteria for referral - The mental health clinic is open to all patients of the participating general practice Surgery. Referral to the service is via the GPs within the surgery.

Project management
The CMH Clinical Team Leader and the IPA Project Officer were the main drivers in getting the service up and running and oversee its operation.

Information systems - E-mail systems are used. A record template was designed by CMHT to be used by the surgery and this became part of the clinic record. CMH also have their own set of referral forms, these are used by the CPN when further assessment by CMHS is required, if a client is referred to an alternative service the IPA regular referral forms are used.

Roles, responsibilities and accountabilities – clinical
GP - All GPs at the participating surgery can utilise the clinic and refer existing and new patients with mental health needs for assessment by the CPN. The newly designed clinical record is completed (this was used for the pilot outcome data).

CMHT - The CMHT introduced the pilot scheme to the general practice staff. They provide a CPN form their team to run the two half-day clinics at the GP surgery. They were also responsible for collecting and analysing the outcome data to present as the findings of the pilot.
New Roles - Based at the GP surgery, the attachment role of the CPN provides mental health clinical assessment and advice where required. They also monitored past clients of CMHS who had been discharged in to the GP’s care.

Clinical arrangements
Service profile - The CPN runs a mental health clinic for two half-days a week at the GP surgery. Clients are referred by the GPs to the CPN for mental health assessments. The CPN then makes any referrals, for further assessment by CMHT or to other agencies if required. Clients can transfer back to the GP if/when they no longer require secondary services, the CPN then monitors their care and medication through the clinic.

Referrals - All GPs at the participating surgery can use the clinic and refer clients to it. Referrals on for further mental health assessment are made by the CPN.

Training
For whom/By whom - No training is provided in association with this service. An initial introduction to the scheme was given to the general practice staff.

Funding
Programme/Services - Progressive Health IPA help fund the service by providing a consultation room and use of a computer etc, CMHS provide the CPN from their team. The patient pays to see the GP but any referral to the CPN clinic is free.

Medication - No funding is available to cover medication.

Evaluation - Currently in the process of consulting with the Service User Co-ordinator regarding questionnaires to be sent out to consumers of the service and a presentation of the pilot findings has been given to the Multi-Agency Group

Summary of Pilot
Referrals - 50 referrals received in the first 3 months. 1st May 2002 – January 31st 2003 – 53 referrals received.

Demographic - 29 female and 21 male. 2 Māori, 2 Pacific Islander 42 European and 4 Other.

Diagnosis - 23 Depressive episodes unspecified, 6 with Fear Complaint, 4 Major Depression, 4 Anxiety Disorder, 4 Adjustment Disorder, 2 Post Traumatic Stress Disorder, 2 Bipolar, 1 Relationship with Spouse, 1 Personality Disorder unspecified, 1 Anger problem, 1 Panic Disorder, 1 Obsessive Compulsive Disorder, 1 Intercranial Injury, 5 Alcohol use (note that of the 50 clients some had a dual diagnosis e.g. alcohol and depression).

Recommendations - It is hoped that a new 12 month pilot can be introduced in the near future. Ideally this new service would differ from the old in that it would be extended to more GPs in the area, provide mental health training for the GPs, give some assistance towards the cost of medication and provide more equipment for the CPN, for example a laptop and vehicle.

Update
The CMHT has recently met with the DHB and put in a proposal for extra funding, the GP’s have also raised the issue of the costs associated with use of their offices, practice nurse time and computers. As at March 2003 there was still no feedback from the DHB.

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Appendix M – Wellington Independent Practice Association Primary and Secondary Care Mental Health Liaison Programme

Profile
Location Wellington, Porirua and Kapiti
Dates 1998 – present

General description
Primary and secondary mental health liaison programme to evolve clinical care, both physical and mental health, for people with mental health needs so that they are getting the right treatment in the right place at the right time, from the right practitioner with the right skills and with the right support systems in place. It is a service partnership between three stakeholder groups, Capital Coast Mental Health (CCMH), Wellington Independent Practitioners Association (WIPA) and the Wellington Mental Health Consumers’ Union.

History
Late in 1996 the WIPA board and Chief Executive Officer (CEO) met with the CEO and senior management team at Capital Coast Health (CCH) to discuss areas of common interest where joint efforts would bring health gains or better management of resources. A major re-structuring of the Mental Health Service (MHS) and CMHT at the time had raised a number of issues and concerns regarding: waiting times for specialist care; lack of consultation between GPs and specialist care and caseloads. It was realised early on that, to be successful, the programme would need a very focused and specific design. WIPA and CCH began a dialogue on these issues. Following further input from consumers, community mental health staff and general practice staff a set of areas were identified which were directly related to the issues. A discussion document *A Real Life at Last* was put out to the wider mental health sector for comment in June 1998 and the programme was further defined before the first client was transferred in Porirua in October 1998.

Programme
A liaison programme involving:
- Joint governance arrangements, both at the strategic and local levels
- Development of new interface protocols between secondary and primary care regarding discharge arrangements
- Development of a new template for care planning
- Introduction of new specialist team staff role – the ‘Primary Care Liaison Worker’ (PCLW)
- Provision of education and support to general practice staff regarding the administrative aspects of mental health care in general practice
- Capitated funding arrangement with GPs so that target population receive free consultations for mental and physical health needs
- GP Education
- GP Resource Manual

Aim
- To better match consumer needs with clinical response
- To promote recovery
- To resolve barriers to transfer between specialists MHS and general practice care

Size - As at May 2002, 215 consumers enrolled, 28 people have left the programme since the start, of whom 13 returned to MHS, 7 moved out of the area, 7 transferred to other medical care and 1 died.
Demographic – 47% female and 53% male; 7% of whom identified themselves as Māori, 3% Pacific and 3% from Asian Communities, 22% Unknown and 65% Other.

Diagnosis – 55% Schizophrenia & other psychotic disorder, 28% Mood disorder (with psychotic component), 14% Depression, 2% Personality Disorder, 1% Others (e.g. Anxiety).

Criteria

Entry - The programme entry criteria were assembled in order to target those consumers most likely to experience barriers to discharge from specialist services. Criteria included:

- DSM IV Axis I & II diagnosis
- A clear need for ongoing mental health support
- Review by a psychiatrist within the previous 6 months
- Holder of a Community Services Card (CSC)
- Consumer’s agreement to join the programme

Exit - Exiting of funding - clients will stay on the programme as long as they continue to meet the criteria and funding continues to be available. Client’s eligibility will be reviewed periodically by the care team (GP, PCLW, anyone else involved in care) at 12 months post transfer and at 6-monthly intervals. Only if the client no longer meets the criteria for needing the programme will they leave the programme.

Who applied criteria - The community team care manager identifies potential enrolee from caseload and the PCLW reviews consumer files with a clinician or with a multi-disciplinary team to decide if the individual is suitable and fits the criteria for transfer to the programme.

Application for Capitated Funding - the care manager, individual clinician or PCLW applies for the capitated funding. The programme manager will approve applications when they are satisfied that the client meets the criteria. Approval of special cases funding will be dependant on budget limitations.

Project management

General oversight/Reference Groups - In the interest of common goals and in pursuit of partnership, the programme was set up with joint governance arrangements, comprising:

<table>
<thead>
<tr>
<th>Group</th>
<th>Membership</th>
<th>Function</th>
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<tbody>
<tr>
<td>Overview Group (2 monthly)</td>
<td>GPs, CCMH senior clinical leadership, Consumers Union</td>
<td>To provide overall guidance on strategy</td>
</tr>
<tr>
<td>Education Reference Group (bi-monthly)</td>
<td>GPs, Practice Nurse, CCMH senior and local clinical leadership, Consumers, Academic staff</td>
<td>To provide guidance on the development of priorities, content and schedule for mental health education to general practice</td>
</tr>
<tr>
<td>Porirua Steering Group (2 monthly) Wellington Steering Group (2 monthly) Kapiti Steering Group (2 monthly)</td>
<td>GPs, CCMH local clinical leadership, CCMH clinicians, Consumers that are on the programme</td>
<td>To provide guidance on the implementation of the programme to the Porirua – Wellington and Kapiti community, and resolution of related issues</td>
</tr>
<tr>
<td>Consumer Group</td>
<td>Consumer representatives who were members of the above groups</td>
<td>To provide a dedicated caucus for the consumer representatives</td>
</tr>
</tbody>
</table>
Day-to-day - The WIPA project manager was responsible for the day-to-day running of the programme.

Roles, responsibilities and accountabilities – clinical

GP - GPs work with the PCLW and the client in producing the individual’s Care Plan. They are expected to attend training sessions as part of the Education programme and have governance roles as members on a number of the Steering/Reference Groups. This is obviously in addition to providing services for physical needs.

CMHT - A new specialist team role was created, based within the CMHT. This role was the PCLW who has an exclusive focus on supporting the consumer in the transfer from specialist care to primary care. The role of the PCLW includes:

- Liaison with clinical colleagues regarding referrals
- Providing information about the Programme
- Supporting the consumer with key choices, such as their preferred GP
- Liaison with GPs regarding their involvement in the Programme
- Working alongside the consumer and GP to build the Care Plan
- Co-ordinating the practical transfer arrangements, including the ‘hand-over’ meeting with the consumer and GP
- Undertaking data collection activities to support the programme evaluation

There are two PCLWs, one based in Porirua/Kapiti, the other based in Wellington.

New Roles - A consumer fieldworker was employed to administer some of the evaluation tools; their contribution included:

- Production of Consumer Information
- Participate in steering and governance meetings
- Attend education reference groups
- Identify quality improvement issues for Programme
- Liase with consumers on the steering and governance groups
- Programme presentation

The fieldworker took part in a number of evaluation activities, including:

- Interviews with consumers
- Focus groups with mental health staff
- Interviews with PCLWs
- Documentation for evaluation

Community Co-ordinator - The Community Co-ordinator is a non-clinical role, the service provided aims to link people with mental health needs in primary care with existing community resources by helping the individual identify their own unmet needs. The service is also accessible to existing Community and Primary services that require information on local resources. The Community Co-ordinator does not provide a service to individuals within secondary services or any individuals within the community that has a case manager within a secondary service.

Clinical arrangements

Service profile - The basic transfer process involved:

- Informing the consumer about the Programme
- Supporting the consumer’s choice
- Informing the nominated GP about the Programme
- Supporting the GP’s choice whether to accept the nomination
- Use of the Care Plan template
- Development of Care Plan content that covers all the important care requirements
• Completion of hand-over meeting in the GPs surgery, involving the consumer, GP & PCLW

*Consultation time* - If a Consumer is required to be seen for clinical /psychiatric reasons more than the capitated funding allows for i.e. 1.5 visits per month, the GP has the opportunity to apply for special circumstance top up funding to the Project Manager.

*Care plans* - GPs, specialist staff and consumer representatives agreed on a new Care Plan template. The individual Care Plan is completed by the PCLW in conjunction with the client and GP. The purpose of this form is to provide information and an agreed plan on how the needs of the client will be met, identifying who is responsible for meeting each need. It includes relapse prevention and early warning signs to enable a shared agreement on management of any future problems that may arise. A discharge summary letter provides more extensive information if required.

*Referrals* - Following a patient’s transfer the PCLW is available for clinical consultancy to general practice.

*Reviews* - WIPA helped to develop administration and recall systems to ensure appropriate appointments and follow-up.

*Concept of recovery* - To support a successful transfer it was necessary to ensure all aspects of care were covered. It was essential consumers were involved in this as “ownership” by all parties would facilitate use of the plan, and ensure its relevance. It was anticipated that this would also promote the recovery concept, which was a part of the education programme around care planning.

*Training*

*For whom* - The need for the general practice team to up-skill in mental health care has been viewed as a necessity for this programme. To support optimal care in general practice, the Education Reference Group developed an education programme, which targeted information prioritised both by GPs and as a result of the needs of those consumers involved. The initial focus of the education programme has been directed at severe mental illness but it also includes other changes such as use of care plans and working with other professionals.

The GP syllabus involved 6 modules as follows:

- Māori Mental Health Promotion
- Care Planning
- AIMS testing
- Acute Phase Management
- Management of Schizophrenia in General practice
- Management of Bipolar disorder in General practice

Further Topics that are being offered for GP CME

- Pacifica Mental Health
- Bi cultural model of working with mental health crisis (Māori Mental Health)
- Polypharmacy
- Mental State Examinations/Assessments
- Risk Assessment and Management
- Acute Phase management
- The Consumer experience of Mental Health Crisis
- Assessing and Treating Anxiety Disorders
- Detection and Management of young People at Risk of Suicide
Practice nurse study sessions contained broadly similar themes to the GP programme. The Nurses, and receptionists, also attended a one-day session designed in association with WMHCU, which incorporated material to address stigmatisation and discrimination issues.

In addition to this, the Education Reference Group also designed and built a Resource Manual for general practice, aimed at providing GPs with key information to support consumers in primary care. It is made up of Decision Support Tools as well as other mental health resources and guides.

By whom - WIPA organise and carry out the training sessions.

Funding
Programme/Services - To remove the burden of cost from the consumer on a low income, CCH and WIPA agreed a fixed capitation fee for each consumer. Paid quarterly in advance to GPs by WIPA who then invoiced CCH, the capitated amount was based on an estimated 12-15 visits per year. The annual cost of visits to general practice, excluding the GMS component, the burden of cost to Capital Coast Health is $394 per consumer per year. In addition GPs claim GMS each time the consumer visits the surgery for a consultation.

These arrangements meant that there was no charge to the consumer. There is a 6-monthly review of the funding need for each client.

An additional cost is that of the salaries of the PCLWs. This was calculated as a one off cost by dividing the total annual salary of the PCLWs by the number of consumers transferred in the same 12 month period, e.g. during the 12 month period between May 1999 and April 2000 there was an average 1.5 FTE (full time equivalent) PCLWs involved with the scheme, during this time 60 consumers were transferred, so 1.5 FTE salary divided by 60.

Medication - No extra funding towards the cost of medication to consumers.

Communication and Liaison
Consumers - Consumers have to agree to participate in the Programme (clearly stated as one of the entry criteria). They are involved in producing their own Care Plans, alongside the GP and the PCLW. Consumers also play a major role in Programme’s joint governance arrangements and have representation in all of the Steering/Reference groups. Consumers also gave written consent to participate in the evaluation.

Māori and Pacific - The GP Manual contains documentation about Te Whare Tapu Wha and Te Tiriti o Waitangi. Māori providers and tangata whaiora groups have been consulted as part of the community consultation. Te Whare Marie, Māori Mental Health Services, CCH Mental Health have been involved in the GP education programme and staff from CCH are invited to all meetings at all levels of the project. They have reviewed the project documentation including the GP resource manual to ensure that issues for Māori are appropriately covered. A Māori perspective has been included in governance arrangements (as provided by service leaders from CCH’s Māori Mental Health Service).

Information systems - A GP utilisation form was developed, that asked for details on each consultation, including date, degree of urgency, whether it was a physical or mental health problem, and whether it was the GP or the practice nurse who saw the person. Existing information management systems at CCH were used for the provision of data regarding consumer use of specialist services. This included use of community teams, specialist sub-services, the crisis response team, and inpatient beds.
Summary of programme’s evaluation

Undertaken by - ‘In house’ staff - to support improvement in services arrangements, the Overview Group built a framework for evaluation, to find out the effects of the arrangements on consumers and to provide a mechanism for the systematic and continuous attention to quality improvement. The project manager planned and co-ordinated the evaluation from its inception, however a number of people provided support helping with the collection, management, and analysis of data and the editing of the final document, they included the Consumer Fieldworker and the two PCLW.

The Mental Health Commission agreed to fund the evaluation; in line with this funding approval the evaluation period was set as April 1999 – March 2000. The following evaluation criteria were identified:

- Changes in client health status, so that they are more well
- Changes in consumer perceptions, so that they are more satisfied with service arrangements
- Changes in GPs perceptions, so that they are more satisfied with service arrangements
- Changes in service utilisation, so that more service is provided per dollar

The following research tools were used:

- Consumer and GP satisfaction questionnaires
- Consumer and PCLW interviews
- Health status outcome measures (EuroQoL, SF-36, HoNOS, BPRS, Life Skills Profile)
- Focus groups for the CMHT

Findings

Achievements - the programme has:

- Addressed the barriers that exist for mental health consumers to access primary clinical care through the development of effective transfer processes including new roles and capitation funding.
- Maximised individual consumer choice as the capitation funding follows the consumer.
- Comprehensive mental health consumer involvement in the planning, implementation and evaluation of an innovative primary and secondary healthcare development.
- Governance and implementation-steering groups that ensure partnership and local steering groups ensure the ongoing development of the Programme responds from the local level up.
- Delivered mental health education to all general practice staff.
- Been fully evaluated.

Health status - While each of the health status outcome scoring systems used in this evaluation is subject to limitations of small sample sizes, it is striking that they all show a similar pattern, mental health status for clients who enter the programme is at least maintained or improved somewhat.

Utilisation - Utilisation of specialist services significantly dropped. GP contacts averaged 0.83 per month with a range of 1 to 40 visits. For 72% of these visits the client was seen by the GP, 21% saw the Practice Nurse, and 7% were seen by both.

Participants feedback - Clients expressed a high level of satisfaction with the programme, with the majority preferring the primary care arrangement to care from the specialist MHS. Clients were very confident in the ability of GPs to manage their mental and physical health issues.
GPs were ambivalent about the value of the programme at the beginning, but tended to be more supportive once they had experienced it for 12 months.

Both PCLWs felt isolated in their roles and felt that the care plan was perhaps developed too much in favour of the GP and should be made more consumer friendly.

CMHT attitudes towards the programme were mixed. In the teams where the scheme had been running for a longer period there was more acceptance for the changes. Where the Teams had only recently implemented the programme staff were more anxious and concerned. Across the Teams there were different views about client eligibility and the procedures for selection onto the programme. Overall the staff thought it was too early to assess whether the programme was a success or not.

Māori - Although the number of Māori to benefit from the Programme was still low, in general, Te Whare Marie staff had a greater acceptance for the Programme in that it was in line with the philosophy to “get people back to their whanau”. More Māori would benefit from the Programme with the development of a Māori PCLW to complement the current liaison positions. It is encouraging to note that Māori and other non-European consumers produced scores within the SF-36 and EuroQOL tools that suggest noticeable gains in health status as a result of their enrolment on the programme.

Families/whanau - There is a need for the programme partners to review governance arrangements in order to take greater account of the perspectives held by two stakeholder groups in particular – Māori, and families/whanau.

Training - Training modules were generally well received by GPs, as were the practice nurse and general practice administration staff education sessions. High attendance, along with positive feedback, indicates that the education programme has been a successful method of delivering education to the GP Team.

Care plans - Use of care plans was audited to check the effectiveness of the care planning process, including the initial information, usefulness and review. The results showed a high rate of initial use of care plans (95% of clients signed the confirmation) but only 22% were reviewed (this is likely to reflect timing as the care plans may have a different review dates).

Governance - Overall the Programme partners believe that shared governance can and does work. The key learning from the Programme arrangements so far are that the key driver for this is a shared understanding of each partner’s values, interests and issues, together with regular liaison to resolve issues as they emerge.

Access criteria - A number of different findings support the contention that the access criteria are suitable and are being applied correctly, however there are many people not currently receiving services from CMHT who would meet the criteria for entering the programme. This needs to be addressed within the wider context of mental health and primary care strategies.

Limitations of the evaluation - A limitation to the evaluation was imposed by the rate at which clients transferred to the programme, this was lower than had been anticipated, consequently the number of data points did not always support statistically significant conclusions. The programme partners are committed to an ongoing evaluation, however, the Mental Health Commission was clear from the outset that the evaluation funding was limited to the first year of the programme – alternative sources of funding will have to be found.
Update
Further developments for the programme are now being looked at by the stakeholders. WIPA and C&CH have agreed to expand the programme to deliver the following components:

- The provision of Shared Care for consumers that require it.
- The inclusion of Consumers on Methadone within the programme.
- Availability of PCLW to be available for consultation to GPs.

Both parties are also pursuing the following areas of development:

- Availability of Psychiatry time for reviews and direct access for GPs
- Shared Care Roles and Responsibility
- Role of PCLW within Shared Care
- Shared Care Funding implications
- Placement of Programme on Capital and Coast Health Client Pathway
- Role of PCLW, avenues for development/expansion of the role
- The use of HoNOS as a assessment tool within the programme

Documents and Outputs

Capital Coast Health & WIPA, Mental Health & General Practice Leaflet – Consumer Information for the Primary & Secondary Mental Health Liaison Programme (Leaflet)

WIPA, Mental Health Liaison News – The Primary & Secondary Mental Health Liaison (Programme Newsletter)

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Appendix N – A quick and easy template for planning evaluations

Pre-programme – what to do before the programme starts to undertake an evaluation
1. Develop evaluation proposal and establish
   a. Aims of programme
   b. Evaluation steering or advisory group including consumer representatives
   c. Purpose of the evaluation and who it is for
   d. Evaluation methodology
      i. What data to collect, when, from whom, how and how analyse
      ii. Obtain permissions for outcome measurement use if applicable
      iii. Ensure you have the expertise to carry out all aspects of the evaluation
           including the analysis
      iv. Address ethical issues of evaluation with relevant Ethics Committee
   e. Funding availability for evaluation
   f. Timeline for evaluation
   g. Who is responsible for completing different aspects of the evaluation
   h. Agreement by all stakeholder groups of evaluation plan and terminology such as
      what constitutes a consultation (e.g. telephone call, visit)?

2. Devise data recording and reporting systems for:
3. Programme data such as changes to a programme and rationale for the changes; issues
   that arise and how these were addressed
4. Base-line demographic and clinical data of participants
   a. Demographic – e.g. age, gender, ethnicity
   b. Clinical – e.g. Diagnoses; health outcome measures such as HoNOS, SF-36
   c. Service use data – e.g. previous 12 months use of GP, outpatients, inpatients,
      crisis team
5. Obtaining accurate programme utilisation data e.g. contacts with Liaison worker,
   consultations GP and practice nurse
6. Tracking people’s progress through the programme such as being given information,
   completing consent procedures, completing evaluation tools

During-programme
7. As people join programme complete all baseline data
8. Monitor regularly that receiving all data identified as required, put effort into obtaining
   complete data sets.
9. Only change the planned data collection type and methods if obstacles encountered
   cannot be overcome.

Undertaking analysis
10. Ensure all data is accurate
11. Do analysis within agreed time line
12. Take care not to report on findings until analysis is complete
13. Take care in generalising findings

Post evaluation
14. Write up results so as they are accessible by others (may need several versions depending
    on the audience)
15. Ensure all programme participants are able to access results of the evaluation
16. Consult with Steering group with a view to revising programme in light of evaluation
    findings
References


Intern Health Care Evaluation Project). Dunedin: Department of Preventative and Social medicine, Otago Medical School.


The Royal Australian College of General Practitioners, & The Royal Australian and New Zealand College of Psychiatrists. *Primary care psychiatry The last frontier* (Joint consultative committee): National Mental Health Strategy.


