



To: C&C DHB Board
From: The Journey Forward
Through: Margot Mains, Chief Executive Officer
Date: December 2007
Subject: Improving Access to Primary Care and Mental Health Services: An Integrated Framework

1. PURPOSE OF THIS REPORT

C&C DHB has developed a comprehensive plan for mental health and addiction services, *The Journey Forward* (2006)¹ (TJF). A key task of TJF is to establish an integrated framework for primary care services and C&C DHB mental health services (C&C MHS) leading to effective care pathways for the treatment of common mental illnesses.

This report seeks the Board's endorsement of an integrated framework, and associated initiatives, as developed through TJF *Improving Access to Primary Care and Mental Health Services Workstream* (the Workstream).

This document reports to the C&C DHB Board on the development of an integrated framework as required in the TJF summary plan.

2. RECOMMENDATIONS:

It is recommended that the C&C DHB Board:

1. **Endorse** the proposed framework for managing and integrating the interface between primary care services and C&C MHS, and its associated initiatives (see attached framework).

The Workstream proposes establishing stakeholder governance through the creation of one central Collaborative Group which will:

- i. Assist the formulation of cross-sector operational relationships which enable improved access and effective consumer care; and
- ii. Encourage local change and service improvement to local access issues through the development and support of "Local Innovation Groups."
- iii. Form the information and data hub for the district;

2. **Endorse** the following initiatives:

- i. Investigating the potential impact and feasibility of establishing a Link Worker position within primary care services; and,
- ii. Ongoing study and early evaluation of a physical health care initiative between a Primary Health Organisation (PHO) and C&C MHS.

¹ The Journey Forward, Capital and Coast District Health Board Mental Health and Addiction Service Development Plan 2005-2006

3. **Note** these recommendations are supported by TJJ Leadership Group, and ties to the national strategies.
4. **Note** that the proposed framework is part of the overall TJJ change process, and will be supported by developments in other workstreams including the development of appropriate information and co-ordination systems through the Information, Co-ordination, Quality and Evaluation workstream
5. **Note** the proposed framework will align with the Board's commitment to Maori, Pacific Island, and low income people
6. **Note** there are education and communication issues that are still to be addressed as the implementation proceeds
7. **Note** additional Blueprint funding from 07/08 has provisionally allocated for the development of the initiatives in this proposal.
8. **Note** the improving access to primary care and mental health services integrated framework is one step to the process

Approved for release:

MARGOT MAINS
Chief Executive Officer
Capital & Coast District Health Board

Improving Access to Primary Care and Mental Health Services: An Integrated Framework

1. EXECUTIVE SUMMARY

This report to the C&C DHB Board, required by the TJF plan, presents options to establish an integrated framework for improving access to primary care and secondary mental health services.

There has been considerable communication and engagement with key stakeholders in developing a framework and options for integration.

What has emerged from this stakeholder engagement is a pragmatic way forward that builds on existing innovative activities, current relationships and takes into account the limited funding options for service expansion.

A framework for managing and integrating the interface between primary care and secondary mental health services is proposed, consisting of a collaborative group and local improvement groups. A number of initiatives that will be supported through this framework have been planned and there is some limited Mental Health Blueprint funding to support these.

2. BACKGROUND

2.1 TJF and Primary Care

*The Journey Forward (2006)*² (TJF) is C&C DHB's comprehensive plan for mental health and addiction services. The continuum of services outlined in TJF relies on a systemic infrastructure review to enable the development of coordinated, relevant and high quality services.

The future primary care approach to mental health should be more holistic, minimise stigma associated with seeking help for mental illness, and recognise and support the current reality that for every person with mental illness who seeks help from a Community Mental Health Team (CMHT), ten people seek help from primary care services.³

The potential to improve services and access given the significant link between chronic disease and mental health is also signalled in TJF.

Through the Workstream, C&C DHB intends to implement an approach that improves access and responsiveness to mental health services through better integration of primary care services, C&C MHS and Non-Governmental Organisations (NGOs).

The Workstream was directed to lead the development of options for an integrated framework, and the development of evidence-based pathways for common mental illnesses where required. The specific objectives of the Workstream outlined in TJF are to:

- Review the current primary care service and C&C DHB mental health service framework, including what works well and opportunities for improvement and development;
- Develop options for an integrated service framework for primary care services and C&C DHB mental health services;

² The Journey Forward, Capital and Coast District Health Board Mental Health and Addiction Service Development Plan 2005-2006.

³ Ibid page 17.

- Develop evidence-based pathways that span and support the integrated service framework ; and,
- Develop implementation plans for the evidence-based pathways (including primary care and mental health contributions) and the approach to dissemination across primary and mental health services and NGOs, including Māori and Pacific providers.

There are currently some well established services that integrate primary and secondary mental health in creative and effective ways, although they are limited in scope and funding. The Workstream has been mindful of building on the successful attributes of these schemes in developing an integrated framework, and further initiatives.

2.2 Purpose of the Framework

The main aims of establishing an integrated framework are to:

- improve access for consumers to a broader range of mental health services through mutually recognised cross-sector operational relationships;
- form multidisciplinary networks that collaborate with and support primary care providers who offer support and treatment to consumers within their localities
- encourage local change and service improvement to local access issues through the development and support of “Local Innovation Groups.”
- in time develop collaborative partnerships between public and private mental health services and continue to develop our partnerships with NGOs.

3. STRATEGIC CONTEXT

3.1 Primary Mental Health Strategic Context

The wider strategic context for primary mental health has been set by the Minister of Health, Ministry of Health and C&C DHB^{4 5 6}, Currently, C&C MHS provides specialist treatment and support for people with moderate to severe mental health needs, and primary care services provide care for people with mild to moderate mental health needs.

An estimated 17-20% of the population is treated at primary care services for mild to moderate mental illness at any one time. As well as the assessment and treatment of those with a mild to moderate mental illness, primary care services are expected to work with specialist mental health services to address the physical health needs of people with severe mental illness and support their recovery and management in the community. A recent MaGPie study⁷ of the mental health needs of people accessing General Practitioners (GPs) suggests that primary care services are also seeing people with moderate to severe mental illnesses, while they are not adequately supported to treat these consumers. This is supported by the presentation of consumer vignettes by Primary Health Organisations (PHOs).

4 Ministry of Health, 'The Primary Health Care Strategy', 2001

5 Ministry of Health, 'Te Tahuu – Improving Mental Health 2005 – 2015: The Second New Zealand Mental Health and Addiction Plan', 2005

6 Ministry of Health, 'Te Kokiri: The Mental Health and Addiction Action Plan 2006 – 2015', August 2006

7 This study was conducted by the Wellington School of Medicine: <http://www.wnmeds.ac.nz/academic/psych/research/magpie.html#1>

*Te Tāhuhu*⁸ suggests about a third of people who consult a GP have a mental health problem at the time of consultation or have experienced one in the past year. This is supported by the results of the MaGPie study, which, if applied to the C&C DHB population, estimate that 36% of people accessing primary care services have a diagnosable mental illness.

*Te Rau Hinengaro*⁹ estimated the lifetime risk of mental illness for the New Zealand population to be 46.6%; with a lifetime prevalence of 39.5%. Whilst the 12 month prevalence rate is 20.7% for the total population, it is higher in younger people and those who are socio-economically disadvantaged.¹⁰ Māori and Pacific peoples are more likely to experience mental health illness. Examples are set out in table 1 for the 12 month prevalence by severity and ethnicity:

Table 1: 12 month prevalence by severity and ethnicity

Twelve month disorder prevalence %				
	Serious	Moderate	Mild	None
Māori	8.4	12.6	8.2	70.5
Pacific Peoples	5.9	11.6	7.6	75.0
Total population	4.7	9.4	6.6	79.5

Some disorders have a higher occurrence in Māori and Pacific peoples, for example bipolar disorder for Māori is (3.4%), Pacific (2.7%) than others (1.9%). Substance use is higher for Māori (6.0%) as summarised in table 2:

Table 2: Disorders

Twelve month disorder prevalence %			
	Māori	Pacific peoples	Others
Anxiety	19.4%	16.3%	14.1%
Bipolar	3.4%	2.7%	1.9%
Depression	5.7%	3.5%	3.0%
Substance use disorder	6.0%	3.2%	3.0%
Total	29.5%	24.4%	19.3%

8 Ibid page 14

9 'Te Rau Hinengaro: The New Zealand Mental Health Survey', Ministry of Health, September 2006

10 Ibid page 31

The data set in table 3 below demonstrates a higher prevalence rate overall for younger people and highlights the need for services for the 16-24 year age group:

Table 3: Disorder Prevalence

Twelve month disorder prevalence %							
	Total population	Age group (years)				Gender	
		16-24	25-44	45-64	65 and over	Male	Female
Anxiety disorder any	14.8%	17.7%	18.2%	13.2%	6.0%	10.7%	18.6%
Bipolar	2.2%	3.9%	2.8%	1.4%	0.2%	2.1%	2.3%
Major depressive disorder	5.7%	8.7%	6.3%	5.2%	1.7%	4.2%	7.1%
Substance use disorder	3.5%	9.6%	4.2%	1.2%	<0.1%	5.0%	2.2%
Total	20.7%	28.6%	25.1%	17.4%	7.1%	17.1%	24.0%

These figures highlight the importance of targeting socio-economically disadvantaged people and certain population groups such as younger people, Māori, and Pacific peoples.

Further review of the health status of the group with a 12 month prevalence of mental illness revealed considerable co-morbidity with an estimated 37% experiencing more than one mental illness 36.7 % also experiencing chronic pain, 7.9% cardiovascular disease, 12.8% high blood pressure, 18% respiratory conditions, 4.1% diabetes, and 5.8% cancer.

Within C&C DHB's population there are people whose mental health needs are currently not adequately addressed in primary care services but who are also not able to access secondary services. These people are termed as having intermediate need. Treatment and support for these people could be enhanced by closer working relationships between general practice, the NGO sector, other community and cultural organisations, and secondary care.

There are people who receive treatment and support from the secondary and tertiary MHS who have limited access to the full range of primary care options to support their recovery and management including physical health needs.

A United Kingdom study¹¹ identified a similar group they termed 'the neglected majority'. These are people who have the following characteristics:

- continuing mental health difficulties despite several treatment options from primary care;
- employment or accommodation frequently at risk; and
- physical health is worsened by their mental health problem (or mental health is worsened by their physical health problems).

¹¹ The Sainsbury Centre for Mental Health 2005, 'The Neglected Majority: Developing intermediate mental health care in primary care', 2005

3.2 From Strategy to Action

Resources

There is unlikely to be significant additional resources available for C&C DHB mental health service developments over the next few years. We have been proactive in reaching our share and maximum proportion of additional Mental Health Blueprint funding in past years, there are funding pressures in mental health services associated with the redevelopment of the Adult Inpatient Ward, and C&C DHB new initiative funding is currently limited due to the priorities in reducing the C&C DHB's deficit.

Although there will be further limited allocation of Blueprint Funding in future, strategies associated with system improvement will also have to be resourced through the reconfiguration of existing revenue streams.

Stakeholder Engagement

To date there are over 80 members of the wider mental health and addictions sector engaged in change orientated workstreams, tasked to reach the aspirations for service and system improvement outlined in TJF.

All relevant mental health and addictions change orientated projects affecting C&C DHB are being organised under TJF workstreams in order to promote a sector wide shared engagement and responsibility for change management, and organise and prioritise the substantial amount of work involved.

3.3 Supporting Innovation and Growth

Within C&C DHB mental health services there are already many innovative multidisciplinary practices that involve primary care services, aimed at meeting the needs of the population presenting with moderate to severe mental health needs.. However, there would be some benefits to providing a structure for more consistent communication and support.

There are a number of national and localised funding initiatives underway that are starting to address historical service gaps. The aim of these service innovations is to facilitate access to primary care and to increase the capacity of primary care to meet mental health needs.

Locally funded primary care initiatives

Examples of local initiatives targeted at improving access to health care for people with mental illness include:

- Newtown Union Health Service – Mental Health Team
- SECPHO
- Wellington Primary and Secondary Liaison Programme and Shared Care Initiative - a partnership between C&C DHB, Mental Health Consumers Union and WIPA.
- Ora Toa, Primary Mental Health Service

Nationally funded primary care initiatives

A nationally funded Primary Care initiative *Care Plus* is aimed at improving chronic care management, reducing inequalities, improving primary health care teamwork and reducing the cost of services for high-need primary health consumers. The target populations are people with high health need due to chronic conditions, acute medical health needs, mental health needs or terminal illness.

Ministry of Health funded primary mental health pilots

The Ministry of Health's (MoH) primary mental health initiative funded over 35 short term pilot projects across the country, including C&C DHB, aimed at improving health outcomes for people with mild to moderate mental health illnesses by providing access to an enhanced variety of services through primary care. The focus is on disadvantaged groups, for example Māori, Pacific peoples, child and youth, and low socioeconomic status groups.

Examples of the variety of services accessed through these initiatives are therapies such as psychology services, social support services, occupational support services, and social work services.

TJF Leadership Group has supported an extension of this funding stream, by agreeing to write to MoH to request a continuation of these pilot schemes. This was superseded by an MoH announcement that the pilots will receive an extension until June 2009

These pilots provide useful practice information to inform the development of the integrated framework.

4. APPROACH TAKEN TO DEVELOPING THE INTEGRATED FRAMEWORK

Seven steps for gathering information and developing options for an integrated framework were identified:

1. Establishing the Improving Access workstream;
2. Analysis of C&C DHB and MoH existing strategies;
3. Meeting with C&C MHS staff and PHOs to establish what is currently working well and areas for development;
4. Review of developments underway within the district and current international literature;
5. Meeting with mental health funded NGOs to gain feedback on proposals being developed by the Workstream, CMHTs, and PHOs;
6. Focus groups with four of the target populations Māori, Pacific people, youth and people of low socioeconomic status; and,
7. Identification of initial service improvement cycles through Plan, Do, Study, Act (PDSA) methodology.

Process Mapping

In 2006 the TJF Acute and Crisis Workstream initiated a series of process mapping exercises, which is a collaborative process that plots the consumer journey through services from a consumer perspective and identifies barriers or problems, and solutions.

While the main aim of these workshops was to explore acute and crisis services it was found in many instances that if earlier options were available to consumers then the need for acute and crisis services may have been reduced or eliminated. Some findings from the workshops are therefore also relevant to the development of this integrated framework.

5. STAKEHOLDER FEEDBACK AND FINDINGS

Key themes and issues through findings and feedback received from the Workstreams' engagement processes are summarised below:

Communication and Relationship

It was commonly reported that the quality of the service that the consumer receives is improved when communication and collaborative relationships between providers are enhanced, for example, when CMHTs and general practices are able to interact, offer advice, and share expertise. There were, however, many examples provided of where communication and relationships needed to improve.

Consumer focus groups were highly supportive of strategies that encourage the development of cross-sector relationships. They identified a number of potential benefits for consumers including less travel time, better communication, reduced need to 'repeat your story', reduction in mixed messages received from different workers, and a reduction in the time involved in going to different services.

Consumer focus group participants were supportive of the proposal to make more mental health assistance available in primary care services, provided access to professionals within mental health services was also maintained.

Accessibility

Consumer access can be through specific mental health services and primary care services but also extends to other community agencies and NGOs, including those without specific mental health contracts. Access to secondary services was noted by many as problematic.

Culture language and gender seem to be important factors when considering how consumers access mental health services. Many consumers were confident in a GPs' ability to deal with mental health issues but for some this was not the case and seen as a barrier.

There was also a strong emphasis on cost as a barrier for consumers in accessing primary care services for both physical and mental health needs. Both aspects of health are believed to improve where cost barriers are removed.

Physical health

Stakeholders made suggestions that a systematic process be developed for linking people with primary care services for assessment, monitoring and development of healthy lifestyles.

Discussion amongst adult participants of consumer focus groups generally supported any strategies that address the physical health of people who experience mental illness.

Consumers were supportive in encouraging people with long term health conditions to have physical health checks if there was no cost to the person.

Consumers confirmed the challenges and barriers associated with getting their blood tests done, and the need to establish a different approach to enable this level of care.

Consumers' views were not unanimous in this area as some were not particularly interested in their physical health, or could not see the relevance to their mental health condition.

Resources and capacity

The most common concerns with the development of a framework relate to resourcing. These include unavailability of GPs and psychiatrists in some areas creating additional workload pressures, payment to GPs including ability to attend some meetings, and physical resources including space within general practices.

The stakeholders' preferred approach to development is to build on and enhance what is already in place. This would include using PHO structures that have been established to deliver MoH funded primary care initiatives and innovation pilot schemes.

A common concern amongst CMHTs is that consumers with ongoing support needs cannot be fully transferred into the services of NGOs because the NGOs do not have adequate capacity. If NGO capacity and expertise in acute cases was expanded CMHT clinicians would be more available to support primary care services.

There was consensus that further options to address capacity issues need to be explored and may include:

- Analysis of consumer flow through C&C MHS;
- Review of the C&C MHS client pathway, documentation, and Multi Disciplinary Team structure to ensure it supports integration with primary care;
- Analysis of barriers to discharge and development of improved planning processes;
- Better use of NGO support for people with enduring needs and realignment of roles throughout the sector;
- Consideration of time commitment for initiatives; and,
- Review and minimisation of paperwork demands within primary care.

Information needs to enhance access

Consumers have identified different types of information needs that would assist them with access to mental health support. These include:

- General information that assists people to understand whether or not they or someone they know has a mental health problem;
- Specific information about where to go for help in their community; and,
- Information about what type of assistance is available, for example access to counselling services through WINZ.

6. SOLUTIONS

The Workstream have analysed all findings from the stakeholder engagement processes, and incorporated feedback into the development of the proposed integrated framework, and its key initiatives.

Target groups are confirmed as:

- Māori and Pacific peoples;
- Children and youth;
- Low socio-economic groups;
- People presenting with intermediate mental health needs, identified by the following characteristics¹²:
 - continuing mental health difficulties despite several treatment options from primary care.
 - employment or accommodation frequently at risk.
 - physical health is worsened by their mental health problem (or mental health is worsened by their physical health problems)
- Secondary and tertiary consumers who have complex health needs who have do not and/or can not access primary care services

Key Strategies for Improving Access of Target Groups to Primary Care and Mental Health Services

- Improving integration between primary care and secondary mental health services to provide timely access to advice, assessment and an appropriate level of care.
- Increasing the opportunities for mental and physical health needs to be dealt with together.
- Improving data collection to show how our population accesses primary care and secondary services, and the relationship between the two.
- Enhancing communication across the district including the distribution of shared resources and data.
- Investing more in primary care initiatives that can be shown to prevent escalation of mental health problems to crisis and acute phases.
- Implementing care pathways through stepped care based on 'least intervention, first time'.
- Providing a structure that supports continuous quality improvement and promotes local solutions to local access issues.
- Building into the integrated framework existing social agencies that can have a positive effect on mental health.
- Reviewing and promoting what is currently working.

Framework Design

The design of the integrated framework is intended to bring together the knowledge, learning, and outcomes of all current initiatives, and others as they emerge. It will enable capacity building, learning and continuous improvement across the mental health system. The framework will address the areas where services overlap enabling specialised service provision to be effectively maintained.

¹² The Sainsbury Centre for Mental Health 2005, 'The Neglected Majority: Developing intermediate mental health care in primary care', 2005

Collaborative Group

Establishing a process for cross sector governance is generally supported as an important step to integrating the services and improving mental health outcomes both at an individual care level and for the population as a whole.

It is proposed that one central *Collaborative Group* is established, which will:

- i. Form the information and data hub for the district;
- ii. Assist the formulation of cross-sector operational relationships which enable effective consumer care; and
- iii. Encourage local change and service improvement to local access issues through the development and support of “*Local Innovation Groups*.”

Key roles and responsibilities will include:

- Enabling improved access for individuals and priority populations;
- Assisting the formulation of cross-sector operational relationships for effective consumer care and integration;
- Identifying and communicating district access needs with particular focus on the target populations;
- Being a resource for best practice and the central co-ordination interface to collect, producing and disseminating tools that provide the basis of continuous quality improvement;
- Facilitating shared learning, development and capacity building across the district, and providing the means through which innovations from local communities are communicated;
- Enabling and supporting innovations through the sector that seek to reduce health disparities and inequalities for priority populations;
- Providing service oversight and guidance to groups identifying as Local Improvement Groups (LIG);
- Supporting LIGs in measuring the impact of their activities through dissemination of appropriate data; and
- Being actively involved in developing district service improvements, for example development of sector wide referral protocols.

Local Innovation Groups

To recognise the district’s diverse communities and avoid imposing a “one-size-fits-all” solution to improve access for consumers the framework is designed to encourage the growth of local solutions to local access problems.

The key purpose of these groups will be to deliver action orientated solutions to access problems for their communities with a particular focus on target populations. The membership of these groups will vary, and will be dependent on the make-up of their community and need. They will, however, be expected to demonstrate involvement of the target populations from the community they serve and representation from relevant agencies.

The roles and responsibilities of LIGs will vary according to their individual structure and population need but will include:

- Improving access for people who need services, with a focus on intermediate need, unmet need and currently disadvantaged populations;
- Facilitating the development of local solutions for local access needs;
- Providing local leadership;
- Agreeing on local priorities for the target populations;
- Building on existing relationships and ensuring effective communication through cross sector relationships;
- Using a continuous quality improvement approach at a local level through the PDSA service improvement cycle framework;
- Providing linkages with community development initiatives; and
- Having strong linkages with the Collaborative Group on issues and solutions for wider learning on access and service delivery solutions and tools, resources and data.

Management Structure and Accountability

The Collaborative Group will need the C&C DHB Board endorsement to operate within the framework.

It will have a structured interface and direct relationship with the TJF Leadership Group to enable alignment of service developments, funding and workforce development.

It will work within existing structures of PHOs, C&C MHS and NGOs, and utilise what already works for enhancing consumer outcomes.

It will have clear terms of reference and transparent decision making processes.

A membership selection and induction process for the Collaborative Group will be established including the nomination of a Chair. Membership will be formed from a cross-section of the communities, and could include PHOs, NGOs, C&C MHS, Māori community, Pacific Island community, family/whanau, and consumers. An optimum number of members to enable the group's effectiveness will be ensured.

Collaborative Group meetings will be provided with administrative and co-ordination resources to ensure they are run effectively and that clear outcomes are achieved.

Initiatives to Support and Trial Aspects of the Framework

Link Worker

The TJF Leadership Group has agreed that the potential impact and feasibility of introducing a Link Worker into primary care should form part of the framework's implementation phase.

Overall there was a great deal of support by PHOs, C&C MHS, and NGOs for trialling the position, provided it was structured to address gaps in the sector and did not duplicate current roles like GP Liaison or intake workers.

Gaps and opportunities that PHOs, C&C MHS, and NGOs felt could be considered when designing the job description and trialling the position included:

- Addressing cultural issues that arise in primary care for Pacific people;

- Liaison between midwives, GPs and/or maternal mental health services;
- Support for primary care in managing alcohol and drug issues; and
- Clinical support to general practice which may include triage and advice

A literature review suggests the success of these types of roles is context dependent and a range of variables can impact on outcomes, all of which will be considered.¹³

Physical health needs within C&C MHS

Good physical health care is expected to improve recovery outcomes for mental health consumers and early steps towards developing a care pathway for primary care services and C&C MHS are underway.

There is growing awareness of the need for more systematic approaches to ensure the physical health needs of consumers are met. This includes co-ordinated interventions for the potential and the developed adverse effects of prescribed medications.

An initial study is underway to test information sharing processes between primary care services and C&C MHS. This is built on national guidelines, has been documented into a Plan Do Study Act service improvement framework and will be developed further as outcomes are evaluated. It has extremely strong support across the sector as a way to improve outcomes for people, and early indications are showing a positive impact.

This study has no specific funding attached to it, and goodwill is being relied on to test it within a PHO and C&C MHS. The study is currently involving a small sample size of 50 consumers. Cost barriers and access to existing funding schemes are being considered as part of the initial study findings.

Focus on Service Improvements to Reduce Disparities for Target Populations

Māori

Meetings of key stakeholders are being held to help find solutions to access issues for Māori. The formation of LIGs through the establishment of these relationships is anticipated.

Pacific peoples

Analysis of the findings within *Te Rau Hinengaro* will take place to inform TJF developments for Pacific peoples, and enable the Collaborative Group to filter information, data and tools to LIGs and wider services. Meetings of key stakeholders to identify solutions to access issues for Pacific people are ongoing.

Refugees and Migrants

Agreement has been reached to work with Wellington Refugees as Survivors (WRAS – a contracted NGO provider for C&C DHB) to build collaborative relationships with mental health services and support agencies, and enhance access for refugees.

Child and Youth

Service development and delivery options are being considered, and a working group from within the TJF Leadership Group are tasked with scoping the needs of this population to inform the overall TJF structure and service planning.

13 P Bower & B Sibbald BMJ 2000; 320:614-617. R Bing, Mental Health Review, 2004.

The TJF Child and Youth working group have confirmed that this integrated framework could apply to the target group through extending the range of professionals involved, and linking in with alternatives structures. Ultimately, the Collaborative Group could provide child and youth information, data, and tools to LIGs.

Further development in this area relies on C&C DHB Planning and Funding obtaining additional funding to meet Blueprint targets.

7. EXPECTED OUTCOMES

TJF is taking a whole system approach to the development and evaluation of outcomes through its Information, Co-ordination, Quality and Evaluation Workstream. A number of projects have been initiated to improve the overall collection and utilisation of information, which will highlight and improve access for consumers and enhance management decisions going forward. The outcomes of these wider TJF initiatives will significantly enhance the capabilities of the Collaborative Group.

An initial monitoring and reporting tool has been developed based on current information and baseline capabilities. This will guide and measure the effectiveness of the framework's implementation (refer to Appendix "A" of this report).

8. FISCAL IMPLICATIONS

Additional Blueprint funding from 07/08 has been provisionally allocated through C&C DHB Planning and Funding to fund the development of the following initiatives:

- Development of a Collaborative Group - \$35,000 per year ongoing
This money would contribute to securing the necessary quality improvement expertise and provide administrative and communication resource to support the functioning of the group and LIGs.
- Investigate the potential impact and feasibility of introducing a Link Worker in to primary care - \$90,000 per year ongoing

Early evaluation of these study outcomes will further inform the development of the integrated framework, and continuously improve the outcomes sought by these studies.

9. RISK MANAGEMENT

The attached risk register (refer Appendix "B" of this report) identifies current risks associated with the proposed framework and recommends a course of treatment for them.

Appendix A: Monitoring and Evaluation Reporting Framework

OUTCOMES	BASELINES	INDICATORS	TARGETS
Funding – Children and Youth Services			
Increase resourcing to child and youth services that are orientated to primary care and mental health services integration	Current Blueprint funding	Increase in funding	Meet Blueprint target
Primary Care Services - Information Collection Description			
<p>NHI level data for the Primary Mental Health funded Initiatives report the following data sets:</p> <ul style="list-style-type: none"> • age • gender • ethnicity • NZ deprivation quintiles <p>Many PHO IT systems may be able to reveal data for people accessing their services for mental health care outside of the funded initiatives. Work needs to be done with PHOs to establish these reports.</p>			
Improved access to primary care	<p>2006 and 2007 NHI level data for funded primary health care initiatives</p> <p>Source: PHOs</p> <p>Determine population access percentages using Census data</p>	Improvements on base line data	Further targets to be established jointly with stakeholders
Improved access to primary care particularly for Māori	<p>2006 and 2007 NHI level data for funded primary health care initiatives</p> <p>Ethnicity specific</p> <p>Source: PHOs</p>	Population percentage data show improvements in target populations access rates and inequalities in access rates are diminished	<p>Access to primary care services for target population is equal to or greater than that of the total population</p> <p>Further targets to be established jointly with stakeholders</p>
Improved access to primary care particularly for Pacific peoples	<p>Determine populations' access percentages using Census data</p>		
Improved access to primary care particularly for refugee populations	<p>2006 and 2007 NHI level data for funded primary health care initiatives</p> <p>Related to deprivation scores</p> <p>Source: PHOs</p> <p>Determine populations' access percentages using Census data</p>		
Improved access to primary care particularly for children, youth and infants	<p>2006 and 2007 NHI Level Data for Funded Primary health care initiatives</p> <p>Age specific</p> <p>Source: PHOs</p> <p>Determine populations' access percentages using Census data</p>	Improvements on base line data	Further targets to be established jointly with stakeholders

OUTCOMES	BASELINES	INDICATORS	TARGETS
<p>Secondary Care Services - Information Collection Description</p> <p>NHI Level Data for access to C&C DHB community services report the following data:</p> <ul style="list-style-type: none"> • age • gender • ethnicity • NZ deprivation quintiles <p>Service utilisation data for the refugee population may be less accessible as refugee status is not currently routinely collected. Waiting list data can be collated</p>			
Improved access to secondary care	<p>2006 and 2007 NHI level data to demonstrate access rates</p> <p>Source: C&C MHS</p> <p>Utilise census population projection data to calculate population percentages</p>	Improvements on base line data	Further targets to be established jointly with stakeholders
Improved access to secondary care particularly for Māori	2006 and 2007 NHI level data to demonstrate access rates	Population percentage data show improvements in target populations access rates and inequalities in access rates are diminished	Access to secondary care services is equal to or greater than that of the total population for target populations
Improved access to secondary care particularly for Pacific peoples	Ethnicity specific Source: C&C MHS		
Improved access to secondary care particularly for refugee populations	<p>Determine populations' access percentages using Census data</p> <p>Note: Refugee status is not yet routinely reported there data will be incomplete until this is available</p>		
Improved access to secondary care particularly for children, youth and infants	<p>2006 and 2007 NHI level data to demonstrate access rates</p> <p>Age specific</p> <p>Source: C&C MHS</p> <p>Determine populations' access percentages using Census data</p>	Improvements on base line data	Further targets to be established jointly with stakeholders
Improved and collaborative relationships between primary care and MHS	<p>KPI's to be developed for Community Mental health services that demonstrate and support liaison and support practices with Primary care providers</p> <p>Source: C&C MHS</p>	<p>Increased use of telephone advice</p> <p>Identified liaison relationships across services</p> <p>Increased occurrences of shared care</p>	Further targets to be established jointly with stakeholders

OUTCOMES	BASELINES	INDICATORS	TARGETS
Improved efficiency of referral process	Collate data for returned and declined referrals Source: C&C MHS Satisfaction surveys for primary care staff Source: Primary Care satisfaction surveys	Number of referrals returned to referrer Transparent process for triaging referrals Follow through on suggested actions for all declined referrals monitored Decreased dissatisfaction between services around referrals Agreed care protocols for referrals triaged to a waiting list	Further targets to be established jointly with stakeholders
Functional cross sector service improvement process	Collaborative Group established Identified Local Innovation groups PDSAs in action Source: Collaborative group and TJF PDSA register	Increased number of quality initiative supported through quality improvement framework Improved service delivery for target populations Shared referral tools numbers of tools developed	Further targets to be established jointly with stakeholders
District wide shared information	Collaborative group established Communication lines for information dissemination established	Satisfaction survey data show providers report increased level of information and interconnectedness Audit of information disseminated demonstrates key stakeholders are informed	Further targets to be established jointly with stakeholders
NGOs - Information Collection Description This area will be further developed through collection of data by the C&C DHB Service Co-ordination Centre, and the implementation of TJF NGO IT project.			

OUTCOMES	BASELINES	INDICATORS	TARGETS
Impact on Consumers			
Improved overall health status	<p>To be developed jointly with stakeholders including vocational and social inclusion targets, and may include examples described below:</p> <p>Qualitative evaluation through narratives and surveys on consumer satisfaction</p>	<p>Improved awareness of how to maintain mental health and wellbeing</p> <p>Number of consumers holding a relapse prevention plan</p> <p>Number of times consumer re-presents back into services</p>	Further targets to be established jointly with stakeholders
Improved Physical Health for those with enduring mental illness	<p>Audit of consumers at risk of poor physical health outcomes demonstrates baseline data:</p> <ul style="list-style-type: none"> • Physical Health Checks • Physical Health Follow up • Engagement between secondary; Primary health services and consumers 	<p>People with enduring mental illness have regular health checks</p> <p>People accessing secondary services are enrolled with a PHO</p> <p>Improved sharing of information between primary and secondary care</p> <p>Consumers engaged in their own physical health needs</p>	Further targets to be established jointly with stakeholders
Consumer centred services and improved consumer satisfaction	<p>Source: Consumer satisfaction surveys</p> <p>Source: Audit of Assessments</p>	<p>Continuity of care experienced by consumers</p> <p>Reduced repetitive assessments</p> <p>Consumers receive support and treatment</p> <p>Providers can demonstrate mechanisms are in place for communication and coordination between multiple services</p> <p>Consumers report</p> <ul style="list-style-type: none"> • increased satisfaction with services • feel well informed of options • active involvement with treatment and support packages 	Further targets to be established jointly with stakeholders

OUTCOMES	BASELINES	INDICATORS	TARGETS
Impact on carers and family/whanau			
Improved satisfaction for carers and family/whanau	Source: Satisfaction surveys	Carers and family/whanau Consumers report <ul style="list-style-type: none"> • increased satisfaction with services • feel well informed of options (when appropriate) • active involvement with treatment and support packages (when consumer agrees). 	Further targets to be established jointly with stakeholders
Impact on Staff			
Primary care staff	Source: Primary care satisfaction survey	Primary care better supported /resourced to deal with and identify MH presentations Increased percentages of Primary care staff report satisfaction with care offered to MH consumers	Further targets to be established jointly with stakeholders
Secondary care staff	Source: C&C DHB Staff Turnover rates Retention of staff in secondary services Satisfaction surveys	Staff feel able and supported to help providers and consumers in the primary sector Staff turnover rates are acceptable	Further targets to be established jointly with stakeholders

Appendix B: Risk Register

Risk Descriptions	Impact on organisation / population / patients	Current Controls/Planned Actions
<p>That there is lack of funding to invest and support the implementation of the framework.</p>	<p>Stakeholders perceive the small amount currently proposed for the trials are inadequate given there are long standing gaps in services meeting the access needs of the population.</p>	<ul style="list-style-type: none"> • TJF is committed to investing more in primary care through the reorganisation of care pathways. • Early evaluation of trials to inform funding prediction and needs related to the framework will be carried out. • Significant components of the framework are related to the development and enhancement of cross sector relationships, which does not require a substantial injection of funding but a willingness by professionals to engage and work together. • Extensive work is underway to understand the current configuration of mental health spend, identify capacity in the system, and re configure revenue streams as appropriate. • Changes from the framework will be paced in line with the above project dependencies, and the establishment of the collaborative group will take priority.
<p>That given the delivery of the framework is dependent on an ongoing review of resource reconfiguration across primary and secondary mental health services, the implementation phase could be unnecessarily prolonged.</p>	<p>There are high expectations for improved access into services for consumers</p>	<p>The Local Mental Health Services (LMHS) annual planning process has committed the sector to gaining a better understanding of complex service system flows and service dynamics so service duplication is avoided, resources can be reconfigured, and actual results are measured. The following initiatives are being progressed to inform resource reconfiguration:</p> <ul style="list-style-type: none"> • C&C MHS are collecting workload and capacity data. • An NGO collection and use of information project is in phase 2 of its development. • A whole systems service evaluation strategy and plan is in development. • Further work will be done in collaboration with the Primary Care Funding and Planning Team to review and create further capacity in Primary Care Teams. • A Senior Analyst has been contracted within LMHS to help consolidate the overall system picture.

Risk Descriptions	Impact on organisation / population / patients	Current Controls/Planned Actions
<p>That lack of buy-in by the sector on the benefits of the framework's design results in ineffective implementation.</p>	<p>The sector could disengage in the process, and the opportunity for collaborative flexible and accountable working is compromised.</p> <p>That consumer outcomes and improved access rates are not realised.</p>	<ul style="list-style-type: none"> • Gaining approval from C&C DHB Board will provide the necessary mandate to implement the framework, and embed the accountability structures. • The Workstream have been very active in meeting all key stakeholders who may be affected by the implications of the framework. • Stakeholder feedback has significantly influenced the shape of the framework, and existing structures within the sector have been considered in its design. • TJF Leadership Group has approved the framework. • Implementation will be incremental, action orientated and improvement focused through application of PDSA methodology. • The Stakeholder will be actively involved in the framework's implementation with volunteers for participation encouraged. • Results and achievements will be regularly communicated.
<p>That crucial operational cross sector relationships do not foster and enable integration benefits to be reached.</p>	<p>Stakeholder engagement has highlighted that some relationships need to be established and/or significantly improved.</p>	<ul style="list-style-type: none"> • TJF has created a growing stakeholder willingness for collaboration to system improvements, and improved consumer outcomes. • The proposed integrated framework expects improved relationships to naturally occur. • A project which has been initiated to enhance acute and crisis services will be based on developing the same relationships in line with several other TJF initiatives.
<p>That the extent of social problems is overlooked and clinical treatment for mental health is overly relied on.</p>	<p>There is a concern that the medical model will be too rigorously applied and social needs that contribute to mental health difficulties like housing, and employment will not be effectively considered.</p>	<ul style="list-style-type: none"> • The purpose of the framework is to integrate a whole system approach, which will enable a more holistic approach to care. • Evidenced based intervention logic form the basis of the framework. • Intersectoral relationships to provide for more social needs are in development.

Risk Descriptions	Impact on organisation / population / patients	Current Controls/Planned Actions
Fragmentation of services	System bottlenecks, and poor service experience and outcomes by consumer, and poor staff satisfaction.	<ul style="list-style-type: none"> • Articulated Vision to Board for sign off. • Whole system approach to development and evaluation. • There are close working relationships across workstreams, and significant engagement with key stakeholders in the sector • Strong communication and leadership is ongoing. • Standardised processes and procedures will be developed through the Collaborative Group enhancing integration.
Inability to develop and embed desired culture	Poor service experience and outcomes for consumers, and poor staff satisfaction	<ul style="list-style-type: none"> • Those involved in TJF Leadership Group and Workstreams are a catalyst for wide reaching change in attitudes and behaviour. • LMHS have strong buy in and leadership through Clinical Director, & Senior Management Team • A number of forums will be held in the sector to help influence change. • Workforce initiatives will be implemented. • Management information as it becomes available will be utilised to illustrate need, and access solutions.