
A review of a primary mental health service 10 years on

Sarah Taylor

Sarah Taylor is a social worker and a primary mental health clinician working with the South Canterbury Mental Health Brief Intervention Service for the past 10 years. Her thesis research, titled Mental Health Brief Intervention – does it work?, was completed in 2009 for a Master of Social Welfare, Otago University.

Abstract

The past 10 years have seen a shift in mental health care in Aotearoa New Zealand towards early intervention and treatment at a primary care level providing a range of levels of mental health interventions in a variety of settings. Previously specialist mental health care had been the responsibility of community mental health teams and secondary service inpatient care which provided care for people with severe mental illness (3% of the population).

In this article, I look at the move towards the provision of primary mental health care. I describe and review the Mental Health Brief Intervention Service in South Canterbury, one of the earliest primary mental health services initiated by the South Canterbury District Health Board, which started in 2005. I present research findings from my Master's thesis *Mental Health Brief Intervention – does it work? An evaluation of practice*, and discuss how the Mental Health Brief Intervention Service has made a positive change for general practitioners, the client, the interface with other services including secondary mental health services and service delivery in general. Forms of consumer feedback are discussed along with the changes in the service over the last 10 years. It is written by myself, a social worker, who played an integral part in initiating and establishing the service and continues to have an active role as a clinician within the Mental Health Brief Intervention Service. This article is written to provide social workers with an overview of the establishment of the Mental Health Brief Intervention Service and the impact on service delivery. The role of the social worker is discussed as is the role of other health professionals within the team.

Introduction

Mental disorders make up five of the leading causes of disability worldwide (World Health Organisation, 2001). *Te Rau Hinengaro, The New Zealand Mental Health Survey* (Oakley-Browne, Wells, Scott, & Kate, 2006) provided the first comprehensive data on the extent of mental health issues in the country. Key findings from this study showed that mental disorder is common in New Zealand and that 47% of the population is predicted to the criteria for a disorder at some time in their life. These rates are higher for people with Māori (50.7%) and Pacific Island origin (46.5%). Furthermore, 20% of the New Zealand population had

reported having a disorder in the past 12 months, again higher for Māori (29.5%) and Pacific People (25%).

A move towards the provision of primary mental health services has seen the emergence of new services around the country in the past decade. Policies driving this change were The Primary Health Care Strategy (Ministry of Health, 2001) and the Second Mental Health and Addiction Plan: Te Tahuhu (Ministry of Health, 2005). The creation of Primary Health Organisations has provided a vehicle for the delivery of mental health services in primary care for those with mild to moderate mental health issues and increasingly for those with more severe mental health issues.

Primary Mental Health Services (PMHS) around New Zealand are provided through a range of service provision models. These include extended general practitioner (GP) consultations, practice nurse (PN) interventions, use of self-help websites, packages of care (in which specific services such as a psychologist may be contracted for a number of sessions) and provision of mental health brief intervention within general practice or by contracted counsellors.

Primary mental health care can be defined as the assessment and treatment of people with mental health or addiction issues within a primary care setting. It encompasses promotion, prevention, early intervention and ongoing treatment for mental health and addiction issues (www.primarymentalhealth.org.nz). An integral part of primary care are brief time limited interventions assisting people to make change. In a primary care setting these may include assessment, psycho education, talking therapies, skills training, goal setting, lifestyle changes, exercises, guided self help, referral to more appropriate services or resources and advocacy (NZ Guidelines Group, 2008).

Primary care is the first point of contact for the majority of people seeking treatment for mental health or addiction issues. However, barriers to accessing mental health care have been identified as including cost, accessibility to services and waiting times (Bathgate, Curtis, & Romans, 2001). The provision of mental health services in primary care for people with mild to moderate mental illness enables greater access to mental health support.

Many of the depressive disorders that GPs treat are below or just reach the minimum diagnosis for clinical depression. Depressive symptoms are seen more in terms of fluctuating mood disturbances in response to life situations, often with a background of chronic difficulties, physical illness, insecure relationships and deprivation (Best Practice NZ, 2004). Treatment provided within primary care focuses around the specific needs of the client rather than formalised care and a review of the literature indicates that the majority of improvement for clients takes place in the early stages of treatment (Miller & Rollnick, 2002) which fits well with brief intervention. There is good evidence to suggest that therapist factors such as empathy, skill and engagement are more important than the model of therapy used (Thomas, 2007). However, talking therapies such as cognitive behaviour therapy, interpersonal psychotherapy, problem solving and motivational interviewing were identified as useful in primary care by the NZ Guidelines Group (2008). Clinicians working within the Mental Health Brief Intervention Service (MHBIS) draw on the use of interpersonal therapeutic communication skills and different models of therapy as stated above, to ensure effective interventions with and for the clients.

The formation of the Mental Health Brief Intervention Service

In 2003, I was employed by the SCDHB to work alongside a group consisting of GPs, PNs, and managers of secondary mental health services and the SCDHB, South Link Health and a cultural adviser to draw up service specifications for a service to provide mental health care for people with mild to moderate mental illness. The move towards the formation of the MHBIS was in response to finding a way to manage mental health issues that did not reach the threshold criteria for secondary services, and for people needing more input than could be offered by a GP consultation. It was anticipated that the service would free up the secondary service triaging of referrals that did not meet their criteria and provide a resource for general practices.

The service provision was contracted to South Link Health (SLH) (a not-for-profit Independent Practitioner Association with charitable status). The primary role of SLH is to support general practice through the South Island with the provision and development of clinical programmes, support, information technology, and administrative and financial services to the primary care sector. Membership of SLH consists of GPs, PNs, practice managers and administrators representing all areas of the South Island (www.southlink.co.nz).

When the MHBIS started accepting clients in 2005, little was known about the impact of such a service on general practices and clients, how this might affect the interface of primary and secondary care, which models of practice would best be suited to working in primary care and how to best measure the outcome of such a service. Similar models of primary care are now in place throughout the South Island and 10 years on I am now reflecting on the impact of the MHBIS and service delivery in PMHS.

The Mental Health Brief Intervention Service

The MHBIS in South Canterbury provides primary mental health care for people over the age of 18 with mild to moderate mental health issues. These people are referred through their general practice or secondary mental health services. The MHBIS provides up to four free sessions each year. Clients are seen within the general practice where possible. People referred are contacted within 1-2 days of the referral and generally seen within two weeks. A database for notes was specifically designed by SLH and the MHBIS clinicians. The system allows for electronic recording and sending of letters and notes to GPs and the easy retrieval of data and statistics. The area covered by the service is both town and rural based including Timaru, Twizel, Fairlie, Geraldine, Temuka and Waimate. In total there are 26 general practices in this area.

The MHBIS workforce has grown from the initial 1.8 full time equivalent (FTE) positions to 4.4 FTEs. This staffing level for the population base of around 55,000 works well and allows for leave cover and the ebb and flow of workload. The team is multidisciplinary at present comprising of two registered nurses, two social workers and an occupational therapist. Each clinician is assigned to specific practices and works with a range of clients. Weekly MHBIS clinician meetings allow for review of clients and input from different disciplines. Clinician roles are generic in the sense that we all do the same work and bring to this our individual disciplines and skills.

Social workers bring to the team skills in working with complex family and relationship issues and psychosocial issues which are often major factors affecting stress presenting in a primary setting. Social workers contribute knowledge of wider systems and community resources gained from working across non-health care sectors such as care and protection, family services, disability and education. This knowledge and networks assist in navigating pathways to access services for clients. There are few general practices nationally that employ social workers in specific social work roles as funding presents a barrier. Social workers working in PMHSs are in a strong position to raise the profile of social workers in primary care and become a resource for practices to provide information about community agencies when practices are faced with complex psychosocial issues affecting a client's health. The ability for social workers to be registered enables social workers to be accepted as registered health professionals and as such allows greater access to roles in primary and secondary services. Review meetings are an opportunity to discuss more complex cases and draw on the depth of experience of a multi-disciplinary team.

Models of practice that sit well with social work values are solution focused therapy and motivational interviewing. Clients are in control of setting their own agenda and seen as having the solutions to overcoming difficulties and are supported in finding ways towards recovery that work for them. Membership of ANZASW and the Timaru social workers journal forum provides an avenue to feed back social issues that arise in general practice to work towards social change as well as the ability to maintain strong links with social workers.

Registered nurses bring a wide range of experience in working with more severe mental illness and addiction along with experience of inpatient, community and forensic settings. Nurses contribute a depth of knowledge around use of medication, physical illness and the complexities of co-morbid conditions.

Occupational therapy contributes a range of experience gained from individual and group work in a secondary and community setting. Occupational therapy contributes resources around purposeful occupation, job-related situations and stress management.

The MHBIS has links with the Māori mental health team at the SMHS and Arowhenua Whanau Services (an NGO providing a range of mental and physical health services). There is the ability to talk through cultural issues and also for referring clients for culturally appropriate services. Other agencies providing cultural support that we can work with are the Aoraki Migrant Centre and Fale Pasifika (Pacific People working for Pacific People).

Community agencies are often invited to meetings to build networks and understanding of different services. In addition to this MHBIS members attend community network meetings in mental health and disability sectors. The social workers attend monthly meetings with other social workers from a range of agencies.

Does it work? Providing the evidence

In 2008, I completed a Master's thesis research project to look at the effectiveness of the service and consider the question, 'does it work?' (Taylor, 2009). The research involved five focus groups and questionnaires for GPs (N39), PNs (N52) and MHBIS clinicians (N5). Research methods were qualitative and quantitative. The research included statistical data

from the client database, patient outcomes as measured on the Kessler 10 (NZ Guidelines Group, 2008) and feedback from client surveys. Ethics approval was granted by the South Link Ethics Committee, the Upper South Regional Health and Disability Committee and the Ngai Tahu Ethics Committee.

The outcome of this research was published by Taylor & Briggs in the *Journal of Family Practice* (2012, 61(2)). The focus was on the impact of the service for general practices and the SMHS. This article, however, differs in that it is looking at the impact that the MHBIS has made on clients. I am also reflecting on the changes since completing the research.

What difference does the Mental Health Brief Intervention Service make for clients?

The evidence presenting from all those interviewed and surveyed indicated that the MHBIS was making a difference to both the clients and to the general practices. It indicated that MHBIS meets a need for clients who do not meet the threshold for Specialist Mental Health Services (SMHS), and that the service is easily accessed through the GP, with people being seen quickly without the barrier of cost. Clients were perceived by GPs and PNs to be more receptive to being seen within the practice and as more likely to attend sessions than if they were referred to other agencies or a counsellor in the community (Taylor & Briggs, 2012).

Many of the people referred have issues arising from life circumstances around relationships, work or health. The sessions provide a confidential space to talk through issues and to look at how to move forward and support lifestyle changes. The majority of clients made significant recovery over four sessions. Sessions are spaced out for greater effectiveness and to support change over time (Taylor, 2009). Results indicated that clients needed less time off work as a result of a referral to MHBIS. Clients were seen by GPs as less likely to represent if they had been referred to MHBIS (Taylor & Briggs, 2012).

The Kessler 10 (Kessler, Andrews, Colpe, & Hiripi, 2002) scores of a sample group of 100 clients were taken between the period of January 2007 to June 2008. The Kessler 10 was completed at the initial assessment and again on discharge. Of these scores 57% of the people attending MHBIS scored 30 or more at assessment, which is a score that is indicative of a serious mental disorder or serious psychological distress. Whereas, on discharge only 3% of people scored over 30. The results indicate that a significant change had occurred for clients. Scores at the initial assessment ranged between 15 and 48 with a mean score of 30 (SD7). The mean discharge score was 20 (SD6) indicating a significant improvement in mental state ($p < 0.001$) occurring between intake and discharge (Taylor, 2009).

The research indicated that GPs referred fewer patients to SMHS than they had prior to the establishment of MHBIS (Taylor & Briggs, 2012). Statistics in the six months January to June 2008 showed that only 4% of clients seen were referred to SMHS (Ibid). Over the past 10 years there have been changes to how people access the SMHS and there is now a single point of entry where people can self refer. People are then triaged and referred to appropriate community services including MHBIS. The relationship with SMHS allows an easier flow for clients between the services that can best meet their needs.

How are outcomes measured?

Outcomes are measured in a number of ways. Feedback from consumers and from general practices has been sought on a regular basis, with consistent outcomes over the past 10 years. Feedback surveys are sent to a randomly selected group of 33% of all discharged clients every month (20-35 surveys sent per month) with an overall return rate of 24%. Of 50 surveys returned in 2014 and 2015, 45 clients reported that input from the MHBIS had made a positive difference to how they felt. Twenty six clients rated themselves as improved, 21 as improving, one as no change, one as worse and finally one made no answer. Respondents were asked to identify using a tick list the ways MHBIS had assisted them. Forty five indicated that they were listened to, 34 were assisted with helping strategies, 33 were helped to gain perspective, 33 were encouraged, 32 were helped to understand what was happening to them, 25 were provided with information, 19 were assisted with goal setting and seven were referred to another agency.

The Kessler 10 (Kessler, et al 2002) was initially used with people on entry and discharge from the service. It is significant in that it measures the level of distress for people. Various other rating scales have been used as appropriate such as the Edinburgh Post Natal Depression Scale (www.blackdoginstitute.org.au/depression/inpregnancy/selftest.cfm) and the Geriatric Depression Scale (www.stanford.edu/~yesavage/GDS.html) While the Kessler 10 and these other clinical scales give an indication of depression and anxiety they do not capture the overall level of functioning of clients in the various spheres of their lives. Hence why it was deemed appropriate to acknowledge and act on this. In 2014, the MHBIS started to use a feedback informed treatment (FIT) approach (Miller, 2012) to measure outcomes and improve service delivery. After an initial trial this feedback method is now being used with clients.

FIT is a pantheoretical approach for evaluating and improving the quality and effectiveness of behavioural services (Ibid). This involves routinely soliciting feedback from clients regarding the therapeutic alliance and the outcome of care. The information can assist in providing treatment that works well for the client. The measurements used are the Outcome Rating Scale which moves away from a focus on illness symptoms to looking at a wider view of a person's life. Clients rate themselves on a scale in the areas of: individual (personal well-being), interpersonal (family, close relationships), social work, school, friendships) and overall wellbeing (general sense of wellbeing). The Session Rating Scale measures the relationship between the clinician and the client and the work within the sessions. This approach to measure change fits well with a social work perspective and is used by a wide range of social agencies worldwide. FIT was introduced to the service by the social workers, and the team and clients in general feel that this works well for them and the service.

Evidence from research using FIT indicates that this method of gaining feedback is reliable. Routine outcome monitoring and feedback is shown to increase clinically significant change, decrease dropout rates and decrease deterioration for clients (Miller, 2012).

What has changed?

The MHBIS is now an integral part of primary health care in South Canterbury. Referrals are made by all the GPs, the PNs and the SMHS. There is a closer relationship with SMHS

and clients are more easily referred to MHBIS. Information technology has improved the ease of referring and reporting back to GPs. Regular feedback via surveys and more recently the introduction of feedback informed treatment enable clinicians to be responsive to client feedback.

While MHBIS initially excluded referrals solely for alcohol or drug issues, co-morbid conditions are now being seen. Improved communication with community alcohol and drug services allows ease of referral if required.

Clinicians are able to add a further two sessions to treatment if needed where this is seen as making a difference to outcome. Keeping the service expectation of four sessions allows for people to be seen sooner and eliminates the need for a waiting list. Once referred to MHBIS people can access the four sessions as they are needed during the year. This flexibility gives people more control over when they are seen and the ability to have continuity of care.

The SCDHB has initiated a number of other PMHSs which together with the MHBIS provides services for a range of people. The Youth Brief Intervention Service covers ages 12-18 and Youth Alcohol and Drug Service up to age 20. These services are run through Adventure Development (a non-government-organisation providing services for young people). A Post Natal Adjustment Programme offered through Plunket provides support for mothers and families. Arowhenua Whanau Services (a Māori service provider) offers mental health services for clients with mild to moderate mental health illnesses from age 12, with no limit on the number of sessions. The MHBIS works alongside all of these services. As a group of primary mental health providers we meet four times a year to keep updated on service developments and maintain relationships. Clients are often referred between services and Māori clients have a choice of providers. The MHBIS is able to facilitate referrals to other services when longer-term or specialist input is required.

Conclusion

The past decade has seen the growth of primary mental health services throughout the country. The MHBIS is one of many services that are making an impact through providing early brief intervention to clients with mild to moderate mental health issues. Social workers have played a major part in the development and implementation of MHBIS. Social workers form part of a multidisciplinary approach supporting clients in a service which is easily accessed and where they are seen in a timely manner. Social workers are in a good position to contribute to primary mental health services and offer a broad range of knowledge and skills so as to meet the needs of this client group.

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