SYNERGIA

WDHB FIT FOR THE FUTURE: EVALUATION OF OUR HEALTH IN MIND BUSINESS CASE ONE

Report for Ministry of Health

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1. EXECUTIVE SUMMARY

In the 2017/18 financial year the Ministry of Health put out a request for proposals to build on existing initiatives and support the development of an evidence base for interventions targeting people with moderate mental health needs. Auckland and Waitemata District Health Boards (ADHB and WDHB) with its Primary Health Organisation and Non-Government Organisation partners, responded successfully to the FftF proposal. In September 2017, Synergia was commissioned to evaluate the interventions supported through the FftF funding in ADHB and WDHB, following a competitive tender process.

This report presents the findings from the evaluation of the interventions supported through the Fit for the Future (FftF) funding primarily allocated in the WDHB region. This was used to evaluate the activities in Business Case One of the DHB's Our Health in Mind Strategy. Business Case One was designed in response to requests from general practice to improve the interface between primary and secondary care and improve capability and supports available to general practice. This involved:

- **Enhanced specialist support** in the form of consult liaison and direct telephone access
- Additional funding for **enhanced primary mental health initiatives**, including enhancing existing navigation resources, additional Hearts & Minds group packages, complex packages of care for young people through *Health*WEST, Melon eTherapy platform from Comprehensive Care, and funding towards a Health Improvement Practitioner and Health Coach at two ProCare practices.
- Introduction of **Awhi Ora Supporting Wellbeing** to 10 NGOs in WDHB, using a combination of additional and reconfigured funded hours.

Evaluation approach: The evaluation adopted a mixed methods design, drawing on service and outcome data, key stakeholder interviews, client feedback surveys and interviews, and a review of existing data and documentation relating to existing primary mental health interventions.

1.1 How much was done?

Enhanced specialist support has:

- Reached GPs across the WDHB region through direct telephone advice. This advice has provided timely access to secondary service information not available to GPs, supported GPs to navigate referrals and links to other services, and contributed to timely support for people with mental health needs.
- Provided on-site support at four GP practices to build capability of general practice and in some cases, direct support to patients.

Enhanced primary mental health initiatives:

- Navigation resources have provided support to health professionals and people across the WDHB region through the physical, online and app versions of the directory and the health navigator role. Requests were primarily by adult NZ European females for information related to health, community information and resources, migrant and refugee related information, mental health, and parenting.
- Hearts & Minds group programmes supported increased reach by supporting 570 people from the WDHB region through 56 groups. These were most likely to be

attended by NZ European females between 40 and 64 years; 34% of all groups related to depression and/or anxiety.
- *Health*WEST complex packages of care provided additional support to 404 young people. These packages reached young people with a high level of need, and a large proportion of Māori and NZ European people. Completion rates were high; only 6% of young people left part way through the package.
- Melon increased access options for people who were unable or unwilling to attend face-to-face group therapy. A total of 45 people were referred and 30 people completed all the modules (nine were still active in the programme).
- Across the two ProCare practices, 402 people had been referred to the HIPs and 107 to the Health Coaches. Engagement rates were high with 95% of HIP referrals and 90% of Health Coach referrals resulting in an attended appointment. HIP and Health Coaches supported access for Pacifica, Māori, Asian and youth.

Awhi Ora Supporting Wellbeing has:

- Reached a total of 136 people who accessed services and supports through Awhi Ora in the WDHB region. Around eight in 10 people referred to Awhi ora attended an appointment/meeting. NGOs delivering Awhi Ora gathered outcome data for 46% of people introduced to the service.

1.2 How well was it done?

This implementation of Business Case One was supported by a sector wide Governance Group. This group meet regularly during the earlier stages of the Business Case. The group however, was very large and often had different people attending. Feedback on the groups suggests that its decision-making capacity dwindled overtime. This group is currently being reviewed to ensure that it is fit for purpose and offers value for attendees. Aspects of implementation that supported success were:

Enhanced specialist support:

- Timely access to specialist support for GPs when the specialist has capacity to prioritise calls.
- Ability to reach across the broad geographical area of WDHB; supporting reach and efficiency.
- Consistency of psychiatrist providing support to develop relationships, trust and capability building.

Enhanced primary mental health initiatives:

- Providing people with a range of different support options supported reach and engagement by providing flexible and responsive options.
- Facilitating access to immediate supports through primary care via the HIP and Health Coach.

Awhi Ora Supporting Wellbeing

- The previous experience of NGOs in implementing Awhi Ora in ADHB strengthened the roll out. However, engagement with primary care was a challenge and additional project management was required to support roll out.
- The community networks and connections of the Awhi Ora support moved beyond general practice to a broad range of services and supports which are important for addressing the social and economic determinants of mental health.

1.3 Is anyone better off?

The evaluation was designed to identify the benefits for people accessing services and supports, as well as benefits for people providing or supporting access to these supports and the broader system. The evidence from the evaluation is used here to identify the contribution of the different initiatives to these key outcome areas:

Benefits for people accessing services and supports

- Enhanced primary mental health initiatives supported improvements in access and improvements in mental health and wellbeing.
- There is some evidence that access to specialists' supports more timely provision of care to individuals, however, there is insufficient service data to directly explore this link.

Benefits for people providing services and supports

- Increases in GP confidence and capability have been supported by enhanced specialist support provided by direct phone access and consult liaison models. There is also emerging evidence of the role of HIPs, Health Coaches and Awhi Ora in supporting the confidence and capacity of GPs to *"have the conversation"* about mental health.
- There is good evidence on the value of navigation resources for clinicians. A range of different resources are being used. Their value is maximised when they are informed by high quality local knowledge.

System improvement outcomes

- The enhanced specialist support is improving the interface between primary and secondary care including efficiencies in the exchange of information and supporting the management of people in primary care.

1.4 What does this mean for the missing middle?

The range of interventions making up Business Case One have provided an important and timely insight into the value of reaching the missing middle through:

- Strengthening the interface between primary and secondary care, including the timely sharing of skills and information to support primary care-based decision-making and responses for these patients.
- Building the capability of primary care to support people with mental health needs through direct support, navigation resources and links to a broader range of community support services.
- Providing people with choice and support when navigating the options available to them.
- Providing services and supports that respond to the psychological, social and economic determinants of ill health and wellbeing without barriers to entry through Awhi Ora.

1.5 What's next for Fit for the Future?

To support primary mental health care in being fit for the future, the following recommendations are made:

- Further strengthen the interface between primary and secondary care through promoting the direct telephone access and leveraging off this success. Consistent support needs to be available to GPs, a high quality localised response could be supported through engaging with local primary care specialists. Other opportunities for improving information sharing between secondary and primary care should also be considered.
- Increase the capacity and capability of primary care through increasing clinician's awareness of the options available to them. This could be achieved through promoting the navigation resource and the specific options, such as Awhi Ora.
- Increase the range of options available for the WDHB population through increasing connections to Awhi Ora. This could be used to expand the range of options for young people and other key target groups.
- Reaching key target groups will require a range of options. The immediate access to support facilitated through the HIP and Health Coach roles, and the broader support and connections of Awhi Ora have been identified as important here. Further evidence for this is provided in the ADHB FftF evaluation report.

1.5.1 Considerations for sustainability and expansion

Considerations for the sustainability and expansion of the initiatives implemented through Business Case One relate to capacity and funding for the sector to respond to people with mental health needs in primary care.

The level of need for mental health services and supports is growing, particularly for key target groups of Māori, Pacifica, Asian and youth. Delivering within the current capacity is challenging and some organisations are contributing their own investment and delivering more than they are contracted for. While existing services and supports can be increased, there is also an opportunity to broaden the range of options and access points for people. This has been demonstrated by the success of the enhanced integrated practice teams in the WDHB region. The brief support available through HIPs, Health Coaches and Awhi Ora provides the opportunity to reach a broader range of people. While support may be less intensive, this provides the opportunity to free up more intensive services and supports for those with greater need. This was demonstrated by the decrease in the ProCare Psychological Service waiting list at practices with HIPs and Health Coaches.

The primary and secondary care interface is an important element of Business Case One. This was identified as an area for improvement in the ADHB evaluation, and the success of the specialist support in WDHB could contribute to address this. Sustainability of this support must be considered. The psychiatrist(s) providing support must be given the time to respond to these calls. When considering expansion of the service, the option of local primary care specialists to increase capacity while maintaining localised support would support this.

2. INTRODUCTION

In the 2017/18 financial year the Ministry of Health put out a request for proposals for existing initiatives designed to support people with moderate mental health needs. This funding sought to build on existing initiatives to support the development of an evidence base. This evidence base should guide decision making and investment to support the sector in becoming 'Fit for the Future' (FftF), as indicated by the title of the tender.

Auckland and Waitemata District Health Boards (ADHB and WDHB) and their partners successfully responded to this tender. Each DHB worked with its local Primary Healthcare Organisations (PHOs) and Non-Governmental Organisations (NGOs) to respond to the requirements of the Ministry, alongside support from Specialist Mental Health Services.

The DHBs and their partners submitted an application that built on existing work, including:

- Awhi Ora Supporting Wellbeing (ADHB and NGOs)
- The ProCare Stepped Care Model
- The East Tamaki Healthcare Health Coach model
- The Whakaaro Hia to Tatou Ora, Our Health in Mind Strategy (WDHB).

The FftF funding provided an opportunity to establish and evaluate enhanced integrated practice teams in practices across ADHB and WDHB. This included an expansion of Awhi Ora Supporting Wellbeing in ADHB, and its roll out in WDHB. WDHB also used the funding to support Business Case One of the Our Health in Mind Strategy.

In September 2017, Synergia was commissioned to evaluate the interventions supported through the FftF funding in ADHB and WDHB, following a competitive tender process. This report presents the findings from the evaluation of the interventions supported through the Fit for the Future (FftF) funding primarily allocated in the WDHB region. The DHBs however, worked together to support this work and some of the interventions were implemented in both districts. Specifically, Awhi Ora Supporting Wellbeing and the Health Improvement Practitioner (HIP) and Health Coach role were delivered across both DHBs.

In WDHB, Awhi Ora was just starting to be rolled out with ten NGOs in the WDHB region and the HIP and Health Coach roles were integrated into two practices. To support a more comprehensive evidence base, the findings from the WDHB region are presented in the ADHB FftF evaluation report, with specific WDHB considerations noted in this report.

The evaluation adopted a mixed methods design, drawing on service and outcome data, key stakeholder interviews, client feedback surveys gathered by the services themselves, and an online survey targeting general practice. Integrating insights across these data sources enabled the evaluation to provide robust feedback on the delivery and benefits of Business Case One from the Our Health in Mind Strategy.

2.1 Structure of the report

This introduction is followed by an overview of the FftF funding and Business Case One of the Our Health in Mind Strategy. Following this, a summary of the evaluation approach and methods is presented. The report then focuses on the key elements of Business Case

One: Specialist Support, Navigation Resources and additional funding for enhanced Primary Mental Health Initiatives. The results-based accountability framework is used to guide the results section through addressing the questions of how much? How well? And is anyone better off? The report also considers ideas for improvements and concludes with key considerations and recommendations.

3. THE FIT FOR THE FUTURE INITIATIVE

FftF has provided an opportunity for WDHB to build on the existing ideas and interventions from Business Case One of the Our Health in Mind Strategy. The additional funding has also provided an opportunity to analyse and integrate the data collected by the DHB, PHOs, NGOs and youth specific services.

This work builds on the initiatives and interventions of those partners and has enabled additional delivery of some and supported the early development of others. This provided a valuable opportunity to further develop the evidence for interventions designed to support people with moderate mental health needs.

People with moderate mental health needs are those who are unable to self-manage yet don't meet the criteria for specialist mental health services. Often referred to as 'the missing middle', these people have thoughts, feelings or act in ways that are detrimental to their health and wellbeing. This cohort is currently poorly served by a primary care sector that lacks capacity and capability to address the volume and complexity of biopsychosocial needs. This position is unsustainable, hence the need to get 'fit for the future'.

3.1 Whakaaro Hia to Tatou Ora, Our Health in Mind

The purpose of the Our Health in Mind Strategy is to:

- Outline a direction of travel towards a whole-of-systems approach to improving health outcomes in the Waitemata health district
- Provide evidence about why this direction is critical
- Propose an action plan to guide investment
- Respond to the growing burden of disease in mental health and addictions.

This strategy was developed for several reasons, including:

- Making a more-substantive shift towards the objectives of Blueprint II and Rising to the Challenge
- Responding to current and future needs of service-users and their family/whanau
- Responding to providers, in particular GPs', feedback
- Meeting DHB imperatives – Dr Dale Bramley, Chief Executive Officer, initiated a programme of work in September 2015 to develop a five-year action plan for population and primary mental health and addiction.

Business Case One of the strategy was also informed from feedback from GPs noting:

- Limitation of availability of treatment programmes
- Difficulty seeking better support from specialist services (access to advice and access to services)
- Difficulties knowing what's available and how to access it, including from NGOs and broader community
- Building confidence and skill in meeting rising demands.

This informed the development and implementation of specific interventions along with additional funding for enhanced Primary Mental Health Initiatives (Figure 1). The

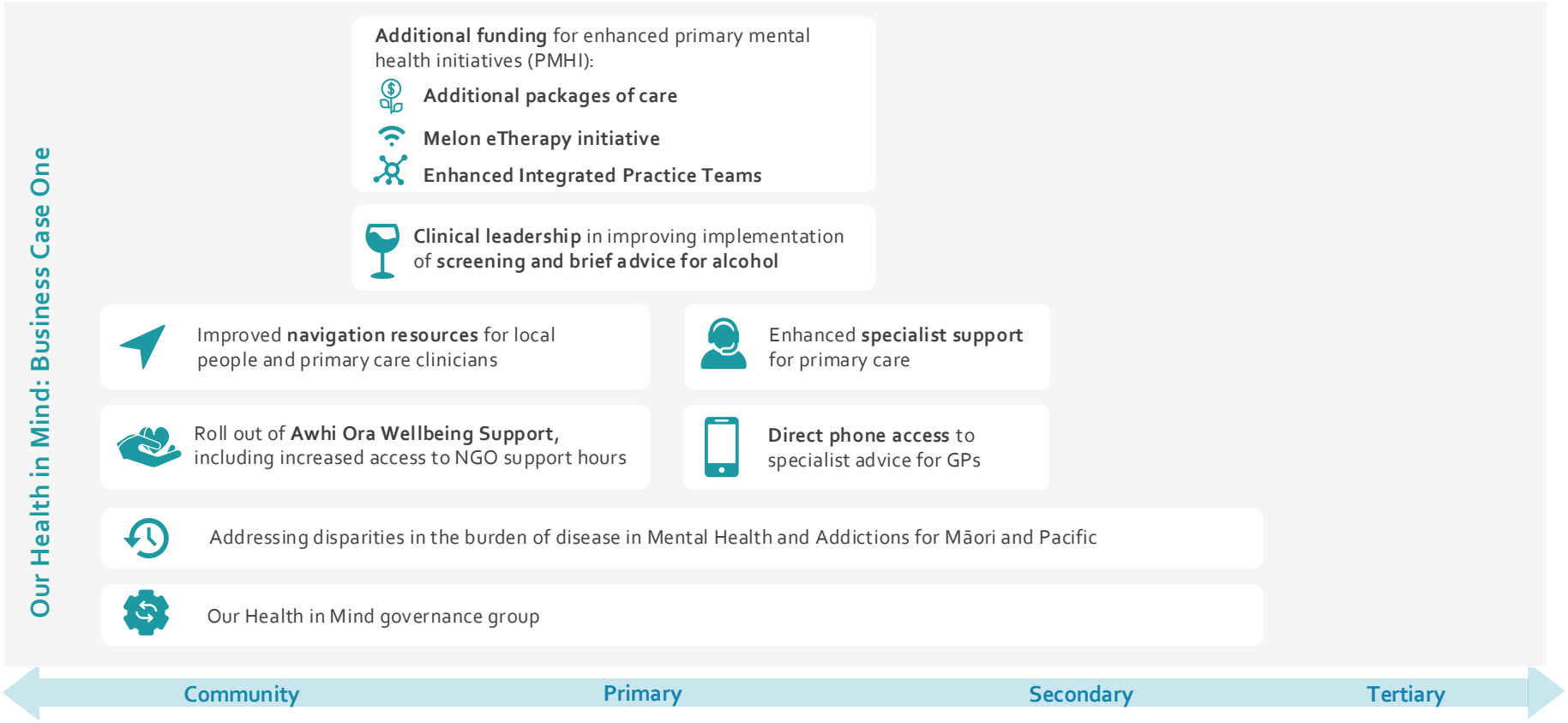
development and implementation of the strategy was also informed by the Our Health in Mind Governance Group. This includes representation from primary, secondary and community mental health experts. This group provided guidance and oversight of the Business Case during its initial implementation.

More specifically, Business Case One included:

- **Enhanced specialist support.** This was through the integration of a Psychiatrists at four practices in WDHB and through the support of a Community Psychiatrist available through Direct Telephone Access across the region. This was designed to improve the interface between primary and secondary care and build the capability of primary care to support people with mental health needs.
- **Navigation resources.** These were targeted to primary care clinicians and people seeking support to navigate services and supports for people. This was supported by an online directory, an App and direct contact with a health navigator.
- **Awhi Ora Supporting Wellbeing.** This was informed by the work happening in ADHB. Awhi Ora provides access to community support to people experiencing life challenges or stress. To support this, Support Workers engage with general practice teams to broaden the range of mental health expertise, psychosocial and economic supports available to people in primary care. Ten NGOs that provide mental health community support hours provide Awhi Ora support, funded through reconfigured contract hour plus additional funding to four of the NGOs.
- **Additional funding for enhanced Primary Mental Health Initiatives.** This included:
    - Hearts and Minds **Group Packages**. Funding for an additional 12 groups for the year.
    - **Melon eTherapy platform** to access psychological support services (Comprehensive Care).
    - Funding for **complex packages of care for young people** supported by HealthWEST.
    - Funding towards a **HIP and Health Coach** at two ProCare practices.
- **Our Health in Mind Governance Group.** This group involved representatives with expertise from across the mental health sector, including primary care. It was designed to provide governance and oversight to the implementation of Business Case One.

As highlighted in the diagram below, the Business Case also involved clinical leadership for improving the implementation and screening of brief advice for alcohol, addressing disparities in the burden of disease in mental health and addictions for Māori and Pacifica. These areas of intervention are not included in the evaluation, as it took longer than anticipated to employ someone to support clinical leadership and the focus on addressing disparities resulted in a research fellow and associated paper for the DHB.

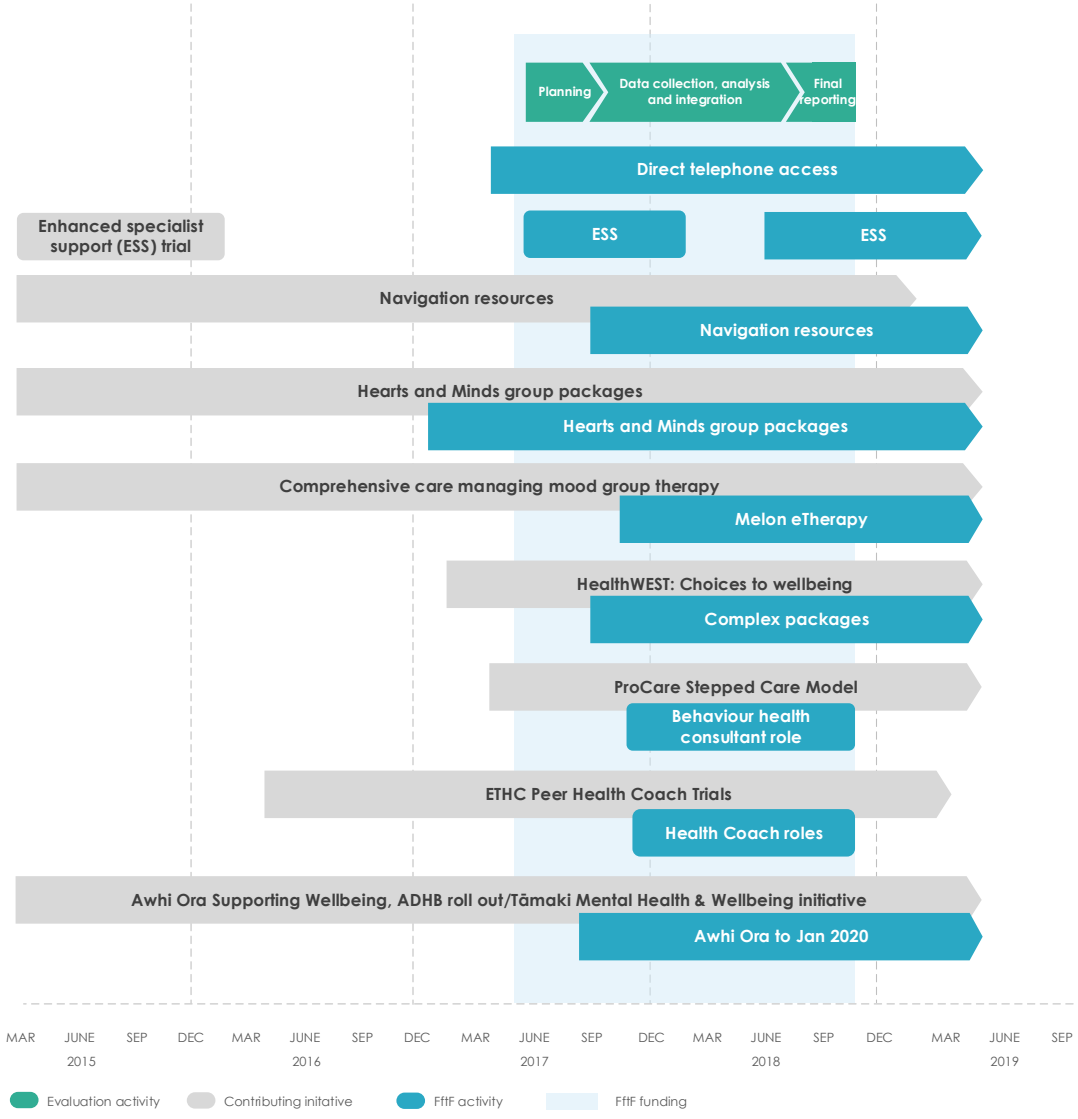
Figure 1: An overview of Business Case One of the Our Health in Mind Strategy



3.2 Implementation of Our Health in Mind

Figure 2: Summary of the timeline for Business Case One and the FftF funding **Error! Reference source not found.** provides a summary of the timeline for the implementation of Business Case One. Further information on the delivery of each intervention is provided in the relevant sections of this report.

Figure 2: Summary of the timeline for Business Case One and the FftF funding



3.3 Key points

- **Business Case One of the Our Health in Mind Strategy sought to improve the interface between primary and secondary care. The Business Case also includes components to support capability building, and the integration and access to services and support within primary and community care.**
- **Business Case One provided an opportunity to test key concepts to support the DHB and its partners in understanding the interventions that are best placed to respond to the gap that exists for people with mental health needs in primary care.**
- **The evaluation focusses predominantly on the specialist support and the additional funding for Primary Mental Health Initiatives. WDHB specific insights from the evaluation of Awhi Ora and the roles of HIP and Health Coaches are also noted. Consideration is also given to the role and functioning of the Governance Group.**

4. EVALUATION APPROACH

This section summarises the evaluation approach and methods used to evaluate the interventions supported through the FftF funding at WDHB.

4.1 Key evaluation questions

The evaluation sought to address the following key evaluation questions and purposes (Table 1):

Table 1 Key Evaluation Questions

How much?	- To identify the reach of the interventions delivered through FftF
How well?	- To identify the delivery of the FftF interventions, including fidelity and adaptation - to identify barriers and enablers to delivery
Is anyone better off?	- To evaluate the effectiveness of the delivery and outcomes of the FftF interventions for people supported by and providing the interventions, and the wider primary and community care system
Future considerations:	- To integrate the evidence across each of the interventions to identify their contribution to supporting people with moderate mental health needs - To identify ideas for improving and modifying the specific interventions and ways of working - To inform future considerations relating to the sustainability and expansion of the FftF interventions

4.2 Evaluation approach

This evaluation adopted a formative approach guided by the results-based accountability framework[1] and programme evaluation theory[2] [3]. This guided the evaluation to address the questions of how much, how well and is anyone better off? Programme theory also enabled the evaluation to move beyond these questions to understand the broader context within which the interventions were delivered. Programme evaluation theory also supported the evaluation to provide rapid formative feedback.

The evaluation adopted a mixed methods design. This supported a comprehensive analysis of the delivery and successes of the FftF interventions. The specific data collection methods were:

1. An analysis of service data collected by General Practice, NGOs and the DHB
2. A time series analysis of psychological distress using a validated tool with people receiving more intensive supports (entry and follow up; for most interventions)
3. An analysis of other validated outcome tools to assess mental health and functioning for people accessing services and supports for HIPs and Health Coaches (entry and follow up).
4. A survey and interviews with people using the FftF interventions
5. Interviews and a survey with people providing the FftF interventions, including practice visits.

Further detail on the specific data collection methods and approaches are provided in relevant section of this report. A brief overview is provided below.

4.2.1 Data collection methods and sources

Interviews with people and organisations providing services, key stakeholders and clients receiving support (client interviews were only conducted at ProCare practices).

Table 2 People interviewed[4]

Category	Number of people
HIP Clients	3
Awhi Ora Providers	7

[1] Ryan, D. and Shea, S. (2012). Results based accountability: Guidelines and resources. Ministry of Social Development, New Zealand. http://www.familyservices.govt.nz/working-with-us/funding-and-contracting/results-based-accountability/resources/guidelines/introduction.html

[2] Funnell, S. (1997) 'Program Logic: An Adaptable Tool for Designing and Evaluating Programs', Evaluation News and Comment 6(1): 5–7.

[3] Donaldson, S. (2005) 'Using Program Theory-Driven Evaluation Science to Crack the Da Vinci Code', in M. C. Alkin and C. A. Christie (eds) Theorists' Models in Action, New Directions in Evaluation, 106, pp. 65–84

[4] This table counts the number of people interviewed by their involvement with FftF. Some people were interviewed more than once at different stages of the evaluation but are only counted in this table once. Some people were interviewed together and in this case are all counted separately.

Table 2 identifies the count of people interviewed by type. These include brief and longer more formal interviews. In total, 51 people's views are represented in this evaluation.

HIPs and HCs	3
Framework Practice Staff	15
Non-Framework Practice Staff	3
PHO Staff	5
PMHI NGO Staff	4
DHB Project Staff	6
Governance Group	5
TOTAL	**51**

Provider data relating to client profile, service delivery volumes and activities and client outcome measures was made available to the evaluation for the primary mental health initiatives. Specific information on the data collected is identified in each section of this report. Providers use a range of outcome tools.

ProCare's enhanced integrated practice teams, for example, provided de-identified data for the period December 2017 to 13th July 2018. Outcome measurement data consisted of the Duke, Patient Health Questionnaire 9 (PHQ9), Strengths and Difficulties Questionnaire, Partners in Health and the Kessler Psychological Distress Scale (K10).

Awhi Ora providers in WDHB provided de-identified data up until June 30th 2018. Outcome measure data consisted of the K10 (entry and exit/follow-up).

NGO providers supported the administration of an Awhi Ora client feedback survey which was collated by Synergia.

4.3 Data integration and analysis

Each data source has been analysed using the method traditionally associated with that data source. For example, interview data was analysed thematically using a general inductive approach[5], and service data was analysed using descriptive statistics. To move beyond the findings of individual data sets, a mixed methods data integration framework was used to identify and understand the contribution of the different methods to the key evaluation questions.

Mixed methods data integration and interpretation has been supported by ongoing engagement with stakeholders as well as two sensemaking workshops.

4.4 Ethics

The Health and Disability Ethics Committee confirmed that the study is out of scope for the requirement of ethnics committee review. The evaluation however, has been guided by the Aotearoa New Zealand Evaluation Association Standards[6]. Formal written consent and engagement with service providers occurred to ensure that clients invited to participate in interview could do so safely.

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[5] Thomas, D. (2009). A general inductive approach for analysing qualitative data. *American Journal of Evaluation,* vol 27(2)
[6] Evaluation standards for Aotearoa New Zealand. https://www.anzea.org.nz/evaluation/evaluation-standards/

4.5 Limitations

The key limitations of this evaluation are:

- The impact of the evaluation timeframe on the window available to understand the FftF interventions. Some initiatives were still in their very early stages, so ongoing monitoring will be important for strengthening the insights from this report.
- Maturity of data collection systems and processes for some initiatives limited the timeframes and level of service level data that was available to inform the evaluation. This included limited data available on the activities of the enhanced specialist support.
- The quality of service data provided by Awhi Ora challenged the ability to track all aspects of delivery.
- The range of data collection protocols and tools used has limited the direct comparison of different intervention types. The Duke is particularly challenging, as it has cohort specific analyses, which challenge the appropriateness of an analysis of effect sizes.
- The primary care survey had a very low response from clinicians and is limited by the self-selection bias.

5. SPECIALIST SUPPORT FOR GENERAL PRACTICE

A primary aim of increasing specialist support for general practice is to respond to primary clinician feedback to improve the interface between primary and secondary care. A survey conducted in mid-2017 by Waitemata DHB, led by Dr Sheryl Jury, was designed as a tool to help focus where improvements would make a difference and track satisfaction of current initiatives. General practice teams across the Waitemata region were invited to participate. The survey generated 40 responses, who were primarily GPs and nurses, with good geographical coverage.

The survey was grouped into three sections and asked their satisfaction within the last three months with a number of factors relating to: Acute or crisis care, ongoing secondary care management, and primary mental health care delivery.

Across the survey, responses indicated that key improvements were needed in areas relating to communication and resourcing. Within acute or crisis care, respondents had lower satisfaction rates relating to discharge summaries, Crisis Team provision of care and communication, and mental health ED communication. Similar themes were noted across ongoing secondary care management, while there was a good rating of services themselves, lower satisfaction levels were noted for community team ongoing communication, and discharge and referral processes. A more detailed analysis of the survey can be found in the Adult Mental Health Services and Addictions Interface Survey baseline results document produced by Waitemata DHB.

The survey also highlighted the value of navigation support and increasing knowledge of community support services. Access and knowledge to community resources were consistently rated as poor. The survey identified several key things to concentrate on, including communication and engagement with primary care, capacity and support for primary mental health care modalities, and referral processes and access. The implementation of specialist support through direct telephone access and enhanced specialist support was designed to respond to these concerns.

5.1 Direct telephone access

5.1.1 What was delivered?

The first component of Our Health in Mind to get underway was the introduction of the direct telephone access hotline where general practice teams across Waitemata can call for quick advice from a psychiatrist. The telephone access line was designed in collaboration with general practice and responded to GP feedback regarding their need for improved access to specialist services.

The psychiatrist responsible for the advice line carried a dedicated mobile phone on their person during normal working hours and had 0.5 FTE allocated for this and enhanced practice support activities. The demand for the service, the types of queries that would come through, and what was needed in the primary/specialist interface were unknown when the service began so these were key areas to be explored in the formative phase of delivery.

Data collection involved the review of two sets of 50 calls by Dr Mimoza Trenceva and Dr Sheryl Jury, looking at the content of the calls and the responses provided. The first 50

calls from when the service started and then subsequently repeated over a six-week period six months later. The criteria collected evolved as the understanding of the service delivery grew. Initially call content was recorded in log books, now this is managed electronically, providing a third source of data.

Generally, the current volume of calls meant that almost all calls can be answered as they come through providing timeliness for when the advice is required. It would usually be afterhours calls that would go to voicemail and be responded to in the morning if appropriate.

What was delivered in each phone call would depend on the needs and queries of the GP. However, the psychiatrist responsible for the hotline in December 2017 indicated that common responses included:

- Accessing any additional information on the patient through specialist information systems, which includes information that may not be visible to the GP. If not at a computer, the NHI was recorded so a check could be done later.
- Education combined with direct advice which often included broadening the focus to the whole person rather than only the medical management. However, medication management was the most reason for calls.
- Navigation support of the system for making appropriate referrals.
- Some calls would include a follow up fax which might include copies of notes or relevant letters and discharge summaries primary care doesn't have, or specific instructions about medication management or additional services, reiterating the advice provided over the phone.

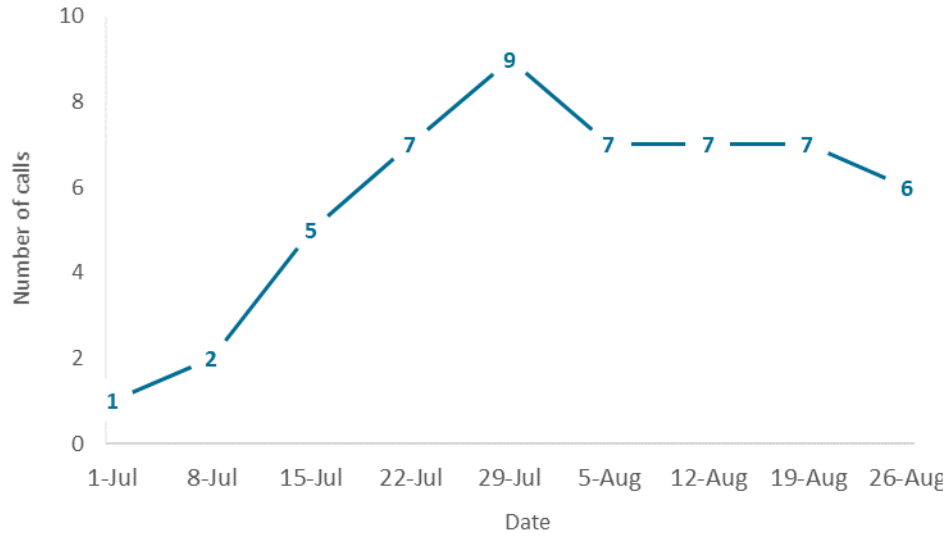
A number of calls were when the GP was seeing the person for the first time. The advice line may be particularly useful to practitioners who see a high turnover of patients. Here they are working through the best approach to take and appreciate the specialist support where they do not have a history with the person.

5.1.2 What is the reach of the direct telephone access?

Initially, administrative data on the calls to the direct telephone access hotline was not systematically collected. As the service has evolved and improved, since the start of July 2018 this data is now routinely captured using HCC. Prior to this, the qualitative analysis of two sets of 50 phone calls provides an estimate of the reach.

The utilisation of the direct telephone access hotline appears to be relatively consistent. The qualitative review of 100 phone calls estimated between one to two calls were received per day with variation from none to six calls in a day (although both were rare). For July and August 2018 for which data captured on HCC was available, there was a total of 51 calls recorded for an average of 5.7 calls per week (Figure 3). It should be noted that the first two weeks of July have low volumes of calls and the average calls per week increases to 6.9 when these first two weeks are excluded.

Figure 3: Weekly phone calls to the direct telephone access line, 1 July to 31 August 2018 (n=51)



A review of 50 calls to the DTA line by Dr Sheryl Jury provides further insight into the typical call patterns (Table 3). There were two days in the six-week review period when no calls were received at all, 13 days when one call was received, eight days when two calls were received, six days when three calls were received and one day when four calls were received. Based on this pattern, a call a day is received for about half of the six-week period, and three calls for the other half. There is no clear pattern emerging in terms of business in relation to specific days. The volume did vary week by week from 4-12 calls being received per week. Analysis over a longer period is likely required to identify trends.

Table 3: Number of calls received by week and day of week

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Totals by Day
Monday	2	1	2	3	1	1	**10**
Tuesday	4	1	1	2	0	2	**10**
Wednesday	1	0	2	3	1	1	**8**
Thursday	3	1	1	3	2	1	**11**
Friday	2	1	2	1	3	3	**12**
Totals by Week	**12**	**4**	**8**	**12**	**7**	**8**	

The direct telephone access hotline appears to be achieving reasonable reach across Waitemata DHB. In each of the two qualitative analyses of 50 phone calls, it was estimated that 30 – 35 practices were represented in each of these samples[7]. The most current data from HCC for July and August 2018 includes the following information on reach:

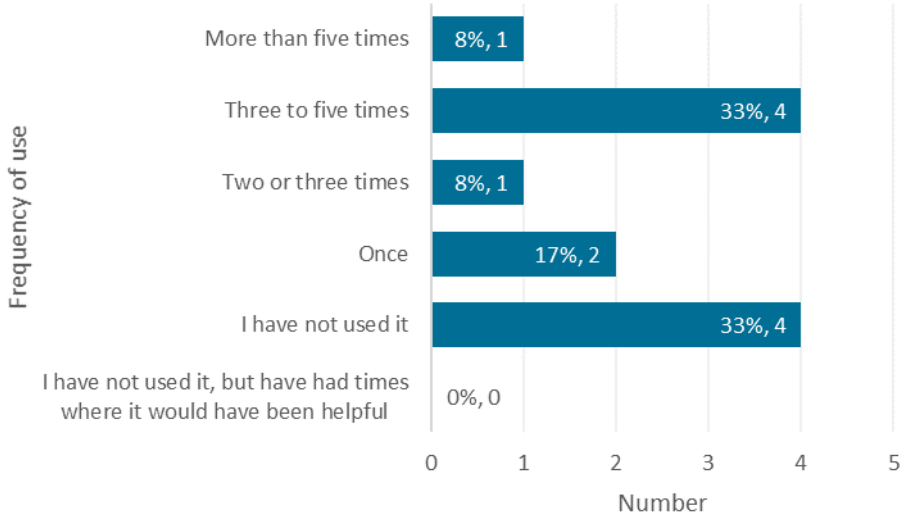
- Of the 21 calls relating to patients who were not already known to specialist mental health services where practice information was collected, 18 unique practices were recorded.
- Of the 49 calls for which information on the calling GP was collected, 46 individual GPs were recorded.

Relative to the roughly 86 practices in Waitemata[8] this demonstrates that the direct telephone access hotline is likely to be achieving reasonable reach but there is room for increasing the awareness and utilisation of the hotline across the DHB area. In December 2017, the psychiatrist noted that some of the calls they received came through the DHB switchboard indicated they did not call the hotline directly but were transferred to the line where it was most appropriate, which may indicate the need for greater awareness of the advice line or GPs who prefer to remember just one number rather than all the individual numbers available for different services available.

Feedback from the primary care survey indicated that of those who were aware of the direct telephone access hotline, half (50%) had used it more than once (Figure 4). While this suggest that the reach across Waitemata DHB may be more concentrated, it also indicates that the service is meeting the needs of those who use are aware of it.

[7] The evaluation is unable to identify which practices are represented in these samples or how many in the second sample of 50 were the same practices accessing the phone line in the first sample and how many were new.
[8] Based on the 2017 PHO register. Figure is likely to be different but is used as an approximate for context.

Figure 4: How often have you used the direct specialist telephone advice line? (n=12)



5.1.3 How well was it delivered?

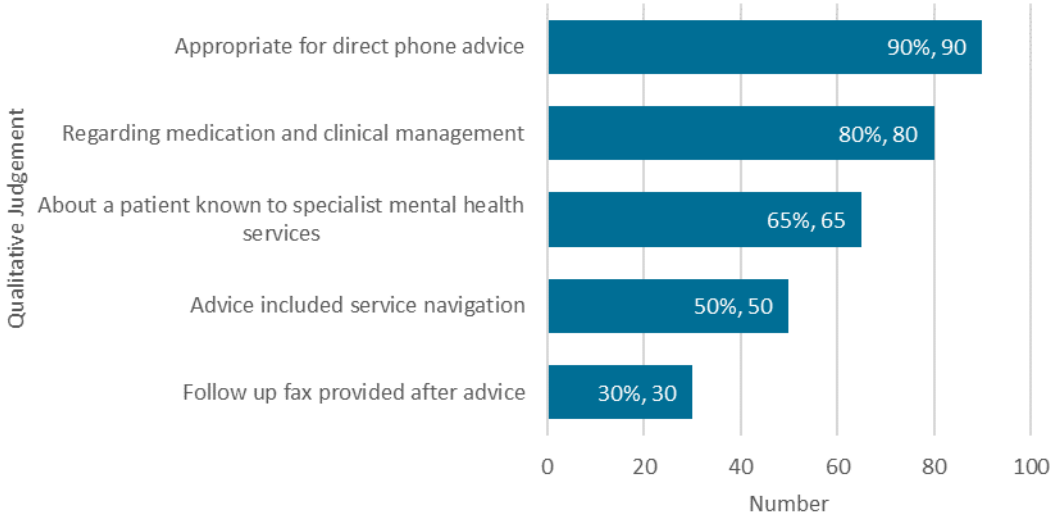
Findings on how well the direct telephone access hotline are largely based on the qualitative analysis of 100 calls conducted by Sheryl Jury and Mimoza Trenceva.

The psychiatrist answering the phone had received a lot of very positive feedback from callers. Over 90% of the time she was able to provide what the caller needed at the time. The Advice line was not a substitute for Crisis Team advice, with calls better directed there transferred.

The qualitative review found that most (90%) of the calls that were made were appropriate for the direct telephone advice (Figure 5). In interpreting the type of advice provided in Figure 5 it should be noted that:

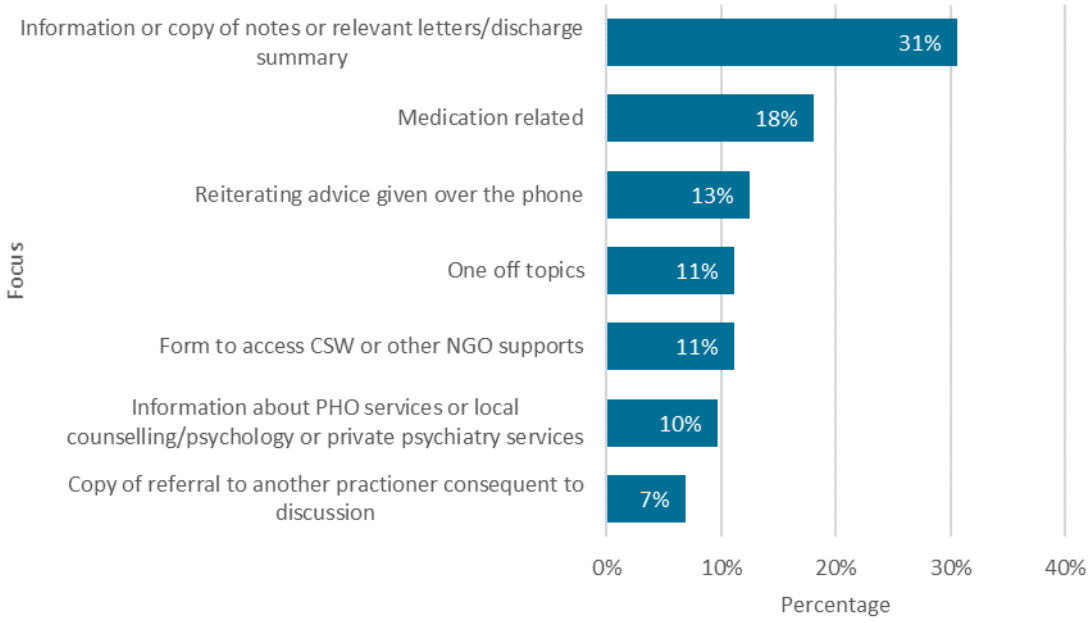
- Calls regarding medication and clinical management are often complex queries which need to be worked through and additional information elicited to feed into the decision making.
- Calls about patients who are also known to specialist mental health services underscores the likely complexity of the management required. The psychiatrist is able to review information electronically which may not be available to the caller. Data for July and August 2018 demonstrates 55% of calls were about a patient known to specialist mental health services.

Figure 5: Qualitative judgement on the type of advice provided (n=100)



For the period of April - December 2017, about a quarter of all the calls received have faxed material provided following. Almost a third of the time the psychiatrist is providing visibility of information that exists electronically elsewhere in the system that the GP wasn't aware of (Figure 6). Reiterating advice given over the phone which can be complex and specific medication titration or switching schedules make up the next most common categories with the remainder supporting service navigation.

Figure 6: What is the focus of the information being faxed?

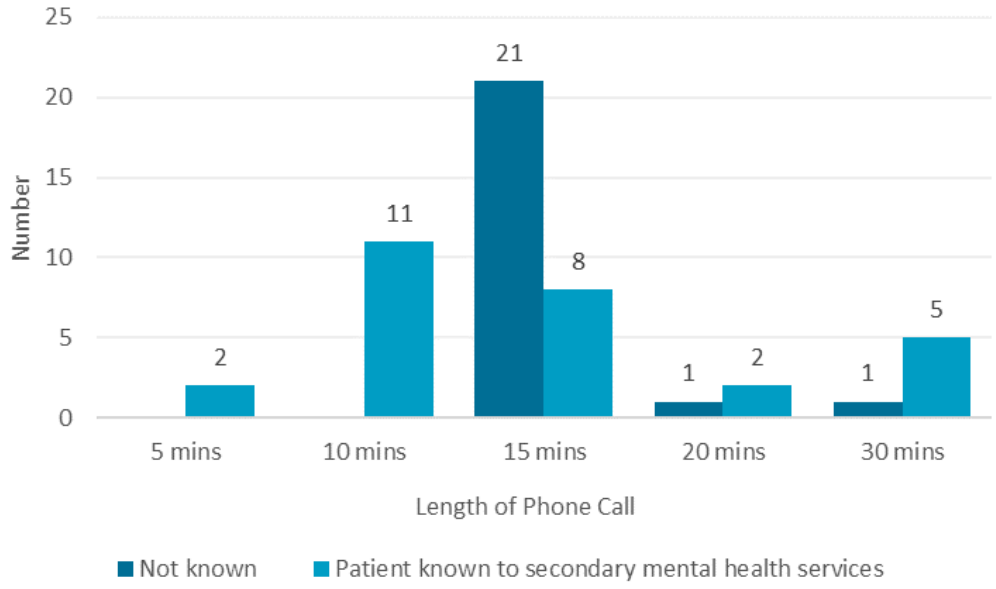


Since data was collected in HCC (the electronic mental health information system) from July 2018, calls that provide advice on patients not known to specialist mental health services capture data on whether medication or clinical management advice was provided. For these 23 calls:

- 20 (87%) provided medication advice,
- 2 (9%) provided coping / therapeutic strategy advice,
- 1 (4%) provided safety plan advice, and
- 2 (9%) did not provide any advice on medication or clinical management.

Duration of calls was recorded within the nearest 5 minutes in HCC. There is a different pattern in the distribution of call duration depending on whether the patient was known to specialist mental health services or not in July/ August 2018(Figure 7). Almost all (91%) calls for patients who were not known to specialist mental health services were completed in a 15-minute duration. Although calls regarding patients who were known to specialist mental health services had a similar average duration, there was much greater variation across calls. Any calls about current clients are re-directed to the appropriate clinical team.

Figure 7: Duration of phone calls recorded by whether patient was known to specialist mental health services, July and August 2018 (n=51)



5.1.4 What are the barriers and enablers to delivery?

The successful delivery of the direct telephone access hotline is supported by the characteristics of the specialist responsible for the hotline. The following considerations can pose as barriers or enablers:

- **Dedicated time to prioritise calls:** The specialist was very responsive to calls when they were working in the community providing enhanced specialist support and working in the community mental health clinic. However, when the specialist was required to work in the secondary care inpatient unit this provided a challenge in being able to prioritise receipt of calls.
- **Knowledge of the local care system:** This local knowledge was important to delivering a service that was useful for clinicians and having the right specialist with this knowledge is a key enabler for the hotline. This could also pose a challenge for different models of providing this advice, for example a national hotline may struggle to demonstrate the same knowledge of local systems and supports.
- **Pragmatic data recording:** One of the early challenges was finding a way to collect data on calls while being mindful of the capability and capacity of the psychiatrist to ensure that it does not impact on the effective delivery of the service. Additionally, the need to add to clinical documentation when the person was known to the service and not duplicate or fragment recording systems. Data recording systems need to be accessible during phone calls and not generate high levels of administration burden. From initial paper log books, there has been progress on implementation of data recording with the use of HCC now capturing administrative data.

5.1.5 How effective is the direct telephone access line?

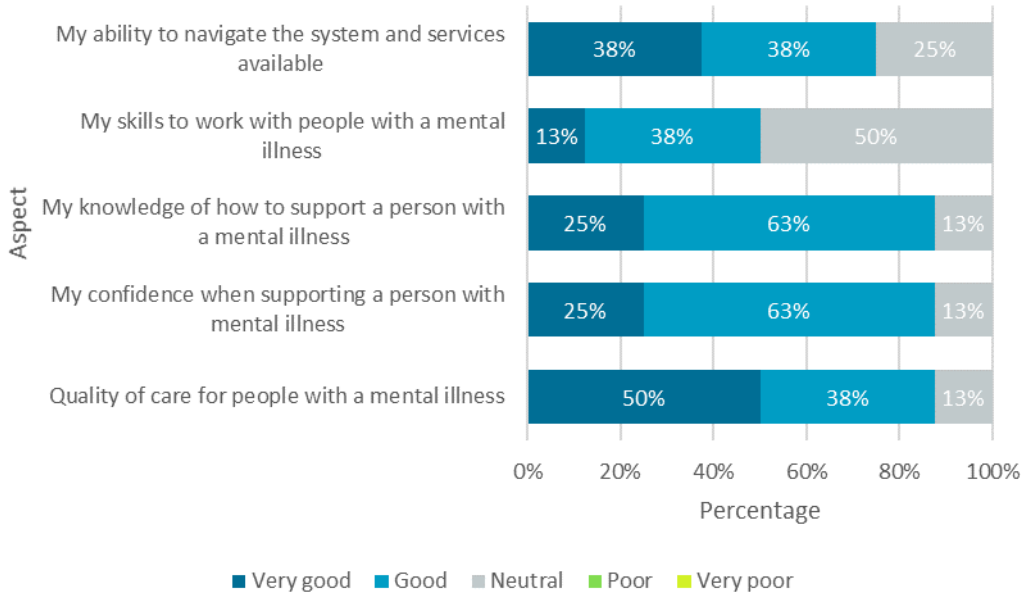
The direct telephone phone advice line is intended to support an improved primary and secondary care interface for mental health. The qualitative review identified that this hotline did play a key role in addressing the frustrations of GPs regarding access to information and improving the interface between primary and secondary care. Specifically, the qualitative review of 100 calls identified:

- Calls are very appropriate to the expertise provided and utilisation is consistent and ongoing
- Supports a timely exchange of information to support better clinical decision making and enables care delivery to proceed
- A positive communication conduit at the interface of care delivery
- Likely increased efficiency as many calls were typical queries that would otherwise have come via written referrals (which have delays associated and the inefficiencies of trying to contact people/referrer to verify information a few days later when the referral is triaged.
- Provides clinical education when it is most relevant for the practitioner.
- Provides the psychiatrist with an understanding of the primary care context which filters through to specialist care design considerations.

Feedback from the primary care survey indicated that of the eight clinicians who used the direct telephone access hotline, all rated their overall experience of the hotline as good (50%) or very good (50%).

Those eight clinicians who used the hotline also perceived that it was effective for improving the quality of care for people with a mental illness, their confidence and knowledge when supporting a person with a mental illness, and their ability to navigate the system and services available (Figure 8). To a lesser degree, they also perceived that the hotline was effective in contributing to improving their skills to work with people with a mental illness.

Figure 8: Please rate the contribution of the direct specialist telephone access line on improving the following (n=8)



In summary the provision of specialist telephone advice fills a gap in timely care provision; and is a positive communication conduit that is supporting primary care in their management of people often with serious and enduring mental illness and addiction issues.

5.1.6 What are the recommendations for improvement?

Overall, the service delivered is working well. Recommendations for improvement focus on improving awareness and reach, and integration with other elements of the system.

One clinician who made a comment regarding potential improvements suggested it might be better if GPs had the chance to meet the specialist previously. It should be noted that the hotline is answered by a speciality who provides consult liaison as part of the enhanced specialist support for general practice. In the evolved model of consult liaison that has been operating since July 2018, the specialist aims to provide a lighter touch in each practice to achieve greater reach. This would further integrate the components of the enhanced specialist support and provide the opportunity for more GPs to meet the specialist providing advice over the hotline.

Given the evidence suggests the hotline is very successful in meeting needs of clinicians and improving the primary / secondary care interface for those who use it, improvement

could be achieved by increasing the awareness and reach of the hotline. While the evolved consult liaison model will support greater awareness, other actions should also be considered. For example, Medinz could be used to communicate to the primary care sector.

There has been good progress made in capturing administrative data using HCC throughout the duration of this evaluation. The next step would be to consider how the use of HCC for data collection can provide information to support ongoing quality improvement. For example, it may be useful to collect information on common types of queries and advice to inform other capability development activities.

5.2 Enhanced specialist support – consult liaison

5.2.1 How much?

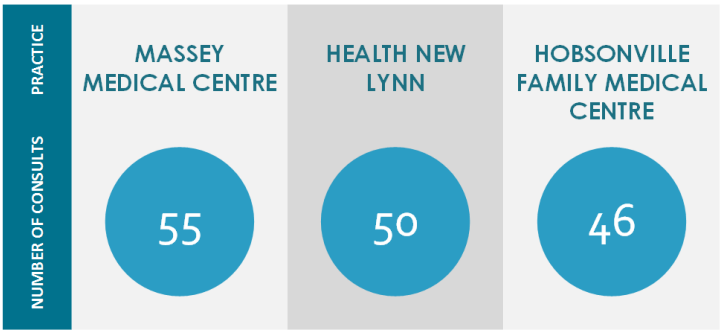
This section describes the reach of consult liaison support and discusses the different methods for how this support was engaged.

Enhanced specialist support – consult liaison has evolved over time. This initiative originally involved the provision of services by two psychiatrists in four practices. The psychiatrists were on-site at the practice for half a day (0.1FTE) per week.

Quantitative data was only available for the consults of one psychiatrist (Dr Mike Louw) across three of the practices (Massey Medical Centre, Health New Lynn, Hobsonville Family Medical Centre) for ten months from May 2017 until February 2018. Enhanced specialist support was also provided to Apollo Medical Centre on the North Shore by Dr Mimoza Trenceva until December 2018, but quantitative data for this site was unavailable.

In total, across the time period and locations for which data was available, there was an average of 50 instances at each practice where consult liaison support was engaged (Figure 9). A total of 151 unique consults were made by Dr Louw across the three practices. A further 14 consults were made as follow ups, resulting in a total of 165 consultations completed by the psychiatrist in West Auckland.

Figure 9: Total number of unique consults from May 2017 to February 2018



The psychiatrists worked in different ways at the practices, with the most common methods of engagement being either face-to-face discussions with GPs, or direct face-to-face consults with patients. On two occasions the psychiatrist consulted with a practice nurse, and on one occasion the psychiatrist spoke to a doctor over the phone.

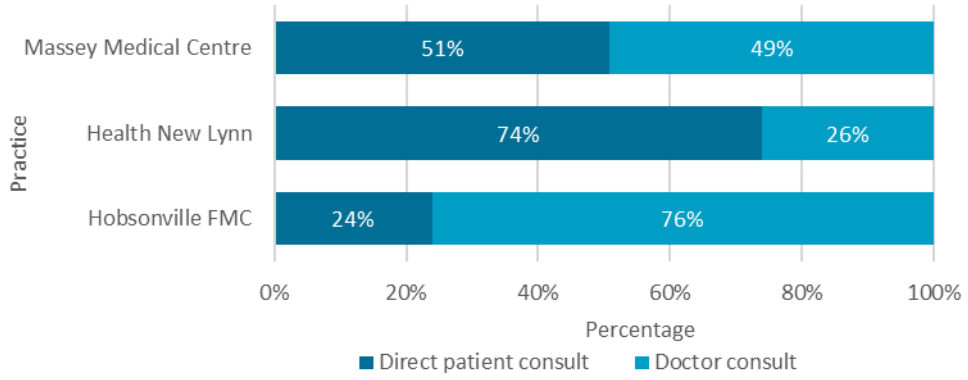
An interview with Dr Louw involved a discussion around the role individual practice contexts and needs played in the differences in how his support was engaged.

Hobsonville Family Medial Centre, engaged with support primarily through face-to-face interactions with GPs. This practice has a group of senior doctors who have known Dr Louw for many years, which likely contributed to them feeling comfortable asking for advice when they need it.

Health New Lynn, is a large and busy practice, with less face-to-face doctor consults as a result. Health New Lynn also previously had a consulting psychiatrist (Dr Lyndy Matthews), who had a strong focus on GP capability development. The data and interview feedback highlights the different approaches between the previous and more recent mode. More specifically, Dr Louw was providing more onsite consultations with patients than the previous model.

Massey Medical Centre had a fairly even split between engagement directly with patients and GP consults. Massey is a smaller practice serving lower socio-economic status populations with varied mental health issues. Figure 10 below displays the breakdown in type of consult across the practices.

Figure 10: Type of consult by practice (n=151)



5.2.1.1 The evolution of the support model

The first round of enhanced specialist support – consult liaison ended in February 2018. It evolved and was restarted in July 2018 and is ongoing, again only in West Auckland. The evolved initiative carries some differences to the original; while scheduled visits from psychiatrists remain at half a day (0.1FTE), they are now every 3-6 weeks depending on the size of the practice (determined by the number of GPs employed in the practice; medium-sized practices have 4-5 GPs, large-sized practices have 10+ GPs). The four largest practices are visited 3-weekly, while the medium-sized practices are visited every 5-6 weeks. This frequency has been set up to allow the supporting psychiatrist to visit several practices and facilitate engagement with the practice teams.

At this stage, the focus has been on visiting and building relationships with ProCare, National Hauora Coalition, and Comprehensive Care. The initial visit is to introduce the Specialist Support psychiatrist role and to discuss how mental health support is provided through the role and provide capability building sessions. Following the initial meeting, a

plan is formulated as to when the visits will take place, which is influenced by space and staffing availability at the practice.

The plan for the near future is to introduce small practices to this initiative, as well as continuing to offer capability building sessions.

The initiative now visits 18 practices across the region, and there have been four direct face-to-face patient consultations to date.

5.2.2 Who is accessing enhanced specialist support?

Enhanced specialist support has provided advice and support to GPs and patients directly in cases where the clinician has been uncertain of the diagnosis, treatment, or when a particularly complex case presents. The analysis of the available quantitative data found that support was primarily provided either to the patient or the GP, with two instances of a practice nurse consulting with the psychiatrist. Interviews with GPs and practice nurses who utilised the support of a psychiatrist indicated that that having a specialist "on the ground" was extremely valuable when faced with patients with complex multi-morbidities or uncertain diagnoses.

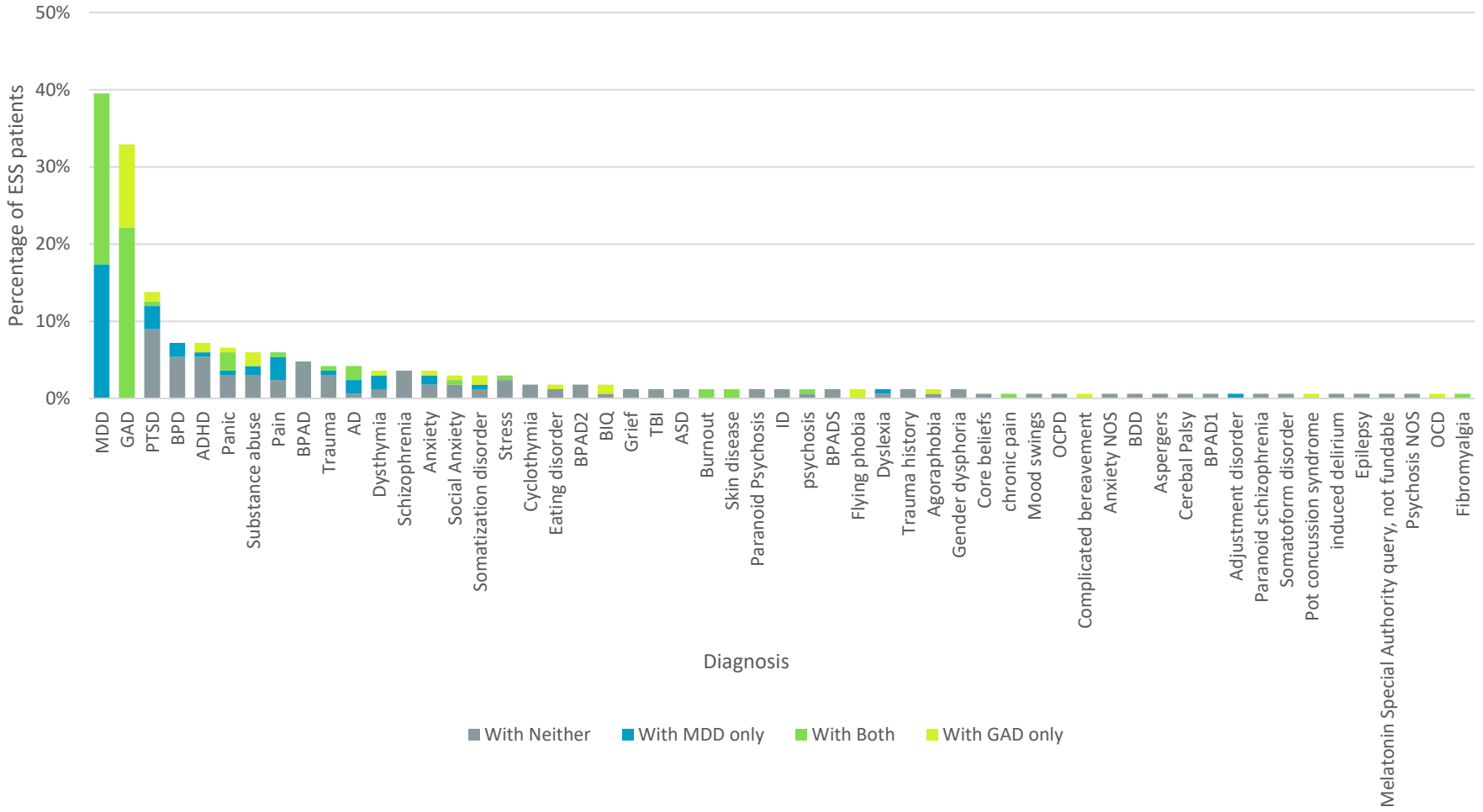
> ***"It was great to have someone available that we could physically speak to – even if just for a quick 'corridor consult'. I've been able to clarify things that I wouldn't have bothered calling (DTA) about"***
>
> ***(GP who had accessed specialist support)***

Interviews with GPs identified that they would also tailor their method of engagement with the consulting specialist based on the type of support required. It was noted that within Health New Lynn, direct patient engagement by the psychiatrists was usually reserved for extremely complex patients or for cases where the diagnosis was unsure. Where there were issues with side-effects, or concerns around management it was sufficient for the specialist to consult just with the GP. This approach was also used when GPs knew the diagnosis but needed support with management, referrals or prescriptions.

5.2.2.1 Complex co-morbidities

Of the 151 consults we have quantitative data for, 101 of these involved patients with more than one mental health concern. A snapshot of the conditions seen within the sample is displayed on the following page in Figure 11, which also shows co-morbidities with general anxiety disorder (GAD) and major depression (MDD). It is clear that a significant proportion of patients that were either consulted with or about have co-morbid conditions relating to mental health. The interviews also indicated that it is likely that a considerable number of these patients also have co-morbid physical illnesses, resulting in particularly complex cases.

Figure 11: Percentage of ESS patients with diagnoses by MDD and GAD co-morbidities (n=101)



In total, over half of patients consulted with or about had general anxiety disorder or major depression, with 22% having both. The full list of diagnoses across the data over this period of time included a total of 55 unique disorders. This demonstrates the substantial diversity in the presenting conditions in primary care. While general anxiety and major depression are the most common, there is a large number of other diagnoses being treated, both on their own, and combined with anxiety and depression. This summary identifies some of the key areas that GPs should feel competent in managing.

5.2.3 How well?

This section explores the effectiveness of the specialist consult liaison support. Part of the enhanced specialist support – consult liaison initiative involves increasing the knowledge and capability of primary care clinicians. This can be examined through the trends in types of consult.

A survey of primary care clinicians across the Waitemata region indicated that 100% of those who had engaged with enhanced specialist support rated their experiences using the support as either very good or good (n=14)[9]. The respondents noted that enhanced specialist support had strong positive influences on their navigation of the system and services available (100% rated either very good or good) and their skills to work with people who have a mental illness (100% rated either very good or good). Clinicians further credited the specialist support as contributing positively to their knowledge and confidence in supporting people with mental illnesses (100% rated either good or very good). It was felt that enhanced specialist support had a very good contribution to the quality of care for people with mental illnesses (75% rated very good).

There were some instances where the role of the consulting psychiatrist was unclear and created some confusion around where patients are best treated. Whether the psychiatrist is available as secondary care in a primary care setting, or their role is for support, advice and capability development should be made clear to the practice teams.

> ***"I'm struggling with which patients to keep in general practice, and which should be under the care of secondary services. We do not have the resources to provide the same level of care."***
>
> ***(Primary care clinician survey response)***

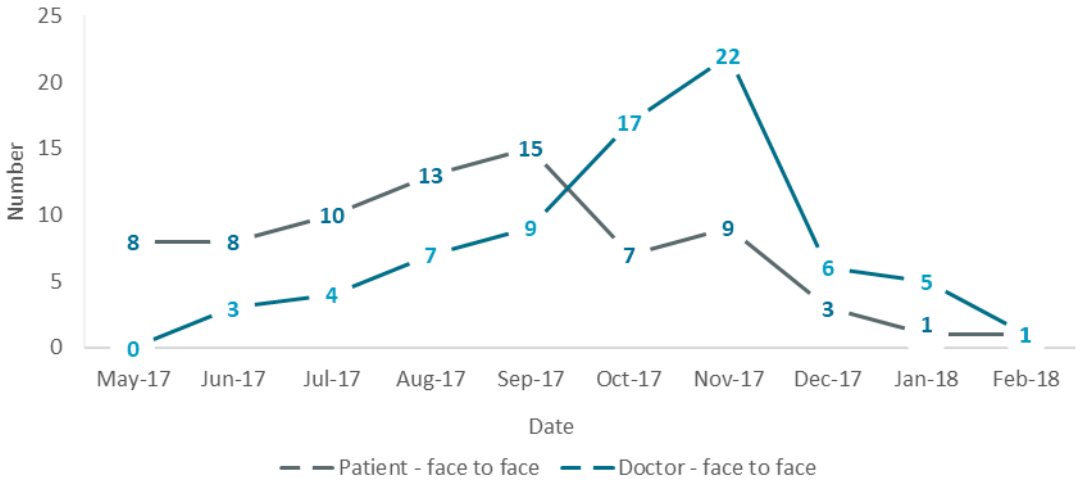
Figure 12 below shows the trends in how the specialist provided support for the duration of the initiative. The trends towards reduced direct patient consults and increased doctor to doctor consults is reflective of the instruction from the Clinical Director Specialist Mental Health & Addiction Services to provide a consult liaison model with a greater focus on increasing knowledge and capability through doctor to doctor

[9] This survey received a very poor response rate, and as such, the numbers should be interpreted with caution. The findings may be skewed, and represent a sample of clinicians that are more engaged in mental health than the general population of clinicians.

consults. Lower numbers of consults in January 2018 are reflective of the reduced availability of the specialist due to annual leave, while lower numbers in February 2018 are due to the fact that support was no longer provided.

An interview with Dr Louw in January 2018 discussed his perceptions of the reduced demand in the last few months of the initiative could be taken as an indication of the improved capability the clinicians were developing. This would infer that doctors are becoming more comfortable consulting with patients about their mental health needs, as opposed to handing them over to the liaising psychiatrist for a patient face-to-face consult. We also understand however, that the variation in the specialist support models was recognised by the DHB who suggest that a greater emphasis on capability building would strengthen the value of the support.

Figure 12: Type of consult across three practices over time May 2017 – February 2018



5.2.3.1 Clinician knowledge and capability

Many of the doctors who were interviewed indicated that over the course of the initiative their own knowledge and capability has increased. Knowing there was a psychiatrist on site, they felt more comfortable broaching the topic of mental health with their patients if they suspected it was an underlying cause for their visit. Clinician confidence in responding to patients' mental health needs has increased significantly – over the duration of this initiative, GPs that were interviewed agreed that they felt much more confident asking about and exploring mental health issues of patients.

> ***"I wouldn't have time to even address the mental health side of things with just a 15 minute consultation, but now I know there is trained psychiatrist just down the hall, I feel more comfortable probing for these things knowing I have support."***
>
> ***(GP who accessed specialist support)***

Having a consulting liaison specialist in the practice also significantly helped increase confidence in navigating mental health services.

> ***"Most often what Mimoza helped with was to do with appropriate referrals and suggest services and supports for patients. Having her there significantly increased confidence in the navigation of mental health services"***
>
> ***(GP who accessed specialist support)***

It was also noted that the contribution of specialist support to increased knowledge and capability is broader than doctors. Practice nurses also benefited from increased knowledge and capability; it was in an interview that nurses can now more comfortably engage with the Mental Health Team as a result of having enhanced specialist support.

> ***"It was used a lot and has left a big hole – DTA is different, can't just have 'water-cooler chats' about patients and gain insights – have to decide to call, doesn't just come up in conversation. Essentially DTA is good, but not as nice as having someone on the ground."***
>
> ***(GP who accessed specialist support)***

5.2.3.2 Bridging the gap between primary care and mental health

Integrating a secondary mental health professional into a primary care setting has the potential to contribute to bridging the gap between primary care and mental health services. Liaison with the Mental Health Team significantly improved throughout the initiative, with facilitation from the consulting specialist.

A lot of the support was regarding access to information. The specialist has access to information and knowledge about patient engagement with the mental health services that is not visible to GPs despite their role in the system delivering care. It was valuable for GPs to coordinate with the specialist and use this knowledge to take the most appropriate and effective action.

Doctors are the first line of care, and with specialist support are able to better advocate for patients on their behalf. Before the specialist support, doctors mentioned in interviews that there were limited options for a GP with a patient who presents with mental health needs other than a specialist referral, which can be challenged by entry criteria and capacity. With enhanced specialist support, doctors could get support from someone on site, and potentially avoid unnecessary or incorrect referrals.

5.2.4 Is anyone better off?

5.2.4.1 Impact on patient outcomes and access to services

While there is limited quantitative data that can speak to the impact of specialist support on patient health outcomes, GPs were asked for their perceptions of the impact this initiative has on patients. **The support of an on-site specialist was found to be particularly valuable for reaching the types of patients whose needs were beyond the**

capability and capacity of primary care clinicians, but are not severe enough to warrant referral to secondary services. In this respect, a significant proportion of patients who would not normally have had access to appropriate treatment or support, are now being managed at the primary care level or referred appropriately with this increased capability. This has benefits for the person accessing services and supports, and for the system through reducing the number of inappropriate referrals and providing people with support through general practice.

There was a perception from GPs that enhanced specialist support has decreased the need for access to the mental health team. Several times, it was noted that things were able to be dealt with at the primary care level and referrals did not need to be made, where they would have been made before.

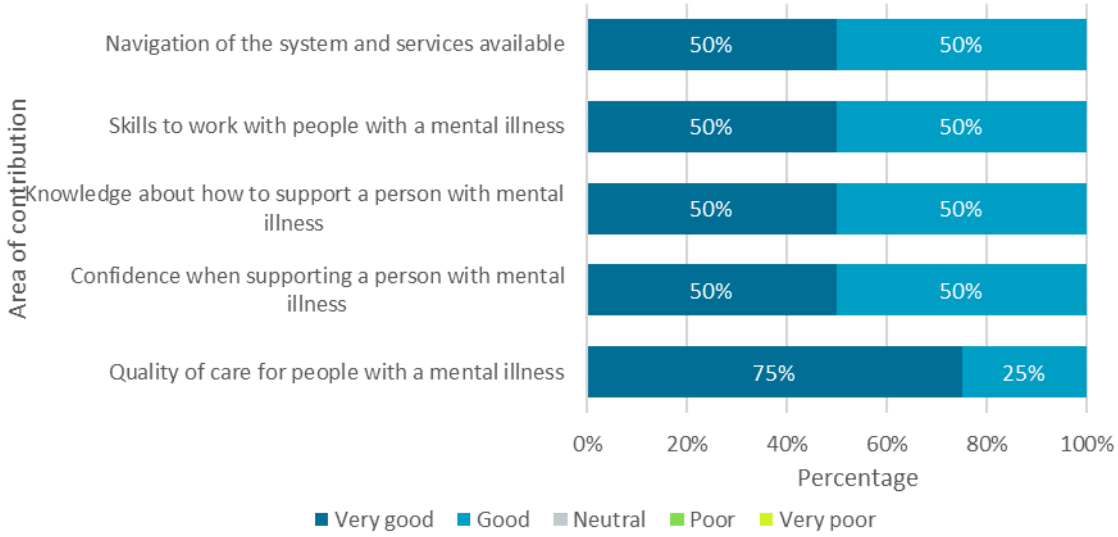
5.2.4.2 Contribution to clinician knowledge and capability

Primary care clinicians were asked via a survey[10] how they perceived enhanced specialist support improved their knowledge and capability. While the response rate to the survey is low, ESS was provided in four practices, so the number of people able to respond to questions relating to ESS would not be high.

Specialist support was regarded positively throughout the survey. On a number of factors, including navigation of the system and services, skills and knowledge to work with and support people presenting with a mental illness, and confidence to do so, all survey respondents considered enhanced specialist support to have either a good or very good impact on their knowledge and capability (Figure 13). 75% of respondents (3 out of 4), identified specialist support as having a very good impact on the quality of care for people with a mental illness.

[10] This survey received a very poor response rate, and as such, the numbers should be interpreted with caution. The findings may be skewed, and represent a sample of clinicians that are more engaged in mental health than the general population of clinicians.

Figure 13: Contribution of specialist support knowledge and capability (n=4)



5.3 Key points

- **Specialists support practices in a manner that is responsive to practice contexts.**
- **The model is evolving to provide support for a broader range of practices, and with an increased focus on capability building sessions and support. This will support the ability to expand the support across the region if desired.**
- **Engagement has begun with medium- and large-sized practices, with smaller practices to be included in the near future.**
- **Supporting primary care clinicians in instances where the diagnosis or treatment is uncertain, or where patients present with complex co-morbidities.**
- **Limitations in availability of quantitative data for understanding how the restarted initiative is reaching the primary care sector.**
- **Survey and interview data demonstrates the value of the support provided to primary care. This enhances the interface between primary and secondary care and supports the building of knowledge and skills to support people with mental health needs in primary care.**
- **Interview data also indicates a positive impact on the appropriateness of referrals to secondary services and other mental health service supports.**

6. NAVIGATION RESOURCES

6.1 Directory support

Hearts & Minds, formerly known as Raeburn House, is a primary mental health provider and community development organisation, with a focus on wellbeing. Hearts & Minds produces a directory containing information about approximately 350 organisations across North Shore, Rodney and Waitakere. The directory covers topics such as abuse/violence, mental health and addiction, age specific services, ethnicity specific services, disability, family, education, women's health, and community information. The 2017-2019 directory is found online in an app downloadable on the App Store and the Google Play Store and 1,200 hard copies are also distributed to health and social service organisations for free. The DHB funds 500 of these copies then Hearts & Minds seeks alternative funds for the remaining copies.

6.1.1 How much? The reach of the directory

The online directory is highly used and was accessed 51,274 times in 2017/18 (Figure 14). There was a peak of 18,007 views between July and September in 2017. The app has been downloaded a total 551 times and 116 times in 2017/18 (Figure 15). The app was viewed at least 3,128 views in 2017/2018 but the number of views are under-reported due to a change in domain hosting the app which effected the information available. Demographic information is not available for online directory and app downloads or views. The directory is available for and intended to be used by members of the public, health professionals and other service providers. However, the available data does not identify levels of access across these different audiences.

Figure 14: Online Directory Access over time Q1 16/17 – Q4 17/18

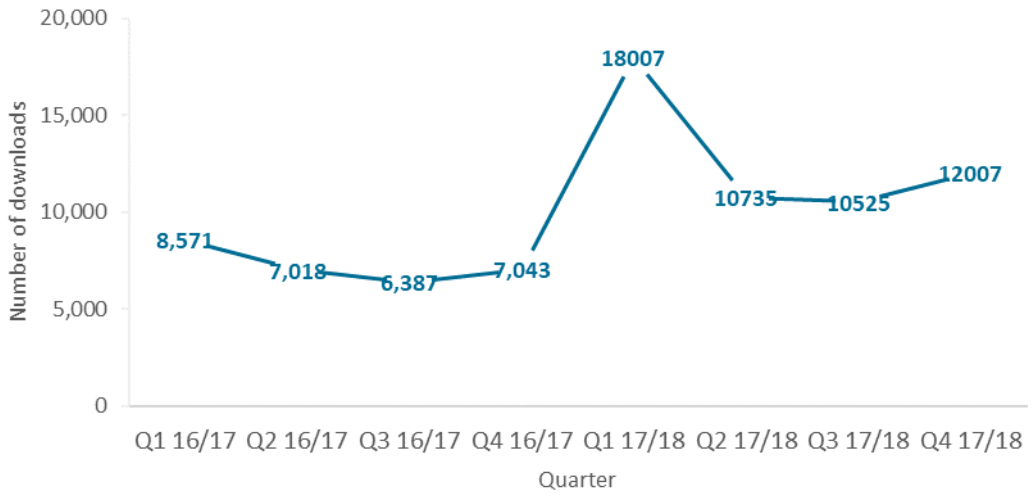
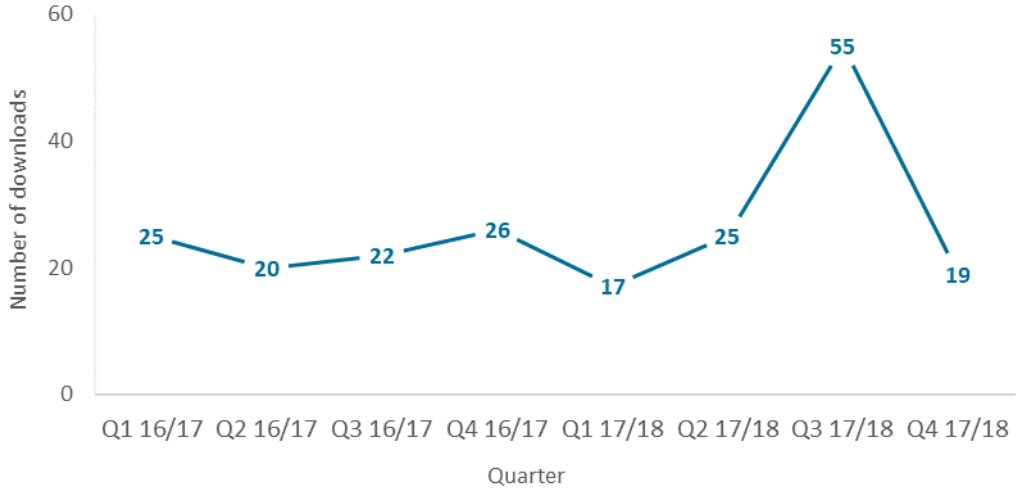
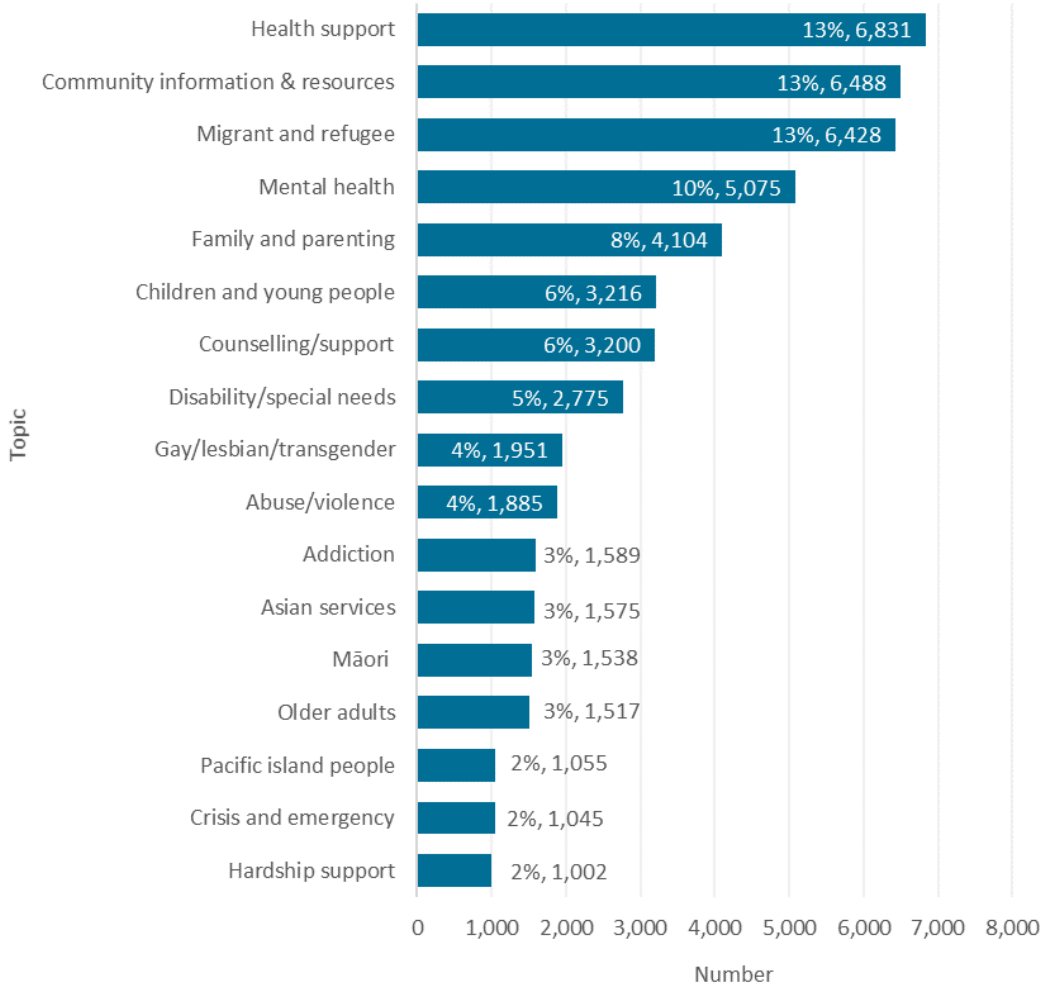


Figure 15: Directory App Downloads over time Q1 16/17 – Q4 17/18



Health support, Community Information and Resources, Migrant and Refugee were the three most accessed topics in 2017/18, each being accessed over 6,000 times as shown in Figure 16.

Figure 16: Online directory access by topic 2017/18 n=51,274



6.1.2 Is anyone better off?

A formative evaluation of the 2015-2017 version of the directory was carried out to help improve the next version of the directory. A survey was sent out to service providers, health professionals and members of the public who had previously accessed Hub services. Thirty-five people responded, and 92% of respondents deemed the Directory useful or somewhat useful. One respondent called it *"an invaluable reference tool for supporting clients to access support in their own communities"*.

The multiple formats of the directory are also appreciated, as it facilitates use and access depending on the person and situation. For example, survey respondents enjoyed being able to quickly access the hardcopy version and having the online directory to access additional information and an easy link to the services' websites.

6.2 Health Navigator

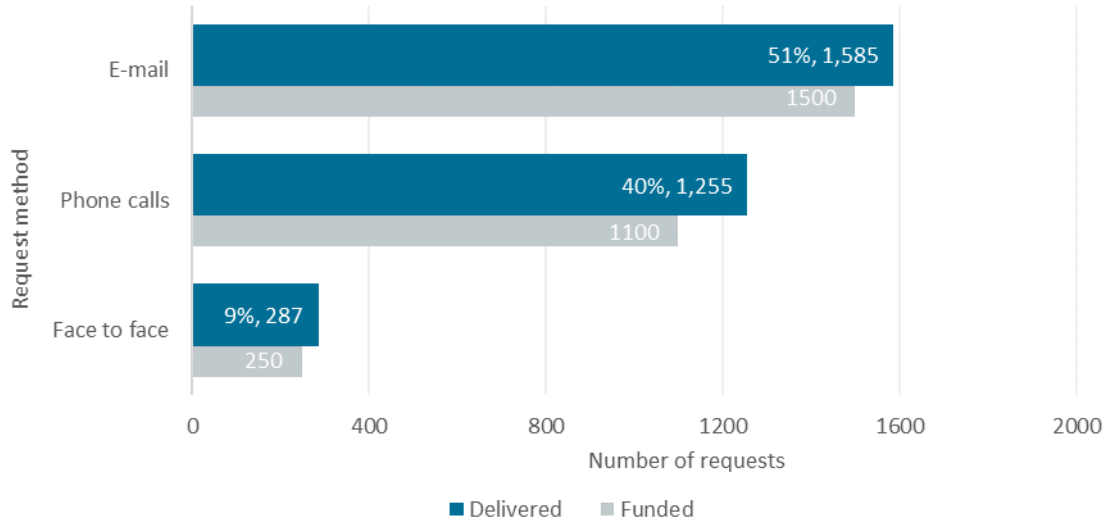
Hearts & Minds employs a health navigator who fields requests from members of the public, GPs and other health professionals, and uses the directory to identify primary and secondary mental health and social services. The service is free and available to any Waitemata resident or organisation that delivers services to Waitemata. They employ a navigator who is 0.5 FTE and is a qualified social worker. Hearts & Minds has a further 0.5 FTE of navigation that is supported by other employees, who are all trained in navigation.

The navigation service is during business hours Monday to Friday. Hearts & Minds' use of their own directory helps the review the usefulness and effectiveness of the directory. The navigation service is promoted by a dedicated employee through community networks, such as the Family Violence network and geographical networks. Hearts & Minds runs wellbeing groups under Enhanced Primary Health Initiatives and the navigation service is promoted to people who the group courses may not work for.

6.2.1 What is the reach of the health navigator?

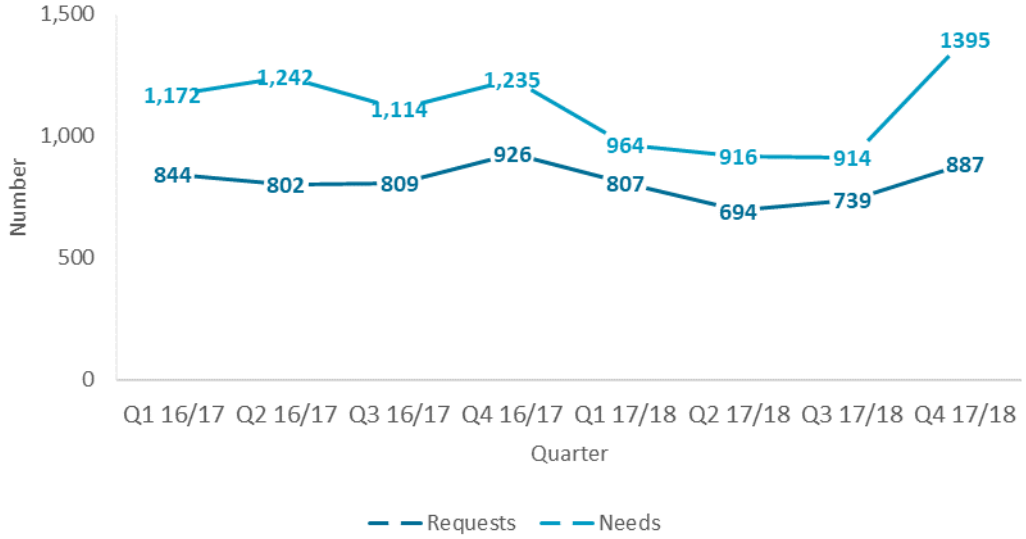
Hearts & Minds received 3,127 navigation requests in 2017/18, via email, phone and face to face, while being funded for 2,850. Hearts & Minds received 1,585 email requests in 2017/18, which was 51% of all requests, 1,255 phone calls (40% of all requests), and 287 face to face requests (9% of all requests; Figure 17). Hearts & Minds also exceeded their contracted delivery in 2016/17, processing 3,381 requests.

Figure 17: Navigation Request Method and Funding 2017/18 n=3,127



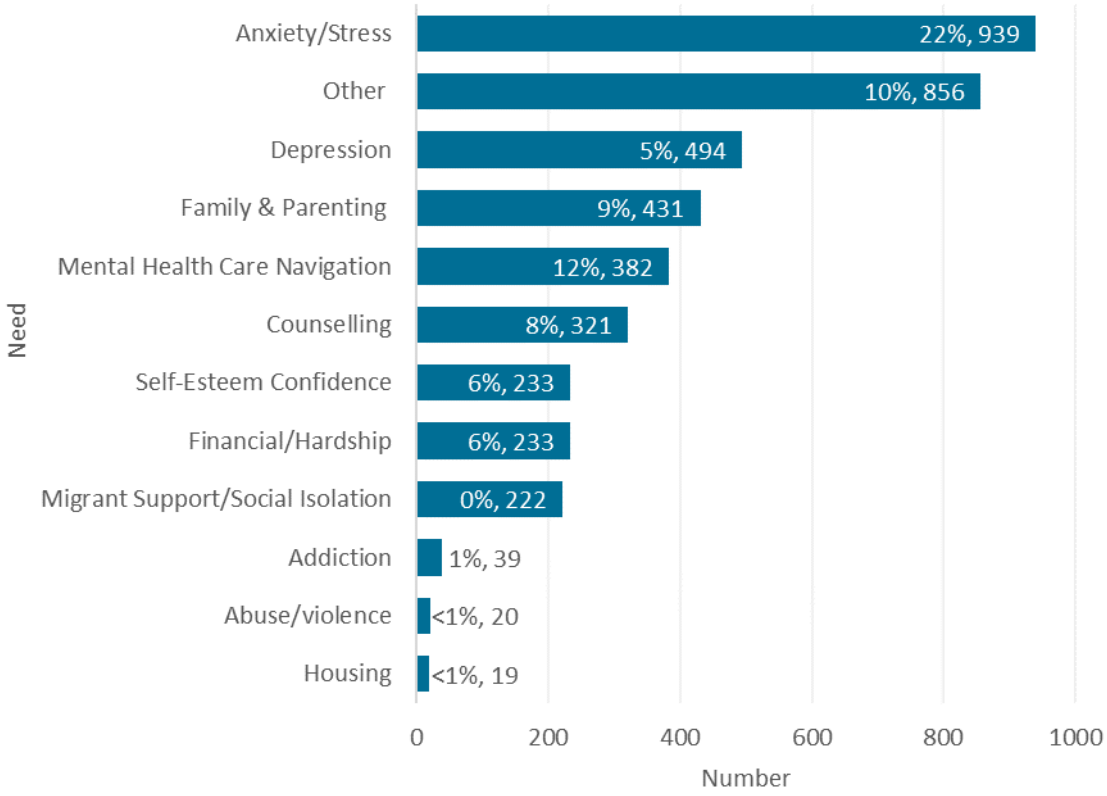
One request can be for multiple needs, and Hearts & Minds records every need for every request, as shown in Figure 18. There were a total of 4,189 request needs in 2017/18.

Figure 18: Navigation requests and needs over time, Q1 16/17 - Q4 17/18



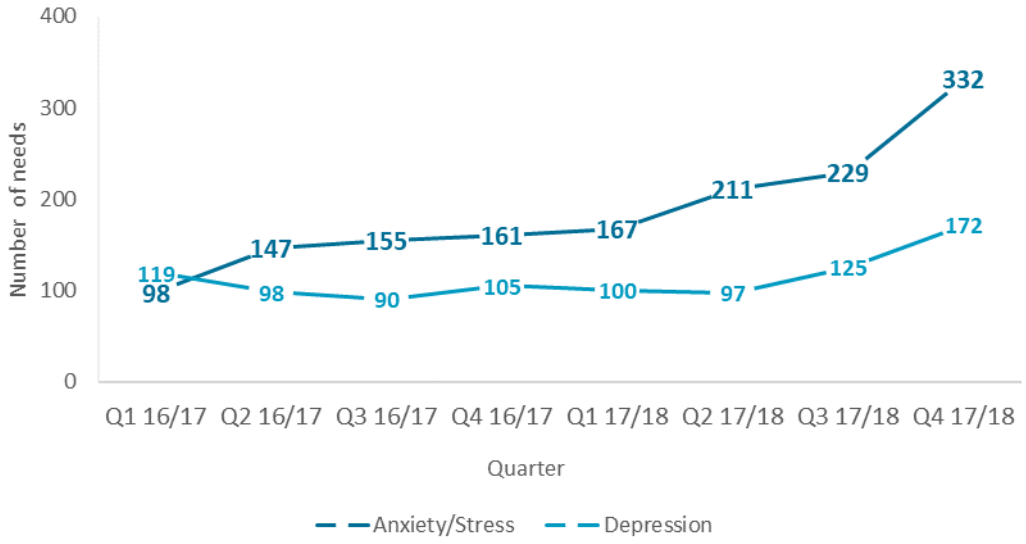
People request navigation services for a range of needs, in 2017/18 the most common need was anxiety/stress with 939 requests which was 22% of all navigation needs (Figure 19). This is a significant increase from 2016/17 where anxiety/stress was 12% (561) of the 4,763 request needs. 'Other' is not coded to more detail but includes needs such as hoarding, OCD, Autism spectrum, chronic pain and others.

Figure 19: Health navigation needs 2017/18 n=4,189



Navigation requests for Anxiety/Stress have been steadily increasing over time from 98 in Q1 2016/17 to 332 in Q4 2017/18 (Figure 20). There were approximately 100 requests regarding depression from Q1 2016/17 to Q2 2017/18 and then increased to 172 in Q4 2017/18.

Figure 20: Navigation Requests for Anxiety/Stress and Depression over time Q1 16/17 – Q4 17/18



6.2.2 Who is the health navigator reaching?

The navigation service is predominantly used by NZ Europeans. The utilisation rates of the health navigator are greatest for 'other' ethnicities at 522 per 10,000, followed by the Asian population at 132 per 10,000. Access for Māori and Pacifica is poor, making up 4.2% of all navigation requests (Table 4). This could be due to Hearts & Minds' historical presence in North Shore and only a recent expansion in availability to the Western areas of Waitemata where there is a higher presence of Māori and Pacifica.

Table 4: Navigation requests and rate of utilisation by ethnicity (n=3,127)

	Number	% of H&M Client	DHB Population Using service per 10,000	% Overall DHB Population
Māori	41	1.2%	21	7%
Pacifica	100	3.0%	80	5%
Asian	701	20.7%	132	20%
NZ European	1817	53.7%	105	65%
Other	351	10.4%	522	5.2%
Unknown/not specified	117	3.5%		0.3%

Two thirds of navigation requests to Hearts & Minds are made by females with 2,096 females requesting navigation, 836 males and 195 people with unknown gender.

Three quarters of navigation requests are made by adults aged 19 – 64, as shown in Table 5. Children/youth (under 18) made 7% of navigation requests and older adults (over 64) made 9% of navigation request.

Table 5: Navigation requests by age group (n=3,127)

Age	Number	%
Child/Youth (under 18)	213	7%
Adult (19-64)	2,317	74%
Older Adult (64+)	291	9%
Unknown/ not specified	306	10%

6.2.3 How effective is the intervention?

Stories about people's experiences with the navigation service are collected and presented to the board of Hearts & Minds. Patients and whānau are better off from their engagement with navigation support services.

Case Study 1: Benefits of health navigation support for the family of a person receiving community mental health services

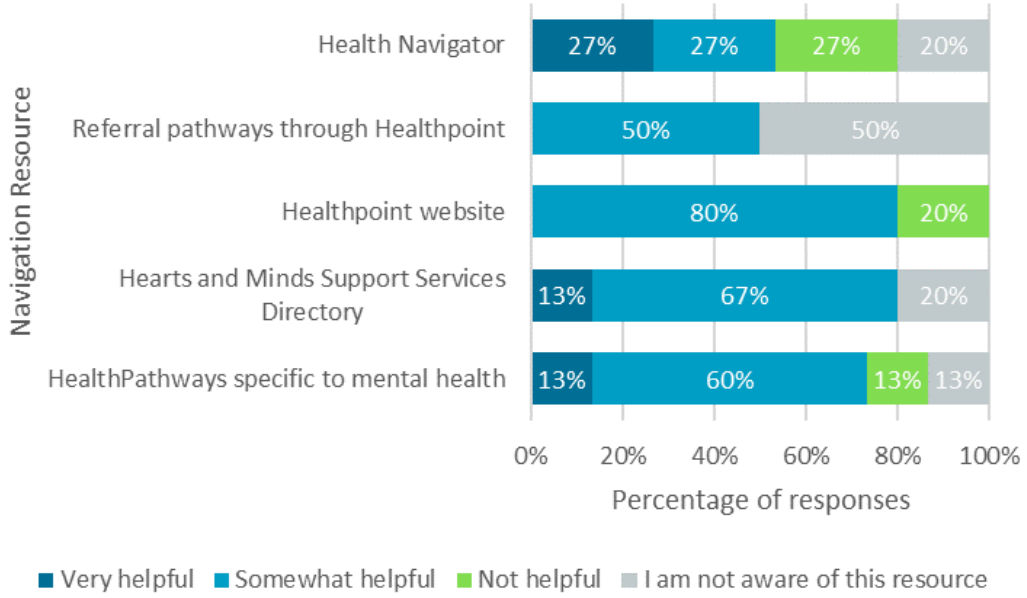
"A woman rang Raeburn House as she was feeling stressed about her adult daughter's mental health and was concerned about the quality of support she was receiving from a major community mental health provider on the North Shore. She was frustrated and keen to find out what other alternatives were available.

Raeburn House shared a range of relevant mental health information. The woman was pleasantly surprised to learn that there are other community mental health providers she could look into. Plus, she was also pleased to discover that there is an organisation that exists to support the families/friends of those experiencing mental illness (Supporting Families). The woman recognised the effects on the wellbeing of the wider family are significant. She very much appreciated Raeburn House for providing her with support options to explore."

6.3 Other resources for primary care

There are a range of navigation support resources available to primary care. The primary care survey asked how helpful common resources were for clinicians for the range of people who present with mental health concerns who are not already receiving existing service. Of the 15 responses, there was greatest awareness of the Healthpoint website although no one thought it was very helpful (Figure 21). While the response numbers are small, the Hearts and Minds Support Services Directory appears to be most helpful overall, while the Health Navigator has varied responses.

Figure 21: Helpfulness of navigation resources for primary care (n=15)



Clinicians indicated that other navigation resources they routinely use include the primary care liaison mental health nurse, PHO resources, direct phone contact with the mental health crisis team, 2-pager on different NGOs in the region put together by the DHB, depression.org.nz, and guidance from colleagues.

Comments indicate a need to continue improving the effectiveness of navigation resources for clinicians. There are too many different resources to keep up with and they need fewer but high-quality resources. Health Pathways for mental health community support has also been added to all NGO resources in 2018 to further support navigation.

6.4 Key points

- **Navigation resources are a valued source of information for health professionals and people wanting to access services and supports.**
- **Locally developed resources, such as that developed by Hearts & Minds offer greater value than nationally based resources. The understanding of local context likely to be important here.**
- **The navigation resources support people in accessing the services that are right for them.**
- **People are most commonly accessing navigation services for help with anxiety/stress, and the demand for this has been increasing over time.**

7. ENHANCED PRIMARY MENTAL HEALTH INITIATIVES

The Ministry of Health secured funding in late 2003 for the Primary Mental Health Initiatives (PMHIs). These were selected through a tender process and sought to develop PHOs and support the implementation of the Primary Health Care Strategy. The principal target population for these initiatives was those with a mild to moderate mental illness.

The overall aims and objectives of the initiatives were to:

- Develop activities to reduce the prevalence and impact of mental health problems for PHOs enrolled populations. This could include education, prevention, early intervention and treatment activities.
- Develop the capacity of primary health care practitioners and their ability to effectively respond to the majority of mental health problems that can be managed in primary health settings
- Build effective links with other providers of mental health care, including secondary services to support effective coordination.

Business Case One of the Our Health in Mind Strategy allocated additional funding to local PMHIs. This section of the report uses data provided by the organisations who received additional funding to understand what was implemented, who it reached and the benefits or outcomes contributed to.

7.1 Hearts and Minds group therapy packages

7.1.1 What was delivered?

Hearts & Minds, formerly Raeburn House, runs wellbeing support groups across Rodney, West Harbour, Waitakere and North Shore. Under Enhanced PMHIs, Hearts & Minds received funding for an extra 12 groups per year to bring their funding to 24 groups.

These groups are aimed at people with mild to moderate conditions and cover topics such as Moving Past Depression and Anxiety, Manging Emotions and Finding Balance, Art Therapy, and Wellbeing Resilience Toolbox for Anxiety and Depression. Skills taught include Cognitive Behavioural Therapy, Diversional Behavioural Therapy, Acceptance Commitment Therapy and Mindfulness.

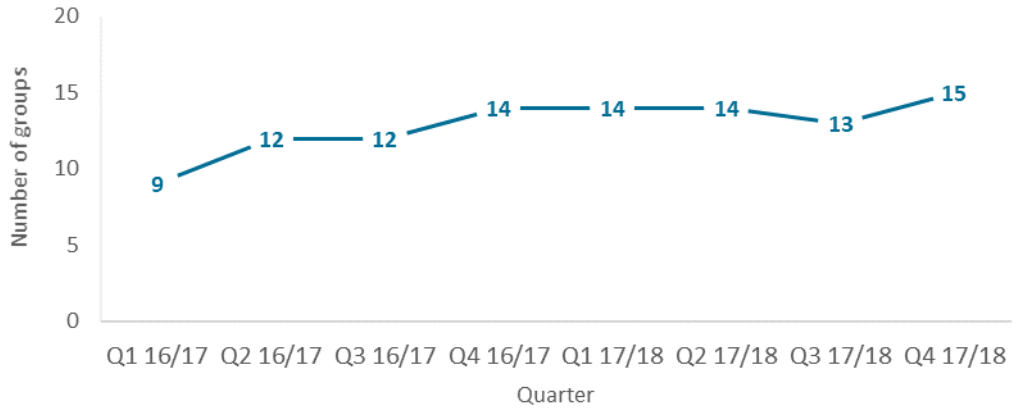
Each school term Hearts & Minds will run the same group concurrently across multiple sites, with their key hub in the North Shore. Attendance is free with a referral from a doctor, and one referral is valid for a year and up to 2 groups per term. Each group is led by a facilitator who is a registered psychologist, counsellor or psychotherapist. Groups are promoted through community networks and general practices alongside promotion of Hearts & Minds' navigation service.

7.1.2 How much? The reach of the groups

Hearts & Minds ran 56 groups across Waitemata in 2017/18, 32 more than they were funded to run due to demand. Since 2015/16, they have seen a 79% increase in the number of groups that they deliver, a 184% increase in the number of referrals that they processed. This was alongside a 36% increase in funding from the DHB. This highlights the demand for this type of support and the value provided by Hearts & Minds.

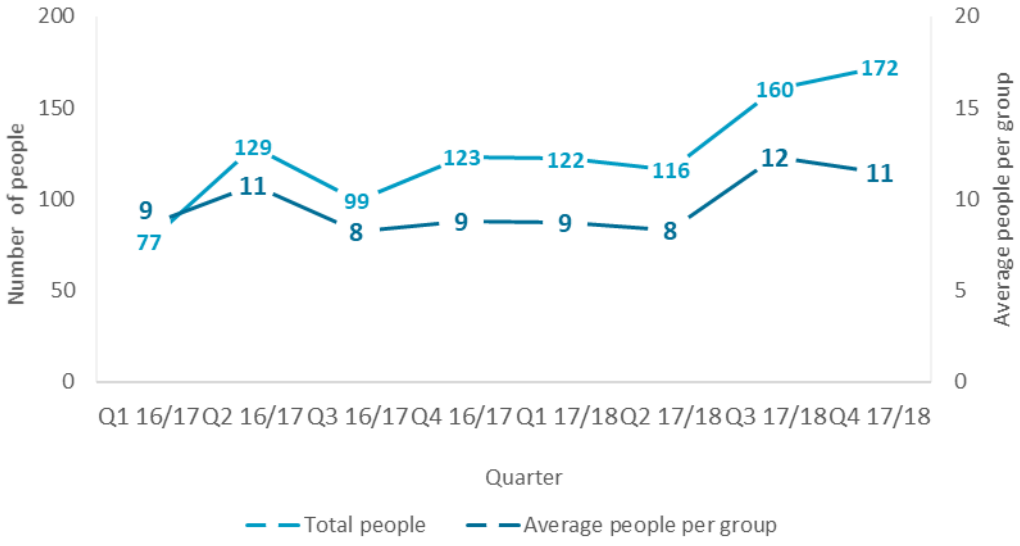
The 56 groups were attended by 570 people. This has increased from 2016/17, when they ran 47 groups which were attended by 428 people. This suggests that slightly more people were also attending the groups. Hearts & Minds ran 13-15 groups per term in 2017/18 and 9-14 per term in 2016/17 (Figure 22).

Figure 22: Number of groups over time, Q1 16/17 – Q4 17/18



Up to 14 people can attend a group with only one facilitator. Between 14 – 17 people requires two facilitators, and more than 17 people results in two groups run by two facilitators, which increases the cost to Hearts & Minds. The average number of people per group has been increasing, peaking at 12 in Q3 17/18 (Figure 23). A person is considered to have attended a group if they received 4 hours of therapeutic intervention, it does not count the people who try out a group session and then do not continue further with the group. While data on completion rates was not available, it is estimated by Hearts & Minds that 70 – 80% of attendees complete most classes.

Figure 23: Group attendees and average people per group over time, Q1 16/17 - Q4 17/18

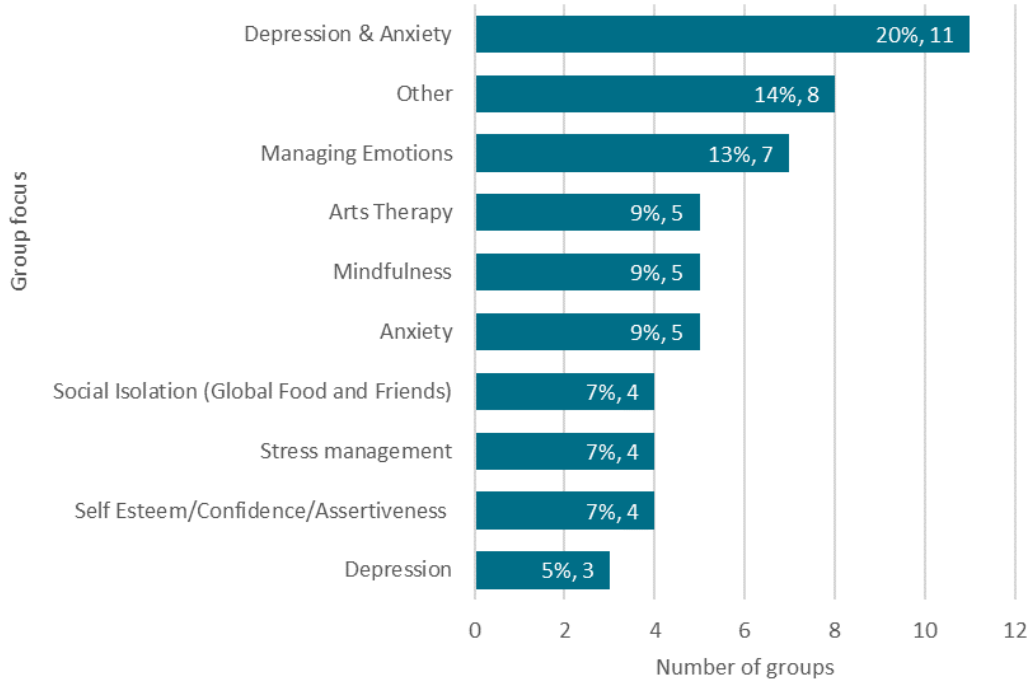


As demand increases, courses are filling up faster which means that some people are having to wait a whole term to be able to attend a class, unless they are willing to travel across Waitemata DHB. Although data on average wait times and incidence of waiting for the next term to attend a class was not available, Hearts & Minds estimate that this is happening 30 – 40% of the time.

7.1.2.1 Focus of group sessions

Groups were most commonly focused on depression *and* anxiety; making up 20% of the groups run by Hearts & Minds in 2017/18, with depression *or* anxiety making up a further 14% of groups as single topics (Figure 24). Other is the second most common purpose and includes music therapy and parenting classes.

Figure 24: Group focus, 2017/18 (n=56)



7.1.3 Who is being reached through the groups?

The groups run by Hearts & Minds are for people with mild to moderate mental health needs. Those who present with severe conditions are offered other services, such as the navigation service to help them connect with services. A person's Kessler-10 score used to be included in a referral to measure the severity of people's conditions, but its use was discontinued as it was deemed a barrier to people accessing the service and they implemented a referral triage process instead. In 2017/18, 115 people presenting to Hearts & Minds were identified as being more severe than 'mild to moderate' and so required other services. An analysis of this group of people found that 42% were experiencing suicidality, 23% had personality disorder and 12% were self-harming.

Over half (56%) of people who attended groups are NZ European (Table 6). The lower proportion of Māori and Pacifica attending courses, and the higher proportion of other

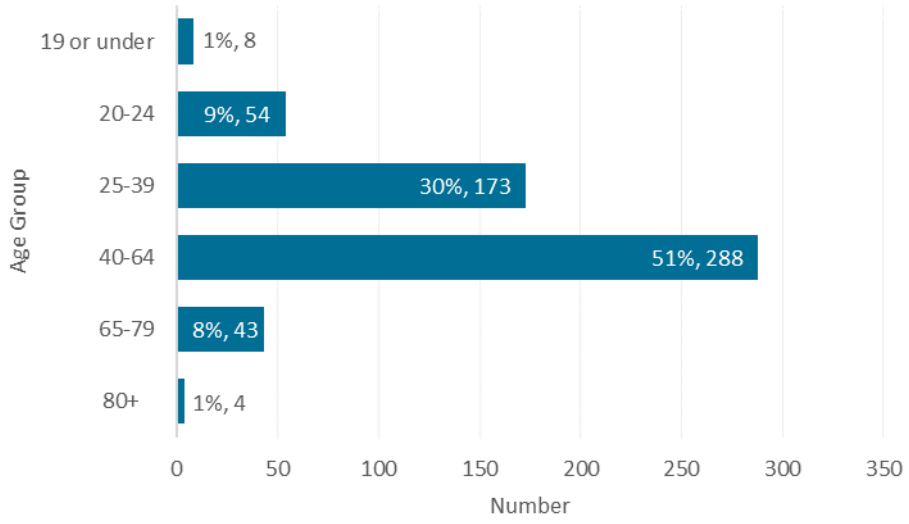
ethnicities is most likely due to the ethnic makeup of the North Shore, where Hearts & Minds is based. Hearts & Minds are working to improve the cultural appropriateness of their groups to work better for Asian, Māori and Pacific populations. As part of this work, they introduced groups in Mandarin to help engagement with the Asian population.

Table 6:Group participants by ethnicity in 2017/18 (n=570)

Ethnicity	Number	% of H&M Clients	DHB Population Using service per 10,000	% Overall DHB Population
Māori	27	4.7%	14	7%
Pacifica	9	1.6%	7	5%
Asian	77	13.5%	14	20%
NZ European	321	56.3%	18	65%
Other	136	23.9%	202	5.2%
Unknown/not specified	0	0%		0.3%

Three quarters of group attendees are female. Half of all group attendees were aged between 40 and 64 year olds, a further 30% were aged between 25 and 39 (Figure 25).

Figure 25: Group participants by age group 2017/18 (n=570)



7.1.4 What are the barriers and enablers to delivery?

Barriers to the delivery of group packages to support people with mild to moderate health needs include high levels of demand and geographical spread.

- **High levels of demand:** Hearts & Minds are receiving a large number of referrals and are overdelivering on the number of groups they run. This is resulting in increased wait times and increased numbers of people per group which is a risk to quality and safe delivery. Hearts & Minds described a reluctance to refuse

taking referrals due to capacity as this would undermine the work that has been done to create relationships and a strong reputation.

- **Location:** Hearts & Minds works across Waitemata DHB but are based on the North Shore. They are working to improve their services in Rodney, West Auckland and other parts of the DHB to improve access for Māori and Pacific populations.

There are also factors that enable Hearts & Minds to deliver a quality service and effectively support people with mental health needs. These include:

- **Referral triage process and integration with navigation support:** a qualified counsellor contacts every person referred to assess their level of mental health need and suitability for groups. If they are not deemed suitable for a group, they are referred to the Navigation service to get connected with the services that they need. This helps ensure that people are accessing the services that will work for them.
- **Reflective practice:** Hearts & Minds' ask for feedback in a participant satisfaction survey across all group attendees. This allows them to monitor the satisfaction with the groups and reflect on any advice for improvements.

7.1.5 How well are the groups delivered and is anyone better off?

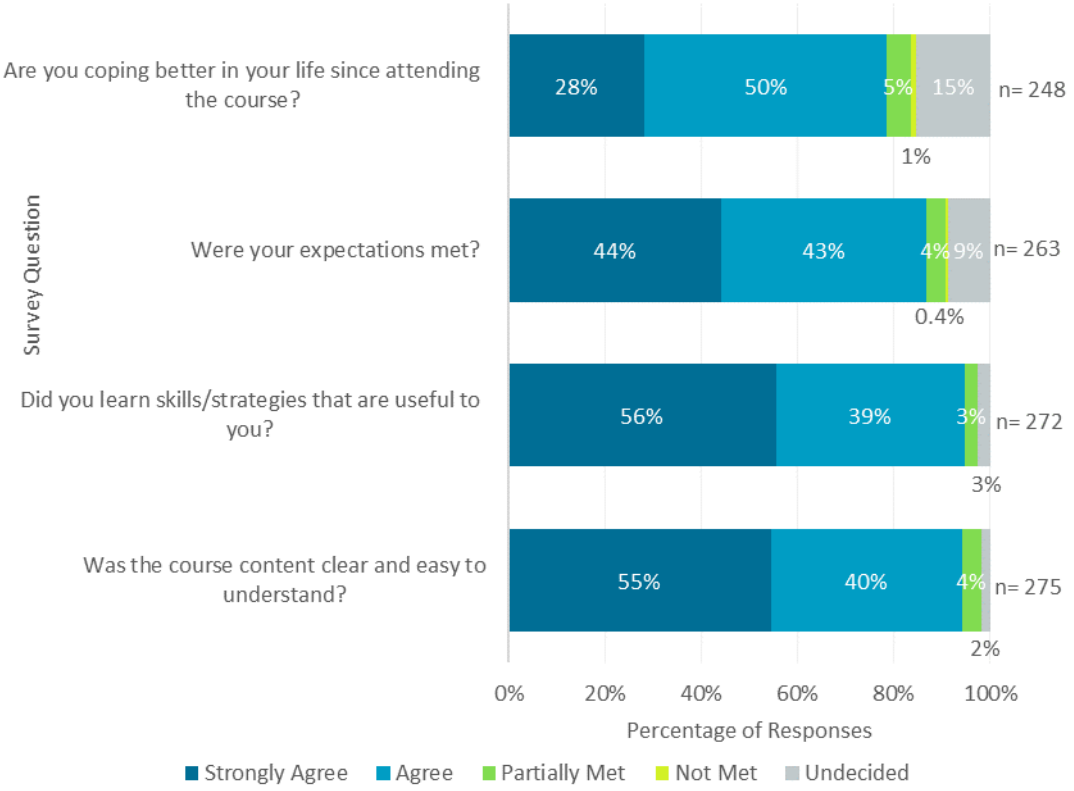
At the last session of the group, attendees are asked to complete an anonymous satisfaction survey about their experience. In 2017/18, 277 people completed surveys, which was 49% of all attendees. The surveys found:

- 94% of respondents strongly agreed or agreed that the course content was clear and easy to understand (n=277)
- The course met 84% of respondents' expectations
- 95% of respondents learnt useful skill and strategies which are useful to them

79% are now coping better since attending the course (

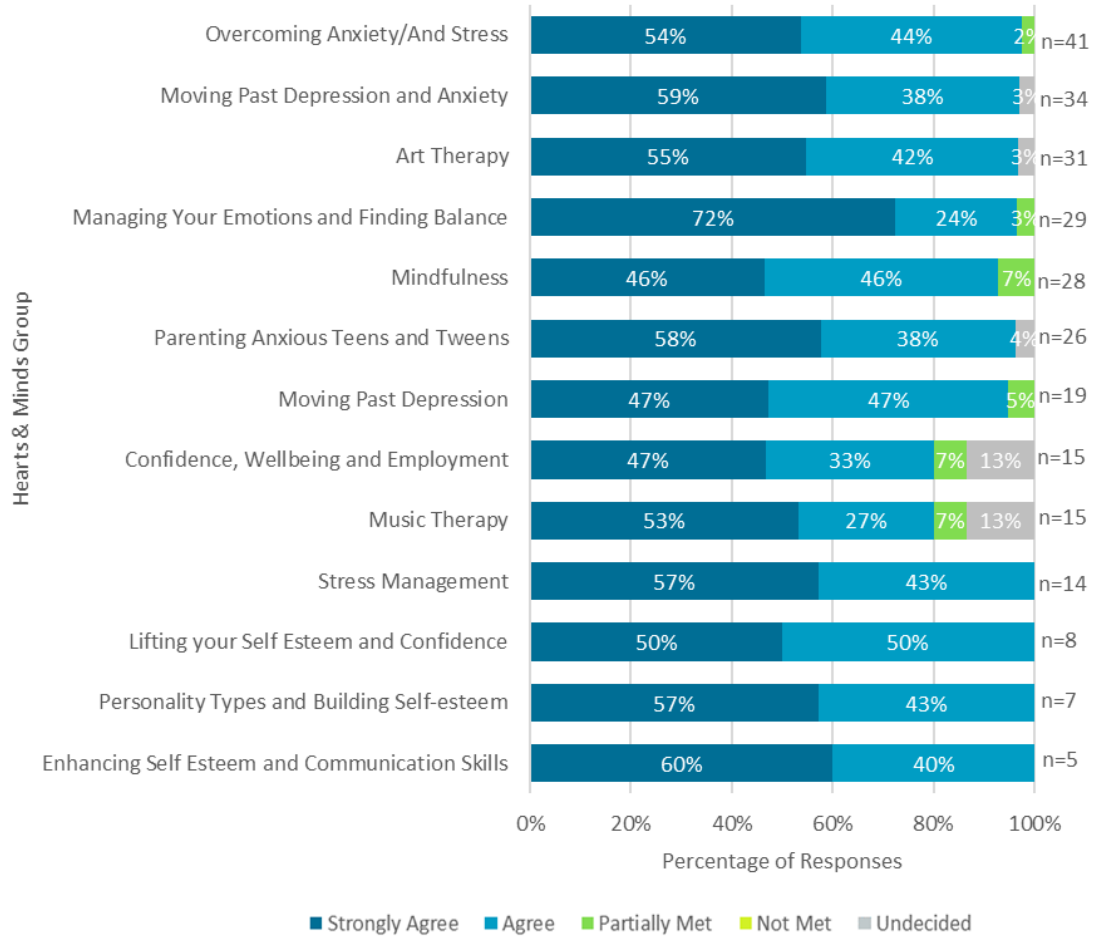
- Figure 26).

Figure 26: All survey responses by question, 2017/18 (n=277)



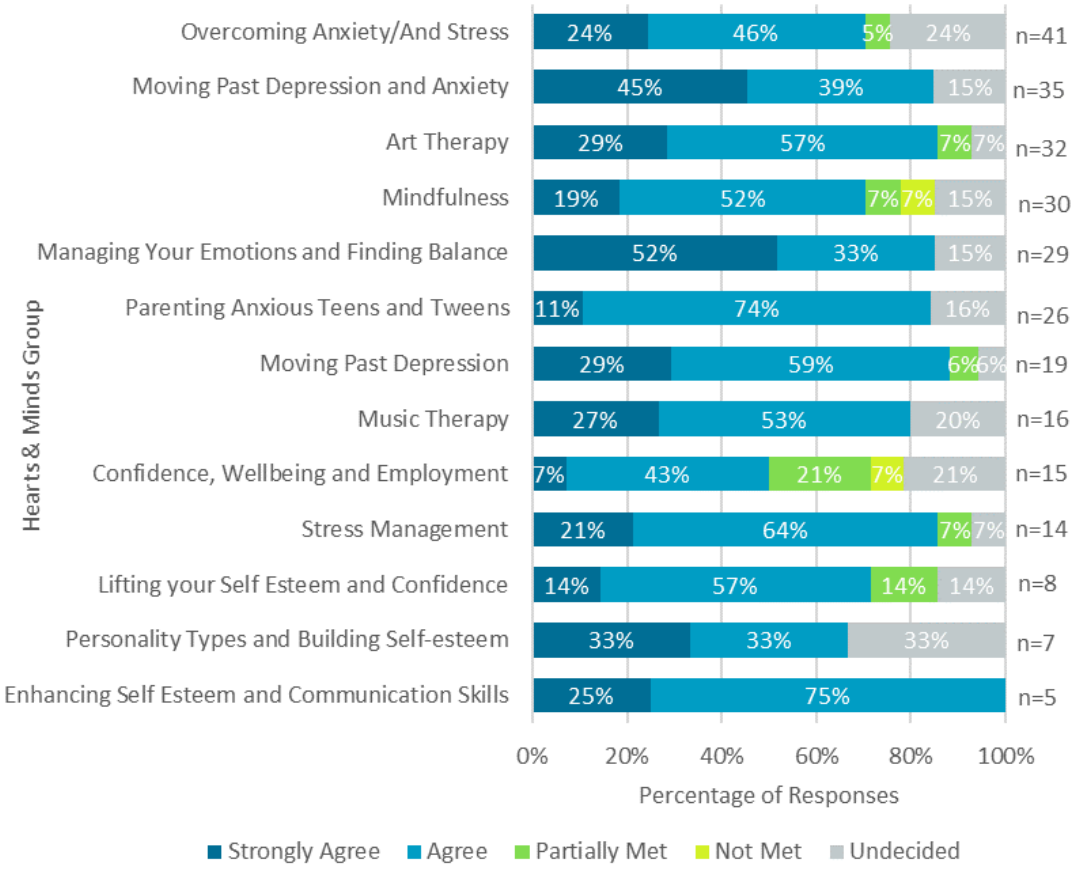
For the most common groups of Overcoming Anxiety, Moving Past Depression and Anxiety, Art Therapy, Managing Your Emotions and Finding Balance, and Mindfulness, over 90% of respondents learnt useful skills and strategies. Music Therapy, Confidence, Wellbeing and Employment had the lowest positive response, although 80% of respondents still learnt useful skills or strategies, as shown in Figure 27.

Figure 27: Group responses to 'Did you learn skills or strategies useful to you?' 2017/18 (n=272)



Respondents overall are coping better in their lives since attending the course. Stress Management, Moving Past Depression (and Anxiety), Art Therapy, managing your Emotions and Finding Balance had 85- 88% of respondents strongly agree or agree that they are coping better in their life. Confidence, Wellbeing and Employment Guidance had the least effect on participants, with only 50% of respondents coping better after the course (Figure 28).

Figure 28: Group responses to 'Are you coping better in your life since attending the course?' (n= 248)



7.2 *Health*WEST complex packages

*Health*WEST is a well-established NGO with Māori provider trust status and existing services focused on youth health and wellbeing. These services include the provision of Your Choice and Choice Plus primary mental health services (Choices to Wellbeing). These packages of care are contracted out to a range of providers across the Waitemata DHB area across West Auckland, North Shore, and Rodney. These services are part of a wider Youth Health Service and work closely with the Youth Health Hub Clinic in Henderson and our satellite clinic in Kaipataki which provides a greater opportunity of partnered care providing healthy youth development.

There is substantial triage and coordination involved in ensuring that the young people are linked with the right supports and provider(s) to best address their needs. Referrals are triaged by a multi-disciplinary team and may be accepted for Choices to Wellbeing packages or recommended for other services or supports. The multi-disciplinary triage team is staffed by Youth Health clinicians who also provide clinical services to young people who are seen under Choices to Wellbeing. Accepted referrals are then coordinated by the Choices to Wellbeing Programme Manager where young people

are matched to the most suitable providers for the young person's needs and preferences. In some cases, this coordination may involve changing providers if young people do not engage with certain providers. Engagement with *Health*WEST indicates that this navigation and coordination is a time consuming but highly important aspect of ensuring young people are linked to the right support for them, within the options and capacity available. Allowing the young person to choose their preferred therapy increases the likelihood of engagement by the young person, and therefore increases the likelihood of successful outcomes from the chosen package of care.

Since January 2017, packages of care provided under these programmes have been limited to either four talk therapy sessions or eight mentoring sessions. When accepting referrals, *Health*WEST are accepting a duty of care for the young person and the limited sessions are not always sufficient to care for a young person with mental health needs, particularly in the following circumstances:

- For young people, who take time to build trust in their providers before opening up about issues which may not have been identified in the initial referral.
- For provision of the systemic work to include whānau in the sessions, especially for children under 16 or young parents. This is particularly important for young people who identify with a Māori world view (Te Ao Māori), where the input of the whānau plays a critical part in improving the health outcomes of the young person.
- When young people are referred back to the Your Choice provider for further therapy after they have been seen by secondary mental health.
- For young people who are not receiving support because they do not fit the criteria for any service, such as those who do not meet the CAMHS or AMHS criteria but do not meet the criteria of mild to moderate mental health. These referrals are sometimes accepted by *Health*WEST as they have providers with the appropriate skills while knowing there will likely be a request for additional sessions.

This highlights the challenges of meeting the needs of young people who do not meet the criteria for secondary mental health services but require more than four sessions.

In July 2017, additional funding was provided for complex packages of care. These complex packages are for those young people who require further sessions to address their needs. Therefore, all young people who receive complex packages have already received services through the Your Choice programme. To apply for subsequent sessions; providers need to complete a request for subsequent sessions template. This outlines current presenting issues, progress that the young person has made to date, and expected outcomes from approving additional sessions.

All requests for additional sessions through the complex packages of care are triaged weekly by the multi-disciplinary clinical team which also includes clinicians from secondary mental health services and clinical youth health staff. This triage process includes looking at the request for subsequent sessions alongside the person's initial referral including the person's age, gender and ethnicity, the original presenting issues and source of referral. The following factors are taken into consideration when approving complex sessions:

- Priority will be given to young people who are Māori, Pacific and underserved.
- Under-served populations are a complex mix of;
    - Poorly engaged young people
    - Young people disconnected from mainstream services
    - Vulnerable population groups such as; gender diverse, young parents, not engaged in school, poor school attendance.
- The level of vulnerability that the young person presents with and the complexity surrounding the young person.
- Barriers to access of mainstream health services including secondary services
- Robust mechanisms are in place to ensure consideration is given to whether or not the young person's issues can be addressed by another community agency

Special consideration needs to be taken into consideration to ensure that these young people are not further marginalised. If complex sessions are approved, depending on their priority rating and level of complexity, an additional two to eight sessions will be allocated:

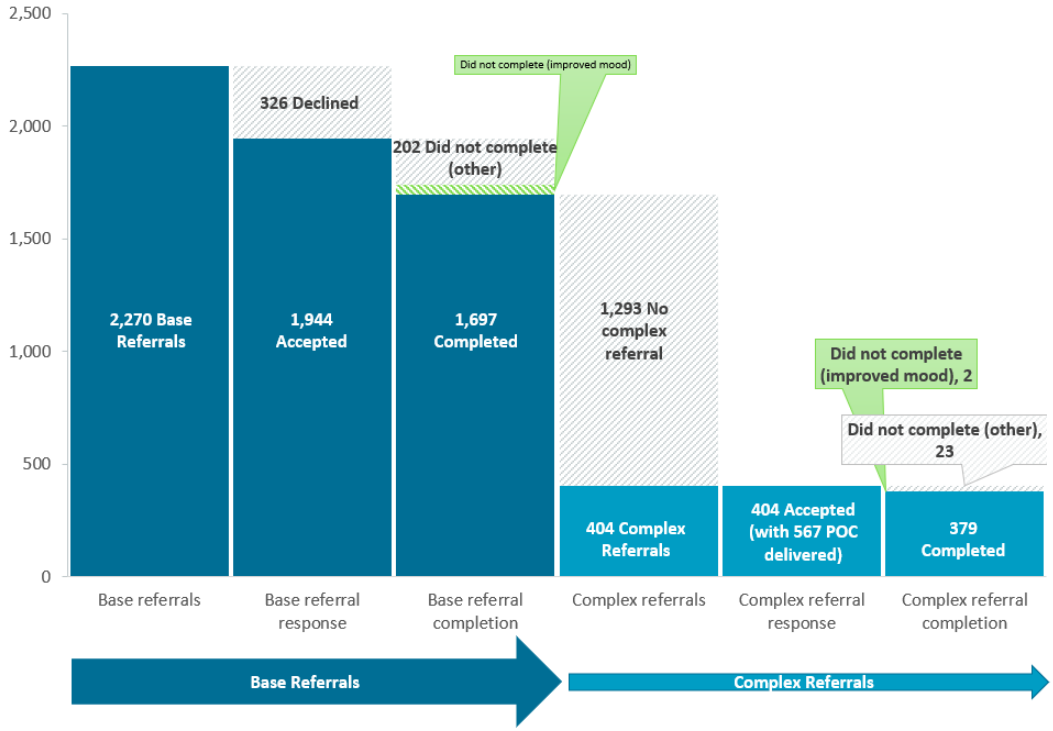
- In some cases, an additional two sessions may be allocated with a recommendation to have a low threshold for referral to other services such as secondary mental health, Taikura Trust for ongoing support, or supporting the person to access a youth group or other supports. In these cases, the providers are asked to use the session to support the young person to access more sustainable services.
- In other cases, an additional eight sessions may be allocated to include both the young person and their family to address their mental health and social needs. In some situations, such as a young person unable to attend school due to anxiety, the provider will also need to involve the school.

7.2.1 What is the reach of the complex packages of care?

*Health*WEST received funding for 376 additional complex packages of care for the year 2017/18 financial year. In this year, 404 young people were referred for complex packages and 567 complex packages were approved[11] (See graph below). This illustrates that *Health*WEST is over-delivering in relation to their funded contract and that a number of young people are receiving more than one additional complex package of care. A package of care is funded for four sessions and young people are receiving different numbers of sessions based on their priority rating in the triage meeting as indicated above. In order for continuity of care, allocation of complex sessions are rarely declined and part of the treatment plan is to ensure a safe transition plan.

[11] Data on the number of referrals for complex packages of care that were declined were not available. However, anecdotally this number is minimal with almost all referrals being accepted, even if only two additional sessions are approved to help transition the young person to another service. For this reason, accepted referrals are assumed to be 100% for the purposes of this analysis.

Figure 29: Reach of complex packages by stage in referral journey



In alignment with the priority given to Māori and Pacifica people, *Health*WEST have been reaching higher rates of Māori and Pacifica in relation to the WDHB enrolled population[12]. *Health*WEST have also been reaching a high rate of people from other ethnic groups (Figure 30).

From a service provision perspective, young people of NZ European ethnicity still make up over half of referrals to the services (Figure 31). It is interesting to note that the proportion of Māori and Pacifica people being referred to complex packages is lower than referrals to base packages. While this appears to contradict the priority given to these young people and the levels of complex mental health needs within these populations, there are some anecdotal explanations that may be contributing:

- The level of complexity of Māori and Pacifica people may be better met by other services, so referrals are made elsewhere, for example secondary mental health services.
- The underlying causes for the mental health needs of Māori and Pacifica may be met by other health or social services.

[12] Ministry of Health PHO enrolments data for ages 12-25 in Waitemata DHB have been used for population denominators. Note that this has some limitations in that 95% of the population is enrolled in a PHO and there are some differences across ages and ethnicity. It should also be noted that ethnicity recording by health services is not always accurate and this may be reflected in the population data used in this analysis.

- *Health*WEST deliver group-based mentoring programmes in schools with high proportions of Māori and Pacifica young people. Therefore, many Māori and Pacifica utilise Your Choice base packages of care through these school based group mentoring programmes. They are therefore less likely to apply for complex packages following these group-based mentoring programmes.

Figure 30: Referrals per 10,000 people by ethnicity for 2017/18

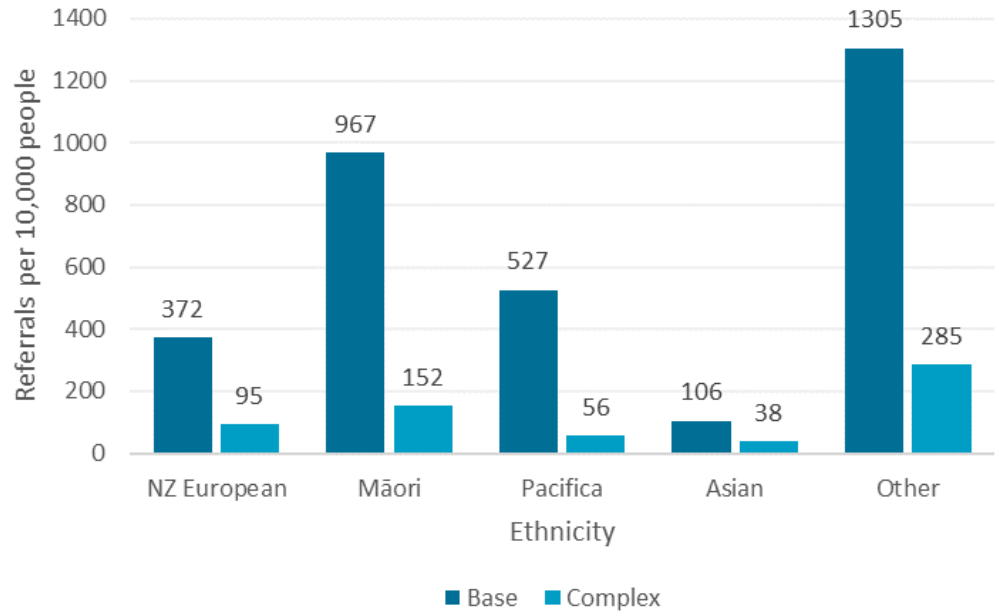
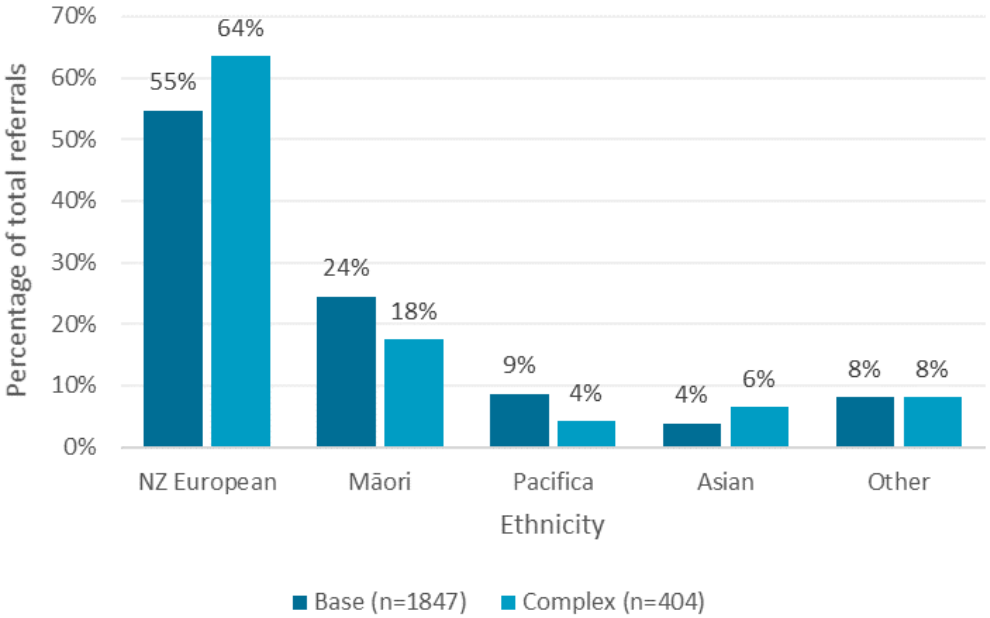
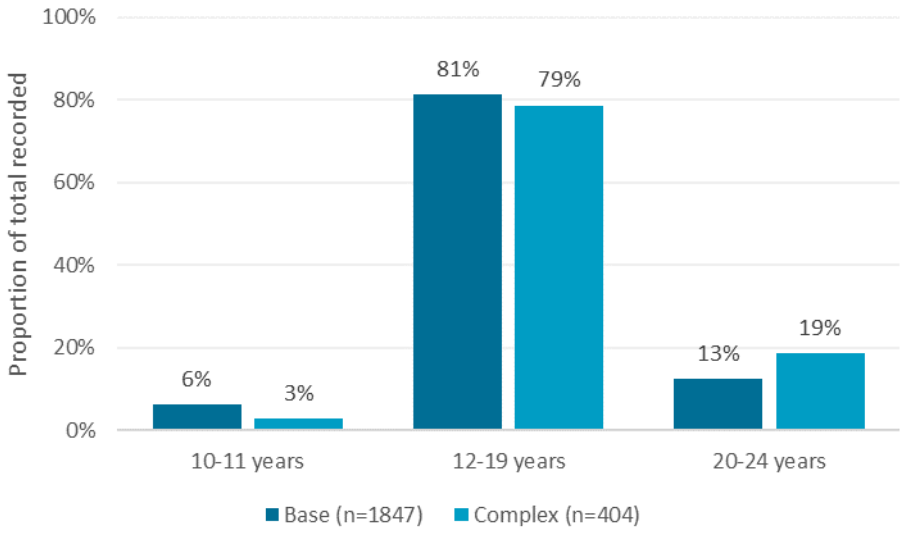


Figure 31: Reach of base and complex packages by ethnicity for 2017/18



*Health*WEST are funded to provide packages for young people aged 12 to 24 years. While the majority of young people being referred to services are aged 12 to 19, there are some young people aged 10 and 11 with mental health needs being referred and those aged 20 to 24 are receiving more referrals to complex packages of care compared to those under 20 years (Figure 32).

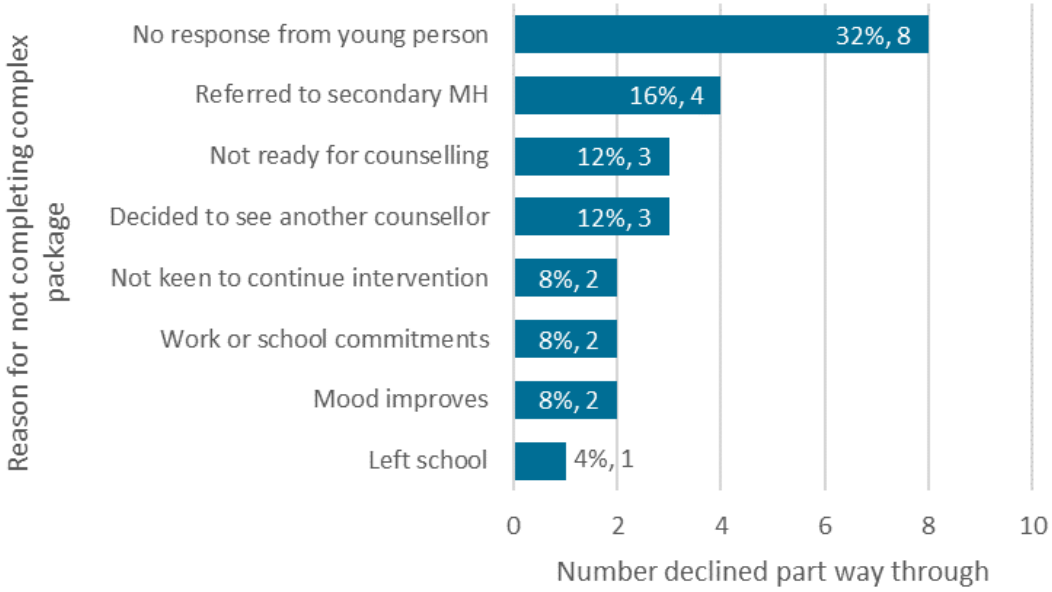
Figure 32: Reach of base and complex packages by age group for 2017/18



7.2.2 How well have the complex packages of care been delivered?

Young people that had a complex package of care approved were highly likely to complete the additional package of care provided. Only 25 (6%) young people did not complete the package once it had been approved with a range of reasons being recorded (Figure 33). This level of engagement with the service would suggest that the intervention is being well delivered: both in the triage process to approve those committed to working through their issues and provision of supports in a way that meets the needs and preferences of young people.

Figure 33: Reasons for did not complete approved complex package for 2017/18 (n=25)



This level of engagement reflects the work that is done by *Health*WEST and their contracted providers in youth engagement. *Health*WEST contact young people by phone, text and letter to engage a young person before they are considered to have 'no response from young person'. Contracted providers are able to work with flexibility and many offer after hours and weekend appointments. Providers are matched with the needs of the young people to ensure they can be offered support which is client-focused and age-appropriate, for example having similar faith-based values if this is something that is important to the young person.

7.2.3 What are the barriers and enablers to delivery?

Barriers to the delivery of complex packages of care to support young people with mental health needs include challenges to both workforce availability and the complexity of the young people's needs:

- **Workforce availability:** One of the challenges is the availability and capacity of contracted providers to support young people that are referred for base or complex packages of care due to the significant increase in demand for services by young people and in some cases skilled workforce shortages. This can lead to wait times of four to six weeks for a young person to access supports. The availability in rural areas of Waitemata is particularly challenging. For example, there is one mentoring service available in Whangaparoa and when they reach capacity there is nowhere else to send young people in this area who have been referred for support. In addition, *Health*WEST is competing with other organisations to access this skilled provider workforce.
- **Complexity of young people's needs:** The number of young people with severe and complex mental health needs is putting pressure across all sectors of the mental health system, including secondary services. *Health*WEST report experiencing 'scope creep' where the young people they are supporting are

presenting with more complex needs that require support from providers with a higher scope of practice. Many referrals are coming from CAMHS and there are growing numbers of referrals for OCD traits and Autism. The availability of services for young people who did not meet the *Health*WEST referral criteria also provides a challenge. Although it is not common, there have been some cases in which a referral has been accepted where they don't meet the referral criteria but who would not be able to receive the required support from any other service.

- *Health*WEST willingness to meet the needs of young people who would otherwise not meet the criteria for internal or external support. *Health*WEST try not to let young people fall through the cracks and have their condition worsen.

There are also elements that enable the delivery of complex packages of care to support young people with mental health needs. These are:

- **Established triage process:** One of the strengths of the service provided by *Health*WEST is the triage process that is conducted by a multi-disciplinary team with inclusion of staff from secondary mental health services. This supports a robust triage process and efficient navigation to the most appropriate components of the health sector to provide the supports most relevant to the needs of each young person.
- **Synergy with the Youth Health Hub:** *Health*WEST provides a range of health and youth development services for young people as part of the Youth Health Hub. This provides a smooth entry into mental health services where youth health clinic staff and youth workers are able to support the young people to be more engaged in entry to supports, through the hands-on approach to making referrals. The availability of skilled clinicians in the health clinic are also valuable in being able to provide brief intervention at the clinic when young people initially present and when young people have to wait to access services. The integration of the triage and coordination of additional complex packages within the Choices to Wellbeing programme allows for efficient use of resources in triage and coordination with 2.9 FTE providing the triage, coordination and review of all referrals for the Your Choice, Choice Plus and complex packages of care. Synergist flow between Choices to Wellbeing and Youth Health Clinic where young people are seen in partnership to meet the youth development needs. One of the strengths of this is the longitudinal relationship, the connection with the Youth Health Clinic, and School Based Health Services beyond Choices to Wellbeing which provides youth development.
- **Flexibility of contracted providers:** The use of contracted providers allows *Health*WEST the flexibility to match young people with the most suitable provider for their needs and preference. Many of these providers are also flexible in their work and offer afterhours and weekend appointments for young people.

7.2.4 Is anyone better off? Complex packages of care

*Health*WEST uses the PHQ9 to collect client level assessment and outcomes data. Young people accessing both base and complex packages of care demonstrated improved levels of wellbeing based on the matched pairs PHQ9 average entry and exit scores (Figure 34). Entry scores for both base and complex packages represent the score at entry to the base package. The exit scores represent the score at completion of the final

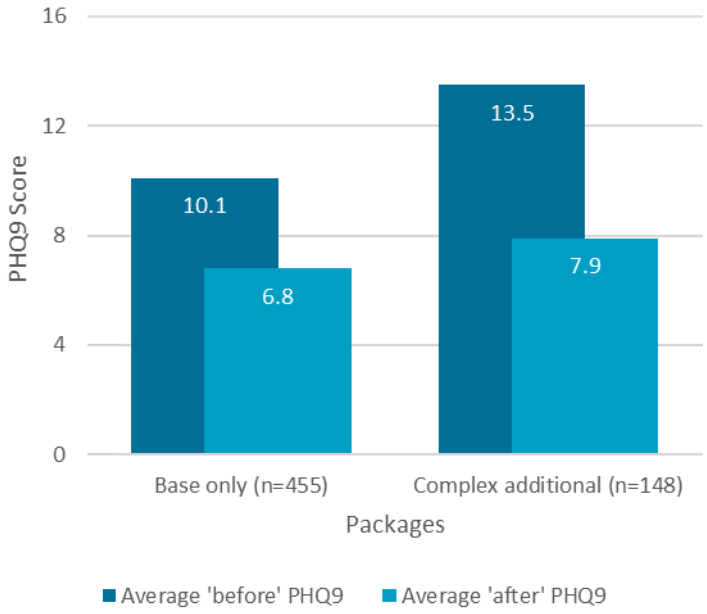
package; there is no data available for the score of those who accessed complex packages after completion of their base package and prior to commencement of an additional complex package.

In understanding the fit of complex packages with the base packages provide by *Health*WEST, it should be noted that young people who received additional complex packages had, on average, higher PHQ9 entry scores. This suggests that the complex packages are being used for those young people with higher levels of need.

In understanding the effectiveness of the complex packages for the young people who access them, the PHQ9 scores demonstrate complex packages are supporting a greater improvement in wellbeing than base packages alone:

- Base packages achieved an average of 32% improvement in PHQ9 scores.
- Complex packages achieved an average of 41% improvement in PHQ9 scores.

Figure 34: Average PHQ9 entry and exit scores for matched pairs for 2017/18



Case studies demonstrate the reasons for requesting additional sessions beyond the base packages provided. They also demonstrate the strategies that the young person found most helpful in making progress on their issues.

Case Study 1: Additional mindfulness to support a young female with social stressors and suicidal ideation

Referral: 17 year old female Indian young women referred from Marinoto West who is struggling with multiples stressors, low mood and has occasional thoughts of self-harm/suicidal ideation, alongside recent suicide attempt.

Request for subsequent sessions: Young person was referred to a counsellor who could offer early evening appointments, had attended 4 sessions and requested further

sessions to continue to build her sense of self through looking at her friendships with different perspectives, building tolerance around silence and awkwardness, mindfulness and trying to stay in the present to help separate from unhelpful thoughts.

Additional 4 sessions approved.

Outcome

Entry PHQ-9 score 15 Exit PHQ-9 score of 6

Progress made: "I don't feel as upset that I'm drifting away from my friends". "I feel a lot happier now, plus I know to prioritise myself". "I know some techniques to use when feeling anxious".

Strategies that the young person felt helpful: mindfulness skills, addressing negative thought patterns and building self-esteem.

Case Study 2: Additional sessions to support a young male with anxiety and school avoidance

Referral: 15 year old male NZE referred by his GP – school avoidance, several days complaining of sore stomach, nausea and vomiting, does not want to see School Guidance Counsellor, spends time computer gaming.

Request for subsequent sessions: Young person was referred to a psychologist and attended 4 sessions, further sessions were requested as school avoidance due to anxiety was still an issue. To date the young person was developing an understanding of his anxiety symptom profile, psychoeducation and relaxation skills to manage physical symptoms and his parents attended an information session.

Additional 6 sessions were approved with a low threshold to refer to Marinoto if limited progress.

Outcome

Entry PHQ-9 score 9 Exit PHQ-9 score of 2

Progress made: Young person is feeling anxious less often and less in severity, "understanding who I am, my triggers and what my symptoms are and how to manage my symptoms".

Strategies that the young person felt helpful: relaxation exercises, confronting my anxiety, understanding my anxiety, being more hopeful I can manage things now, my parents understanding my anxiety and how this impacts on me.

Case Study 3: Additional sessions to support a young female with social anxiety

Referral: 14 year old female Māori young girl referred by School Nurse - presents with social anxiety, disturbed sleep who is a high achieving student.

Request for subsequent sessions: Young person was referred to an Occupational Therapist, had attended 4 sessions and requested further sessions as main issue is social anxiety, as well as co-existing generalised anxiety and sleep issues. OT has been providing psychoeducation on social anxiety, working on anxious cognitions, sleep hygiene, mindfulness and 5 senses.

Additional 6 sessions approved.

Outcome

Entry PHQ-9 score 19 Exit PHQ-9 score 3

Progress made: "I made new friends, talking to more people at lunchtime, even talked to people at the bus stop". "I have better concentration, better sleep and better mood overall".

Strategies that the young person felt helpful; breathing, catching negative thoughts and challenging these, fidget toys for concentration in class, mindfulness and sensory skills.

7.2.5 What is the effectiveness for the people who are delivering the intervention?

The availability of the additional complex packages of care increase the confidence of contracted providers to accept clients for base packages of care. Anecdotal evidence from *Health*WEST indicated that with the reduction in number of sessions funded in a base package of care, some providers were concerned about the clinical risk to accept a client with complex needs if only four sessions could be provided. Having the option to apply for additional sessions provided confidence that they would not be neglecting the duty of care that they accept when they support a young person. There is no evidence to inform how the availability of the option to apply for additional packages of care may influence the way they approach care for the young people.

7.2.6 What are the recommendations for improvement?

The complex packages of care provide value in supporting improvements in wellbeing for those who they reach. However, more young people are asking for help and presenting with complex needs. With this context, the current approach to delivery will be unsustainable within current funding. Recommendations for improvement relate to increasing the use of existing services available and broadening the supports available for young people:

- **Accessing Awhi Ora for young people:** Awhi Ora has been introduced into Waitemata DHB as part of the Fit for the Future funding. Although implementation is emerging, a stronger partnership between *Health*WEST and Awhi Ora providers would be beneficial for *Health*WEST, Awhi Ora providers, and the young people supported. Awhi Ora is intended to address some of the social stressors that contribute to the mental health needs of people and allowing Awhi Ora providers to focus on these issues would allow *Health*WEST to focus on the other issues facing young people.
- **A workforce that is suitable for working with young people:** One of the strengths of the service provided by *Health*WEST is the youth development approach that is applied by all staff across different roles. This provides a youth friendly service

with which young people can engage. Developing and training the wider workforce so that young people can be engaged and supported at other touchpoints of the health system could improve the availability of effective and youth friendly services to support young people with mental health needs.

- **Advocating for a system without gaps:** One of the challenges that was raised was the lack of services available for people who needed support but did not meet the referral criteria for any particular service. For example, a young person with a history of severe domestic abuse and PTSD that is not funded by ACC. Although it was uncommon to accept these young people who did not meet the referral criteria for a service, when they were accepted for a base package of care there was an expectation that they would require substantial resources from the complex packages of care. Access to different types of supports with less restrictive referral criteria are required to support young people. While still emerging, services like Awhi Ora may help meet some of this need.

7.3 Comprehensive Care Melon programme

7.3.1 What is being delivered?

Comprehensive Care already provide primary mental health initiatives in the form of one-on-one psychological therapy and a group intervention called the 'managing mood' group. The additional funding for enhanced PMHIs has been used to work in conjunction with private health technology company, Melon, to establish and fund the Melon platform; an eTherapy intervention that is based on the existing 13-week managing mood group programme for patients who cannot or maybe do not wish to access face-to-face group sessions.

The Melon programme involves:

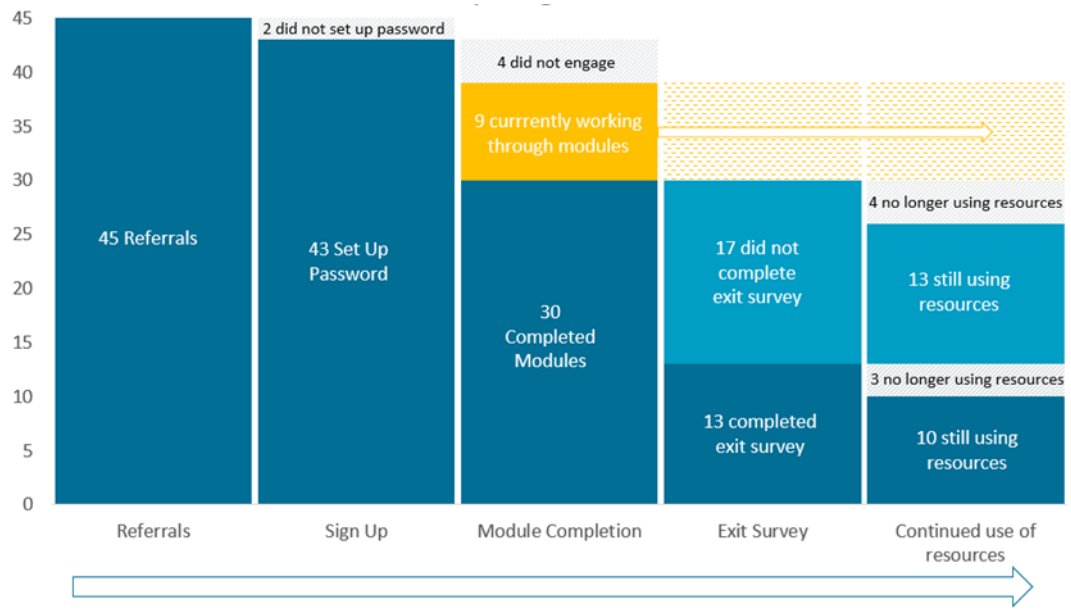
- 12 week online programme with different modules and content available each week.
- Includes half an hour contact with a psychologist each week via safebrowser videoconference. This is the most significant difference compared to other eTherapy models.
- Includes a closed community forum for people using Melon to share stories and comments with each other. This online community discussion is monitored by a mental health nurse from 8am to 8pm, seven days a week to ensure safety.
- Multiple methods of engagement for clients including the modules, community forum, resources, newsletter, diary tracking and ORS (outcome rating scale). People continue to have access to the resources through Melon after they have finished the course.
- The Melon programme has comprehensive processes for managing risk and the interface includes contact phone numbers if people want more help. Although primary mental health packages are intended to be for people with mild/moderate mental health needs, in reality, they are seeing people with moderate/severe needs. As a result of this level of need it is essential for programmes to be comprehensive and safe.

7.3.2 What is the reach of the intervention?

Comprehensive Care had additional funding for a total of 150 online packages of care using the Melon programme and 1FTE psychologist available to provide the weekly video contact as part of the programme. From the period September 2017 to June 2018, 45 people had been referred to the Melon programme and 30 people have completed all the modules.

The reach of the Melon programme across this time period is illustrated in Figure 35. It demonstrates a good level of engagement with the programme with only 13% of people referred who did not engage with the programme. A meta-analysis on adherence to internet-based and face-to-face cognitive behavioural therapy for depression found that an average of 65% of people completed the total intervention[13].

Figure 35: Reach of the Melon programme at 30 June 2018 by stage of the patient journey



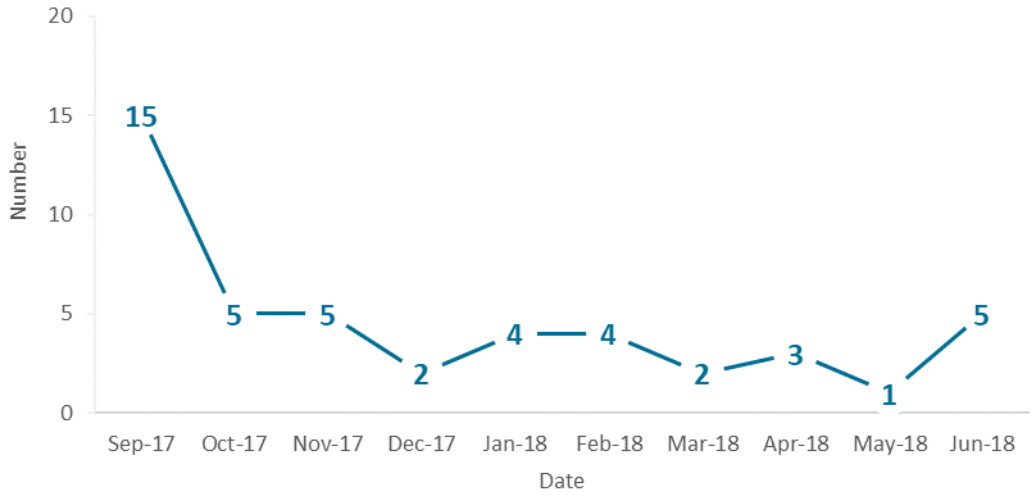
Demographic information on who has been reached by the Melon programme were not available to the evaluation. However, online delivery is intended to support PMHIs to address the needs of those who experience barriers to accessing face-to-face group therapy, for example due to rurality, transport barriers, working hours, other health issues, and/or anxiety about a group environment.

Melon is still in its early stages of implementation. Referral trends show that while a number of people were referred in the first month, there are still only a small number of referrals each month (Figure 36). Interviews with Comprehensive Care also noted that

[13] van Ballegooijen, W., Cuijpers, P., van Straten, A., Karyotaki, E., Andersson, G., Smit, J. H., & Riper, H.(2014). Adherence to Internet-Based and Face-to-Face Cognitive Behavioural Therapy for Depression: A Meta-Analysis. *PLoS One*, 9(7), e100674. doi:10.1371/journal.pone.0100674

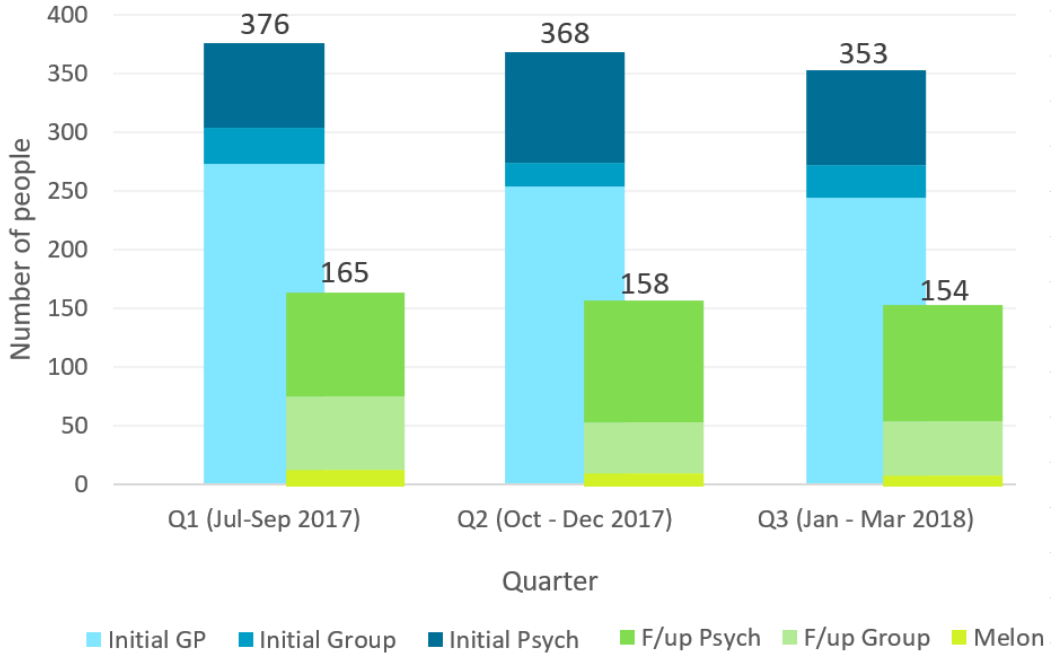
with the limited number of 150 packages available, there was incentive to only refer those who were likely to engage with the programme so that resources are not 'wasted' when they do not complete. This incentive may be influencing the low number of referrals and supporting the high levels of completion of the programme.

Figure 36: Referrals to Melon over time September 2017 - June 2018 (n=45)



The additional funding for Melon is just one component of the PMHIs provided by Comprehensive Care. At present, Melon makes up a small component of the overall services and supports provided to people with mental health needs (Figure 37). It fills a role in supplementing the suite of options already provided by Comprehensive Care. It is intended to increase access for those who would be unable to attend normal face to face groups sessions.

Figure 37: Reach of Comprehensive Care PMHIs at 31 March 2018 (n=1574)



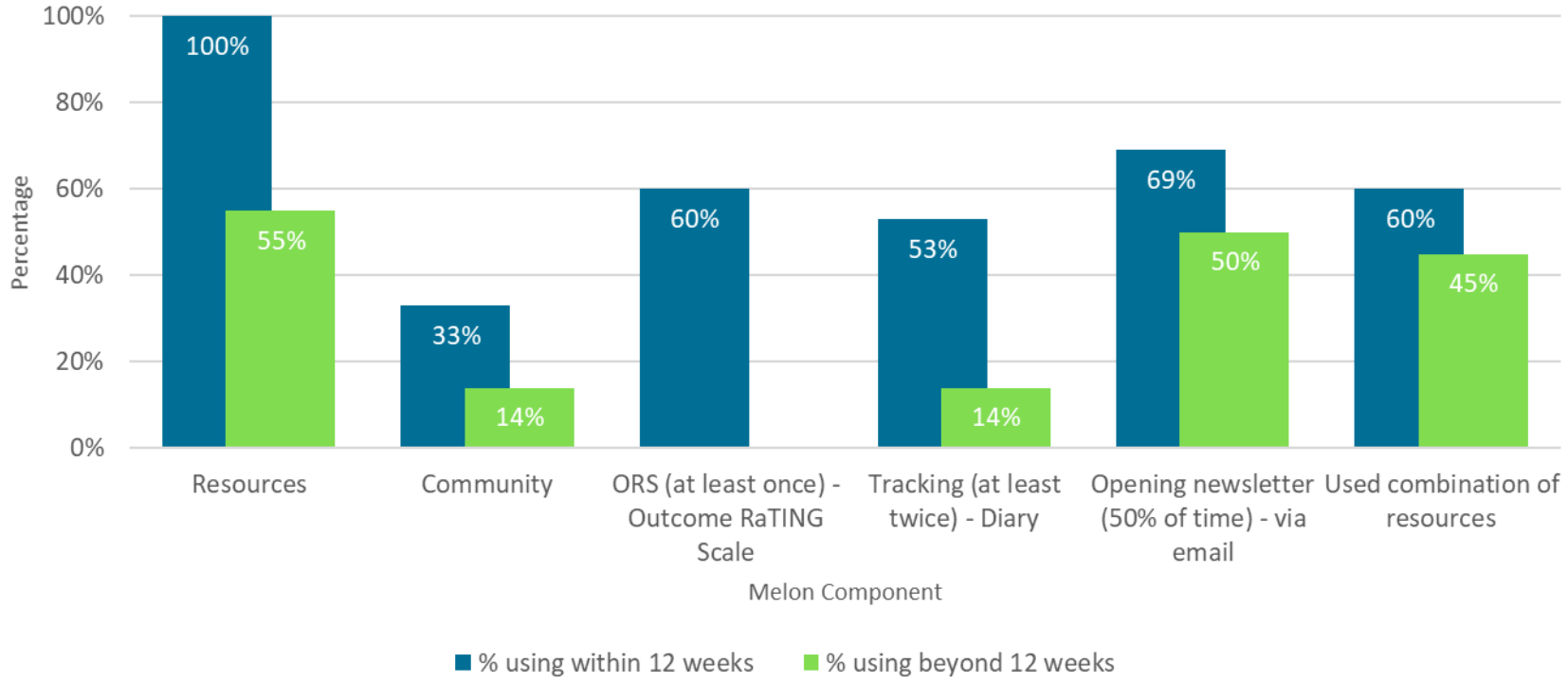
7.3.3 How well has the intervention been delivered?

Early evidence suggests that the Melon programme has been well delivered for supporting people with mental health needs who have been referred to the programme. The low level of drop out from Melon indicated in Figure 35 suggest that the intervention has been well delivered to meet the needs of people who have been referred to the programme.

Level of engagement with different components of the Melon programme and the use of a combination of resources also indicate that the range of engagement methods are well-suited to allowing people to use the components that work best for them (Figure 38). People also appear to be working through Melon at their own pace, with completed users taking an average of 16 weeks to complete the 12 week modules. People are also continuing to engage with the Melon components after completion of the 12 week module programme.

The Melon programme is also perceived by Comprehensive Care staff to be more appropriate and safe for delivering eTherapy compared to previous programmes such as 'Beating the Blues'. They referenced poor completion rates for Beating the Blues and insufficient processes for managing risk if people were presenting with moderate/severe mental health needs.

Figure 38: Engagement with Melon components during and after 12 week modules at June 2018 (n=43)



7.3.4 What are the barriers and enablers to delivery?

Barriers to the use of Melon to support people with mental health needs include challenges to initial engagement and referral and technological barriers to access:

- **Initial engagement and referral:** Perceptions from Comprehensive Care on factors that were challenging implementation included the challenge in getting people to fully engage with the intervention in the first time. This included engaging health professionals to be comfortable making referrals to eTherapy as well as introducing it to people with mental health needs. The limited number of packages available provided incentives for health professionals to not refer people who might be considered more at risk of dropping out (and therefore being perceived as 'wasting' resources).
- **Technological barriers to access:** The use of the Melon programme and the included video conference contact time using safebrowser have a certain level of hardware requirements for both staff and people using the programme. Although they can be met by most people, these requirements may mean certain populations, for example older people, may still experience barriers to accessing Melon.

There have also been elements that help enable the delivery of Melon to support people with mental health needs. They include:

- **Staff belief in the value of the intervention:** Feedback from Comprehensive Care indicated that all staff believe in the value of the Melon intervention. It is perceived to be appropriate for meeting the needs of patients. The way that Melon maintains contact with the person through the video conference component also makes them feel safer to refer people with mental health needs where they haven't always felt safe to make these referrals to other online programmes.
- **Responsiveness from Melon development company:** Comprehensive Care have found Melon (the company that developed the Melon programme) to be very supportive and responsive to communication and making adaptations. They note that while Melon is a NZ software company that already develops health software to support other conditions such as diabetes, they are the first PHO to be using a Melon product in mental health. Being the 'pilot' for Melon may contribute to the high level of attention they are receiving from Melon.
- **Flexible psychologist work hours:** The psychologist providing the one-on-one video conference contact as part of the Melon programme has been flexible working on glide time to deliver a service that can provide contact time at times that suit the needs of patients, including outside working hours.

7.3.5 What is the effectiveness for people who are supported by the intervention?

Melon appears to be demonstrating levels of effectiveness at least as high as the effectiveness of the Managing Mood group therapy. This is demonstrated by the large changes in assessment scores across the GAD, PHQ9 and K10 measures (Figure 40 & Figure 41).

Figure 41: Average entry and exit scores for Managing Mood group therapy matched pairs (n=72)

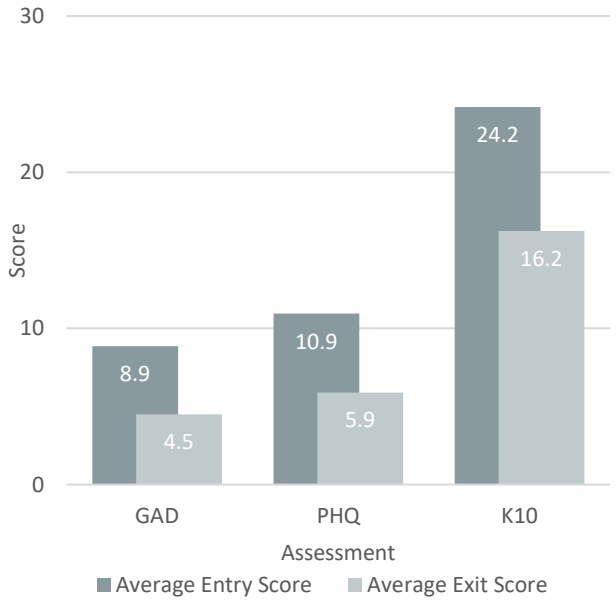


Figure 40: Average entry and exit scores for Melon matched pairs (n=13)

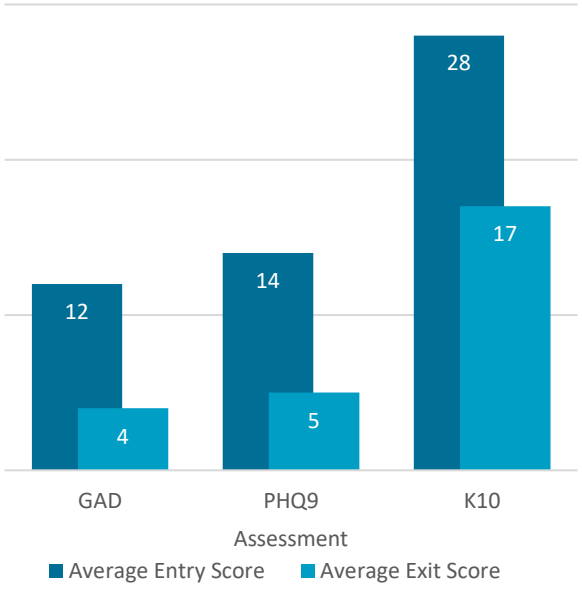
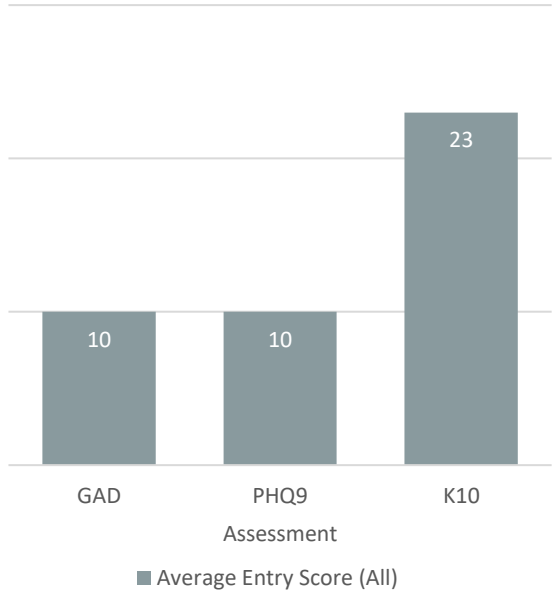


Figure 39: average scores for all Melon entry assessments (n=35)



Although Melon is still in its early stages and there are low numbers of matched pairs to demonstrate the effectiveness for people supported by Melon, the initial finding that Melon is demonstrating greater effectiveness that the Managing Mood group is supported by the recent review by Te Pou on the effectiveness of e-mental health approaches[14]. They conducted a literature review which included 43 systematic reviews and meta-analyses on the effectiveness of e-mental health approaches and found that in comparison to the controls within these studies:

- Moderate to large effects were identified for computerised CBT interventions on adults' anxiety outcomes,
- Moderate to large effects for computerised CBT interventions on youth anxiety and depression outcomes, and
- Small to moderate effects for computerised CBT interventions on adults' depression outcomes.

Feedback from people who used Melon and responded to the feedback survey also indicated positive experiences using the Melon programme. Most people (83%) who responded said they would be likely to recommend Melon to others (and the other 17% said maybe). Open ended responses also demonstrated the value of components of Melon that are different to engaging with the Managing Mood group:

> ***"This was an excellent program. Found it great because I could do it in my own time and go back to resources. Finding time to see my counsellor and work was stressful."***
>
> ***"The community is my favourite part right now, it really eliminates that feeling of being alone which is one of the biggest factors for people going through anxiety and depression. I will still be using the resources available on Melon, the mood diary and journal when I need to, and regularly checking in on the community newsfeed to talk with others and feel a little less alone."***

7.3.6 What are the recommendations for improvement?

The Melon programme is still in its early stages and has been adapted and improved through the process of development and testing that was supported by the additional funding for enhanced PMHIs. Comprehensive Care and Melon have communicated their commitment to ongoing improvement of the Melon programme.

Melon collects and analyses a range of engagement data that is intended to support ongoing improvements to the safety and effectiveness of the Melon programme. This includes using data to understand how certain components of the programme (including specific resources and modules, self-tracking, community forum support, and 'I need help' tips and techniques) impact on the psychometric surveys and ORS ratings. Melon has also started to collect demographic data on people using the programme which will support an understanding of which people are reached and for which people it works best. This will support improvements to the way that Melon is accessed from a

[14] Lai, J. & Jury, A. (2018). Effectiveness of e-mental health approaches. Te Pou o te Whakaaro Nui: Auckland

population health perspective as well as improvements to the design of the platform itself.

7.4 ProCare Health Improvement Practitioner and Health Coach

Health Improvement Practitioners are registered health professionals (most commonly psychologists) who can work briefly with a high number of people (10+ each day) to provide targeted behavioural health support within primary care. Health Coaches are non-regulated workers who support people with health literacy and self- management relating to long term conditions. The warm handover, a face to face introduction that enables immediate or same day consultations, where possible, is an important dynamic of these roles within the practice team. Practical action and self-management plans are developed with people that focus on the wellbeing issues of concern to them and repeat consultations occur as and when required by the client.

Detailed findings on the Health Improvement Practitioner and Health Coach roles can be found in the ADHB FftF evaluation report. This highlights the value of these roles and the wider enhanced practice team framework, including Awhi Ora. A summary of the key findings for the ProCare practices in WDHB are provided on the following pages.

Health New Lynn

1, McCrae Way, Level 1, New Lynn, Waitakere 0600

How much

1 April-13 July 2018

	HIP	HC
Total referred	258	88
Conversion	98%	91%
Delivered consults	306	75

How well

1 April-13 July 2018

	HIP	HC
% Seen same day	51%	46%
% Seen same week	89%	93%

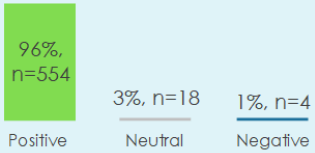
"The immediacy of the HIP and Health coach is a huge benefit – having them on site and available to see a patient then and there is great. The practicality of the care and advice they give is superb – they can help the patient now and don't need to spend months getting to the root of the problem - they focus on providing coping mechanisms that will help in real time".

Better off

HIP Duke, entry and follow up

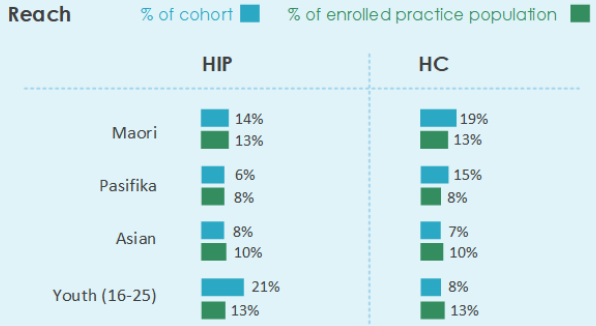
Improved	71% (n = 83)
Stayed the Same	6% (n = 7)
Decreased	23% (n = 27)

Helpfulness

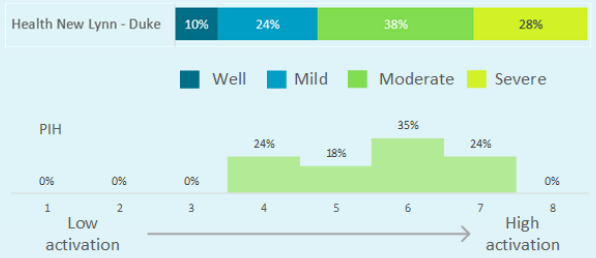


Practice population

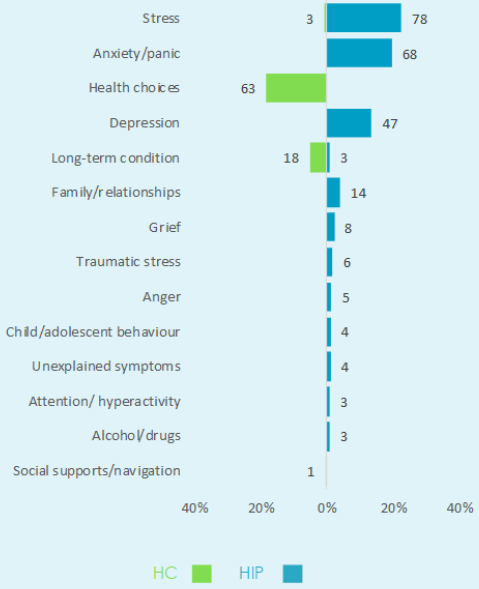
Reach



Severity of symptoms or distress on presenting



Primary presenting needs where defined



Practice information

Practice population	17895
GP FTE	10
Nurse FTE	15.1
HIP FTE	1.3
Health Coach FTE	0.5
Awhi Ora provider	Pathways

"Feedback has been very good from patients – they are accessible specialists who are able to provide immediate help. Being able to get an appointment on the same day or at the latest within the next week is extremely beneficial. People have gone out of their way to express their happiness with the HIP and Health Coach".

peninsulamedical

Peninsula Medical

382 Te Atatu Rd, Te Atatu Peninsula, Auckland 0610

How much

1 April-13 July 2018

	HIP	HC
Total referred	144	19
Conversion	94%	88%
Delivered consults	161	18

How well

1 April-13 July 2018

	HIP	HC
% Seen same day	59%	80%
% Seen same week	94%	93%

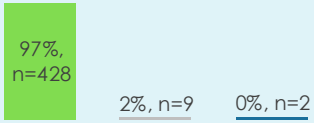
"Having them here means that if the patient has other problems and [the GP] can't address them, there is a different approach".

Better off

HIP Duke, entry and follow up

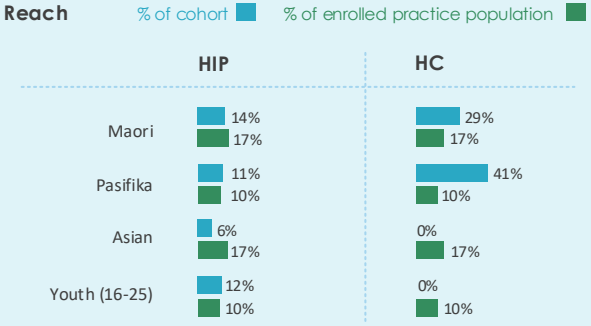
Improved	80% (n = 53)
Stayed the Same	3% (n = 2)
Decreased	17% (n =11)

Helpfulness

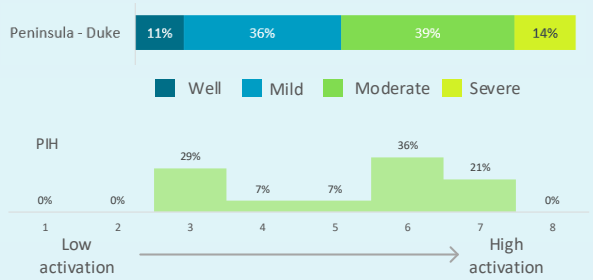


Practice population

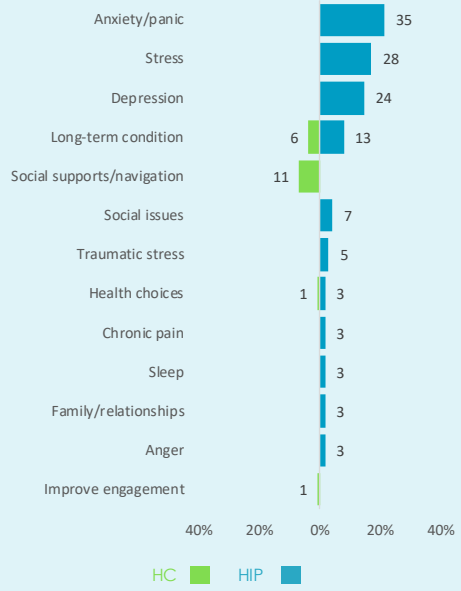
Reach



Severity of symptoms or distress on presenting



Primary presenting needs where defined



Practice information

Practice population	8700
GP FTE	6
Nurse FTE	4
HIP FTE	0.7
Health Coach FTE	0.3
Awhi Ora provider	Walsh Trust

"HIP's mental health nursing background is very helpful for taking pressure off doctors in acute situations and having that immediate support".

7.5 Feedback on the suite of initiatives available to primary care

This section draws on the findings from the clinician survey to provide feedback on the suite of initiatives available to primary care. While the survey sample is small, the open-ended responses also provide useful considerations for improvements.

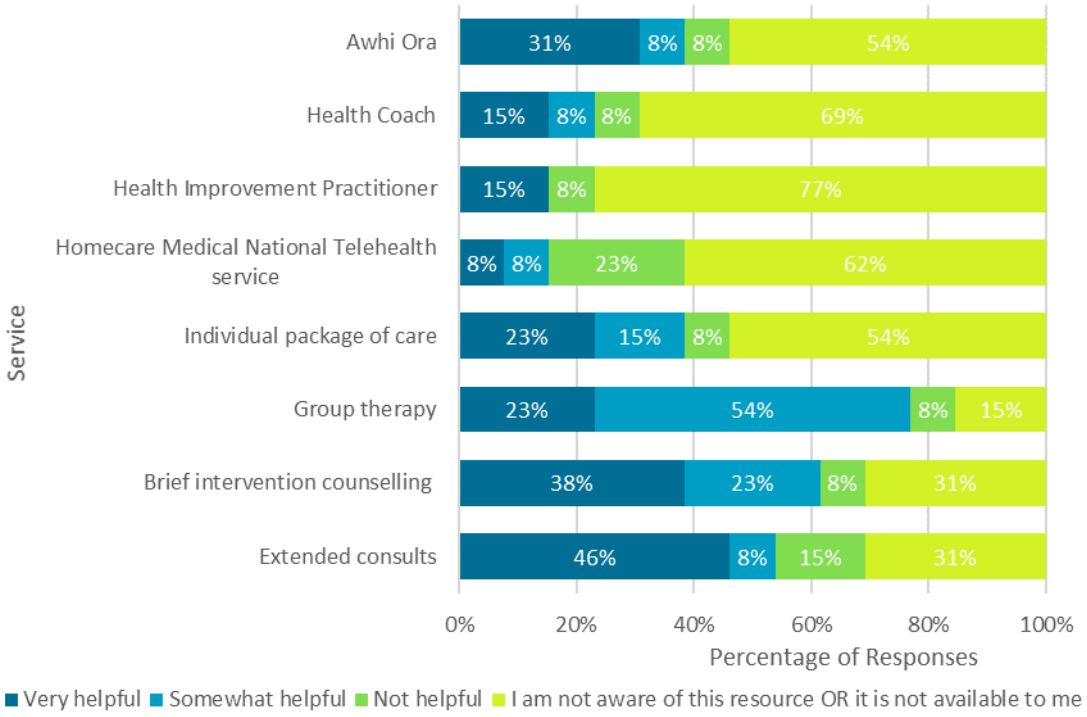
7.5.1 Knowledge and usefulness of initiatives

There are a broad range of initiatives available to primary care, which have varying degrees of use and are at varying stages of implementation. The clinician survey (n=13) asked people to rate how helpful they found the different initiatives (Figure 42). The following initiatives were more likely to be rated as very helpful:

- Extended consults (46%)
- Brief intervention counselling (38%)
- Awhi Ora Supporting Wellbeing (31%)

A high proportion of respondents were unaware of many of the initiatives available to primary care (Figure 42). Of the eight initiatives inquired about, over half of the respondents were unaware of Awhi Ora Supporting Wellbeing, Health Improvement Practitioners, Health Coaches and Telehealth. This highlights the value of increasing awareness of and pathways to options for people with mental health needs in primary care.

Figure 42: Primary care clinician rated usefulness of services and supports that are available to primary care (n=13)



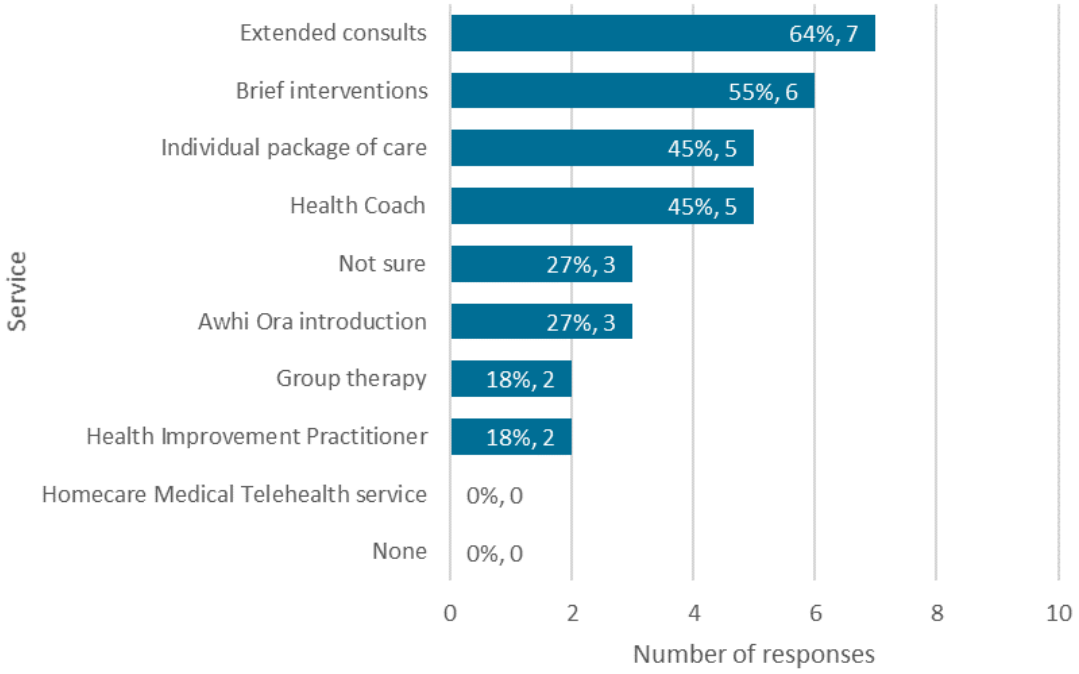
Other resources that are often drawn upon in the primary care sector are from PHOs and other supporting organisations. Counselling services provided by ProCare and Nirvana Health Group were cited as services used in primary care to support patients with mental health, as well as primary care mental health liaison nurses, *Health*WEST's Youth Hub, and the West Auckland Women's Centre.

The usefulness ratings of the primary mental health initiatives correlate with the initiatives that clinicians would like more of:

- Most wanted access to more extended consults (historically these have been limited to Māori, Pacifica and Quintile 5; 64%; n=14) or
- Increased availability of brief interventions (55%).

Clinicians felt that it was important that access to both initiatives is increased, as they work well together.

Figure 43: Services primary care clinicians want more of for their enrolled population (n=11)



Another clinician highlighted the value of increasing access to the other initiatives identified in the survey:

> ***"Group therapy provided by Hearts and Minds is excellent. A health coach or health improvement practitioner would be great – I'm not sure what level of expertise, qualifications or responsibility they would have. Awhi Ora has been a good start, despite some engagement issues."***
>
> ***(Primary care clinician survey response)***

A lack of knowledge of the available initiatives made it difficult for some to comment.

> ***"I can't comment on what I'd want more of as I don't know enough about what is already on offer to us."***
>
> ***(Primary care clinician survey response)***

This is supported by the responses in Figure 43, with three responses (27%) unsure of what services and supports they would like more of.

7.5.2 Changes in knowledge and capability

About two thirds (64%; n=14) of the survey respondents identified a little or large increase in their knowledge and capability over the last year. Comments from clinicians indicate that having mental health specialists, such as primary care liaison mental health nurses and psychiatrists visiting the practice is helpful for increasing knowledge and capability.

Professional development training and CME functions were commonly noted as the biggest contributor to changes in knowledge and capability. One clinician noted in the primary care clinician survey, that attending an antidepressant prescribing workshop was a valuable learning experience and helped them to feel more comfortable in knowing when and how to appropriately prescribe. This highlights the value of the continued specialist supports, direct telephone access and capability sessions happening this year.

7.6 Key points relating to PMHIs

- **Additional funding for the PMHIs has increased the availability and range of support options in WDHB. The funded has supported the introduction of the HIP and Health Coach role at two practices alongside funding from ProCare. Comprehensive Care provide online access to e-therapy, Hearts & Minds increased the number of groups available and *Health*WEST offered young people complex packages of care to those who needed longer support.**
- **Outcome data highlights the contribution of the additional funding to the health and wellbeing of people who have accessed these services and supports.**
- **The introduction of the HIP and Health Coach at the ProCare practices provides an insight into the opportunities to increase access and reach by providing an immediate gateway to support in primary care, and integratin mental health capability into existing practice teams.**

8. AWHI ORA SUPPORTING WELLBEING

Awhi Ora Supporting Wellbeing (Awhi Ora) provides access to community support to people experiencing life challenges or stress. Previously, such support has only been available to people through secondary mental health services. Awhi Ora is designed to enable primary care practices and cross sector agencies to have a lead NGO they can introduce people to who would benefit from wellbeing or social support. Following an introduction, people are seen by a Support Worker. This may be in the GP clinic, their home or in the community. A plan to address the person's presenting need is developed with the Support Worker. Support is usually brief – typically weekly for up to three months – but varies according to need. Other people, with multiple or more complex issues, may require support for a longer period.

Success is described as people having greater control over their lives and maximising their health and wellbeing.

Awhi Ora was funded in WDHB from September 2017. This was part of the Our Health in Mind Strategy (Business Case One) designed to increase access to NGO support hours across the district. The reach and experiences of WDHB Awhi Ora are included in this report as their learning and implementation journeys are intertwined.

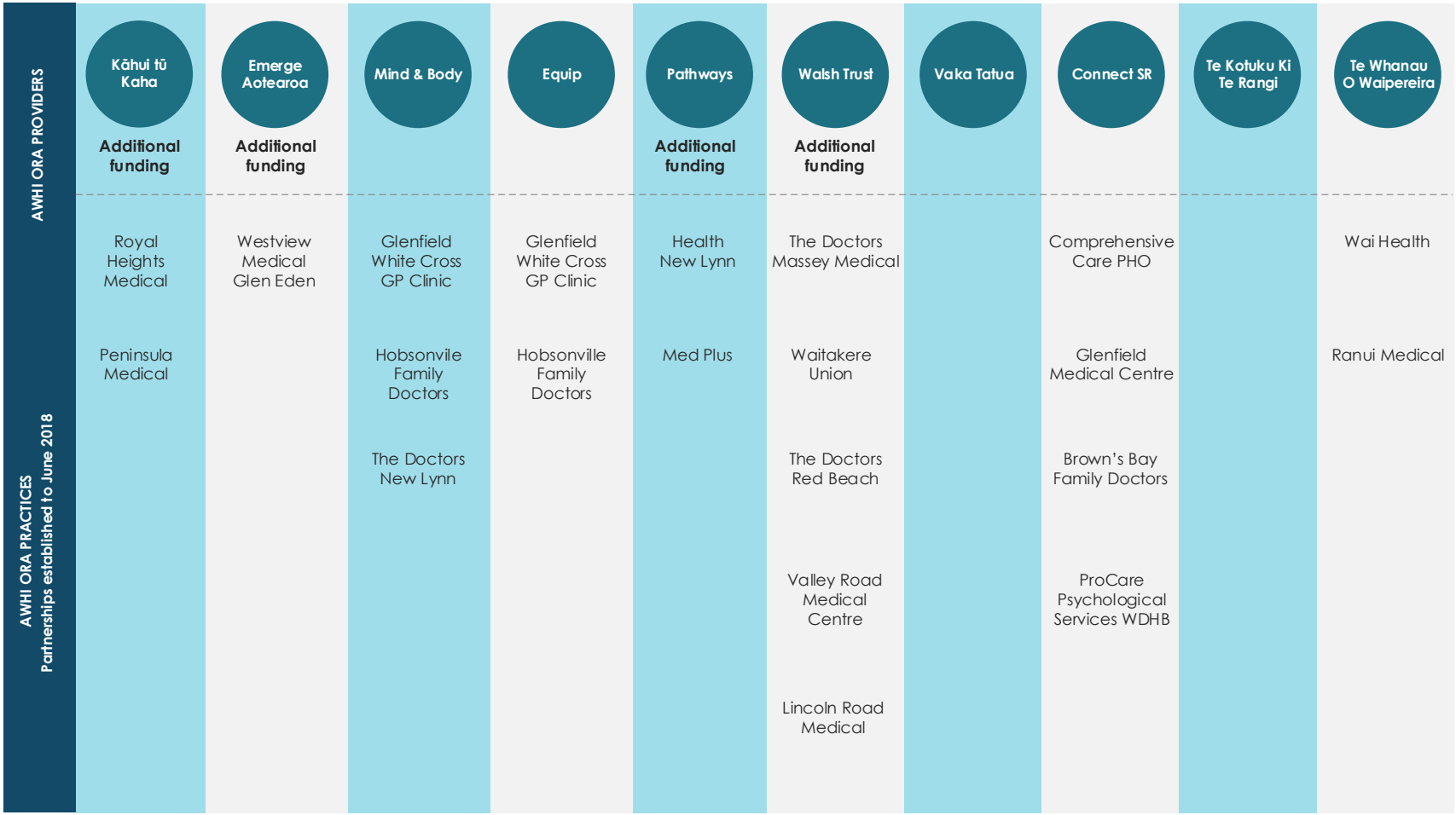
Unlike the staged roll out in ADHB, implementation was intended to be at relatively large scale from day one. Insufficient coordination and communication between the DHB, all NGO providers and primary care practices resulted in a launch that was uncoordinated and confusing for NGOs and practices. Additional Project Management support was made available for WDHB Awhi Ora in March 2018 and a process of consolidation began. This is still underway. This process includes re-establishing links between practices and providers via PHOs.

Walsh Trust's relationship with The Doctors Red Beach is a notable success in this short timeframe. The Awhi Ora support worker is on site two days a week and works closely with the practice team to support people with a range of biopsychosocial needs.

The NGO providers and their introduction partners are identified in Figure 44. Not all providers have formally identified partnerships and some of those identified are very new. There may be other partnerships in place that have not yet been recognised by the Awhi Ora network.

In WDHB there are other providers that are not included in Awhi Ora delivery.

Figure 44: WDHB Awhi Ora NGO providers and associated practices



8.1 Awareness and experience of Awhi Ora (survey feedback)

The WDHB primary care clinician survey identified that 57% of respondents (n=14) were aware of the Awhi Ora: Supporting wellbeing support service. 75% of these knew how to introduce someone to the service (n=8), with five of these having introduced a person at the time of the survey. Clinicians commented on their overall experience of Awhi Ora, with 67% rating their experience as good, and 17% rating their experience as neutral and 17% not being able to comment at this stage.

Awhi Ora was valued by those who had used it for the holistic approach that it takes to supporting clients. It looks beyond the medical side of health and begins to support and address social determinants, which is beyond the capacity of primary care.

On what was particularly valuable about Awhi Ora:

"They [Awhi Ora] were able to look at the social side of my patient's problem, and were also able to see her at home"

(Primary care clinician survey response)

Clinicians also commented on the organisation of Awhi Ora, praising the service for being engaging, informative and well-organised. Considering the importance of communication in cohesive, coordinated service delivery, these characteristics of Awhi Ora have resulted in positive experiences for primary care clinicians.

"[Awhi Ora provided] regular weekly updates on the status of all referrals from our practice – this is very helpful and appreciated, and is reassuringly systematic and well organized."

(Primary care clinician survey response)

8.2 Clinician ideas for improvement

The most significant barrier to successful implementation and use of Awhi Ora as a support service to date is the lack of clarity around the service. Understanding what Awhi Ora is and what value it can add for patients is critical for its continued successful use

"An information website where I can direct patients to would be good as they don't know what to expect, and I don't really know how to explain it."

(Primary care clinician survey response)

"[Have not introduced patients to Awhi Ora because] There is not enough information to make me clear on what to do. It is a confusing name… there are so many names."

(Primary care clinician survey response)

8.3 Key points

The implementation of Awhi Ora in WDHB is still early days, although the findings from the evaluation (including the ADHB region) provide good evidence for the success of Awhi Ora in:

- **Reaching those who needs would have likely gone unmet**
- **Reaching Māori and Pasifika effectively in ADHB region, strong indication of reaching Asian population in WDHB**
- **Reaching those with needs relating to physical, social, economic and behavioural determinants of ill health**
- **This data indicates that two thirds are likely to experience severe psychological distress (K10s only available for 47% of all introductions)**
- **Limitation of data quality for understanding introduction sources and wait times**

9. CONCLUSION AND RECOMMENDATIONS

The evaluation evidence demonstrates the progress and importance of providing services and supports for people with mild to moderate mental health need in primary care. The evaluation also highlights the value that can be provided when DHBs, PHOs and NGOs partner to strengthen the capability and capacity of primary mental health and evolve the care delivery model.

The range of interventions that were expanded and supported by the FftF funding have provided an important and timely insight into the value of:

- Strengthening the interface between primary and secondary care, including the sharing of skills and information to support primary care based decision-making and responses.
- Building the capability of primary care to support people with mental health needs through direct support, navigation resources and links to a broader range of community support services.
- Providing people with choice and support with navigating the options available to them.
- Providing services and supports that respond to the psychological, social and economic determinants of ill health and wellbeing without barriers to entry through Awhi Ora.

The evaluation also indicates that people with complex mental health needs can be managed within primary care, if it is equipped with the capacity and capability to do so.

The findings also indicate that without providing support for people with mental health need in primary care, there is a risk that these people's needs will continue to go unmet, continue to experience poorer health and wellbeing outcomes that impact on their ability to go about their daily lives and contribute to the wellbeing of others. Existing evidence suggests that without appropriate support, a high proportion of these people will go on to require supports from secondary services and/or continue to require other supports from Government agencies and organisations, such as ACC.

9.1 Key recommendations

Further strengthening the interface between primary and secondary care

- Further invest in the Direct Telephone Access to enhance the interface between primary and secondary care, while also building the capability of GPs and Psychiatrists understanding of Primary Care.
- Promote DTA to the sector and continue the evolved role of the specialist in directly introducing themselves and the DTA service to practices across the DHB.
- Develop a series of case studies based on the types of calls received through the DTA. Share these with GPs to support capability through Continuing Medical Education sessions. These sessions could be supported by the GPs accessing and the Psychiatrists providing DTA.
- Consider opportunities for improving information sharing between primary and secondary services to better support GPs to understand the contexts and needs of their patients. This may be part of broader health sector considerations, such

as shared electronic health records. However, given the likely timeframes for widescale implementation of such initiatives, consideration of local opportunities such as improved discharge summaries are also relevant.

Increase the capacity and capability of primary care

- Capacity was identified as a challenge by some of the organisations providing services and supports for people. Capacity could be enhanced by increasing connections and links between initiatives, such as linking Awhi Ora to local health service providers engaging with key target groups. Awhi Ora for example, could expand the range of options available for young people, particularly those who might not be ready for or want counselling.
- Consolidate the role of Awhi Ora within WDHB to increase the capacity and capability of the sector.
- Utilise the HIP and Health Coach roles to increase access to a broader range of supports and access options. These offer fast access to support and have been well responded to by Māori, Pacifica, Asian and youth.
- E-therapy options warrant further implementation, given the geographical spread of the region. This option should also be offered to young people.
- Increase clinician's awareness of the options available to them in primary care. This can be supported by the Navigation Resource but also the direct promotion of options. For example, the clinician survey suggested that Awhi Ora could be supported by an information sheet that could also be shared with GPs and someone who is looking for support.

Governance and leadership

- Review the current project management and leadership. This changed during the evaluation, with a Project Manager role not being replaced. Leadership needs time dedicated to support the success of the Strategy.
- Review the role and membership of the Governance Group to address the limited functioning of the Governance Group in terms of decision-making. We understand that this is currently underway.

9.2 Considerations for future sustainability and expansion

Considerations for the sustainability and expansion of the initiatives implemented through Business Case One relate to capacity and funding for the sector to respond to people with mental health needs in primary care.

The level of need for mental health services and supports is growing, particularly for key target groups of Māori, Pacifica, Asian and youth. Delivering within the current capacity is challenging and some organisations are contributing their own investment and delivering more than they are contracted for. While existing services and supports can be increased, there is also an opportunity to broaden the range of options and access points for people. This has been demonstrated by the success of the enhanced integrated practice teams in the WDHB region. The brief support available through HIPs, Health Coaches and Awhi Ora provides the opportunity to reach a broader range of people. While support may be less intensive, this provides the opportunity to free up

more intensive services and supports for those with greater need. This was demonstrated by the decrease in the ProCare Psychological Service waiting list at practices with HIPs and Health Coaches.

The primary and secondary care interface is an important element of Business Case One. This was identified as an area for improvement in the ADHB evaluation, and the success of the specialist support in WDHB could contribute to address this. Sustainability of this support must be considered. The psychiatrist(s) providing support must be given the time to respond to these calls. When considering expansion of the service, the option of local primary care specialists to increase capacity while maintaining localised support would support this.