Appendix 4: Enhanced primary mental health and AOD responses

Description of the initiative and problem definition	
What is this initiative seeking funding for?	This initiative seeks to provide early mental health and alcohol and other drug (AOD) intervention, particularly for people with mild to moderate mental health needs, through the provision of universally accessible primary mental health and AOD services. The components of the initiative include: • Nationwide enhanced primary mental health and AOD responses • Workforce development for primary care workforce and mental health practitioners • Implementation infrastructure and support. **Nationwide enhanced primary mental health and AOD responses** s 9(2)(f)(iv) [redacted] to access early mental health and AOD intervention. Each DHB would co-design a model of care that best meets the needs of their district, and is based on the successful enhanced primary mental health and AOD responses (evaluated through Fit for the Future) that involve mental health practitioners working in general practices and facilitating access to NGO support to address the social determinants of mental wellbeing as required. This is known as a stepped care model, which is a system of delivering and monitoring treatments so that the most effective yet least resource intensive treatment is delivered to patients first, only 'stepping up' to intensive/specialist services as required. Costs for this initiative are based on the Fit for the Future pilots, but it is expected the exact mix of FTE and balance of services provided in each DHB will be dependent on the outcomes of the co-design process. The levels of stepped care included in an enhanced primary mental health and AOD response are detailed below. *Level 1: Integrated primary mental health and AOD services (within general practice)* General practice teams will be enhanced through the addition of: • Health coaches[1] who offer social support (including one-on-one, whānau, and/or community support), provision of self-management materials and practical advice, primarily for people managing complex or long term health conditions. • Health Improvement Practitioners (HIPs)[2] or Behavioural Health Consultants who deliver screening and brief intervention for mental health and AOD needs within the general practice setting, and provide coaching for general practice teams.

[1] Health coaches (peer or non-peer) include trained members of the local community, people with training and experience in community health and/or people with lived experience of long-term conditions.

[2] HIPs are mental health practitioners/professionals who work as generalists with all age groups to support people to make changes to improve their wellbeing, and build capability within the general practice team. In New Zealand, GPs, practice nurses, and mental health practitioners can be trained to be HIPs.

- Practice nurses who are credentialed in mental health to better identify, support and respond to mental health and AOD needs.

Level 2: Wellbeing and social support

Primary care practices can refer people experiencing a range of needs (such as emotional health needs, substance abuse, family/whānau issues, financial pressures, employment issues or poor housing) to an NGO support worker. NGO support workers with mental health and AOD expertise offer brief interventions and facilitate connection to community resources to support social and other needs.

Level 3: Access to talking therapies

People whose difficulties are not addressed within the general practice team and who do not meet the criteria for DHB services will be referred to talking therapies delivered by external providers in the community.

Level 4: Shared care between primary and secondary care services

To enable better coordination between primary and secondary mental health and AOD services, shared care is available for people with moderate to severe needs who are eligible for secondary mental health and AOD care but want to be managed in the community. DHB psychiatrists will be available to provide assessments and advice to general practice teams, and shared care coordinators will engage with tāngata whaiora, GPs and DHBs to facilitate collaborative care that best meets the needs of the user.

Workforce development for primary care workforce and mental health practitioners

The report from the Government Inquiry into Mental Health and Addiction stated that 'an urgent priority must be a significant increase in capacity and capability of the primary care sector to respond to mental health and addiction needs' [page 134]. As outlined in the Inquiry report, workforce development is anticipated to include:

- More comprehensive and continuing training for generalists (for example, GPs and nurses) in mental health and addiction.
- Extending the capability of those already working in primary and community settings to provide a greater range and depth of support (for example, talk therapies, culturally based approaches, trauma-informed care, and support for co-existing conditions).
- Creating or expanding new roles (such as health or lifestyle coaches, employment specialists and people with expertise in psychological therapies).
- Ensuring specialist clinical support and advice is easily and quickly accessible to primary and community services. [page 124]

In response to these recommendations, this initiative includes investment in primary care workforce development to improve the capability of existing workforces to respond to mental health and AOD needs, provide more culturally appropriate services, and support the development of more diverse workforces (i.e. health coaches and HIPs that can provide brief talking therapies). Please see the workforce training attachment for more details.

Implementation infrastructure and support

A range of implementation support is required to deliver this initiative, including:

- an implementation team within the Ministry to facilitate the design of enhanced primary mental health and AOD responses in each DHB region, set service specifications, manage contracts with training providers and the evaluator, and monitor implementation

	• funding for DHBs, PHOs and practices to manage the shift to a new model of primary mental health and AOD care and incentivise continuous quality improvement • enhancement of the existing IT infrastructure to enable robust data collection, and • an external evaluator to assess the effectiveness of the enhanced primary mental health and AOD models in each DHB region.
Why is it required?	**Mental health challenges are common and associated with a high social and economic cost** Mental health challenges are prevalent, with 1 in 5 New Zealanders experiencing diagnosable mental illness and/or addiction in any given year[3]. The economic and social cost associated with mental health issues in New Zealand is significant, due to decreases in productivity through reduced employment, and increased sick-leave. In 2014, the economic cost of the burden of disease from serious mental illness alone was $12 billion in 2014, amounting to 5% of GDP[4]. **Some groups, particularly Māori, experience worse mental health and addiction outcomes than others** Current mental health and addiction service models are not working for some groups. For example, Māori make up approximately 16 percent of New Zealand's population, yet account for 26 percent of all mental health service users. Māori experience disproportionately higher rates of suicide, mental health disorder, alcohol abuse and dependence, and co-morbidities[5]. **We know there is significant unmet need, especially for those with mild to moderate mental health and AOD needs** The last national mental health survey Te Rau Hinengaro (2006) found that of the people who met the threshold for a serious mental health condition, only 58% had a mental health visit within the last 12 months. Further, only 36.5% of people meeting the threshold for a moderate mental health condition, and 18.5% of people meeting the threshold for mild mental health conditions, had a mental health visit within the last 12 months. While this survey data is now over 12 years old, it is reasonably consistent with what we understand of the current unmet need, if not under-representative. **Access to effective mental health and AOD treatment is limited. Even when care is provided, it is not always matched to a person's need** Most people seeking professional help for a mental health and/or AOD issue will start with their general practitioner. If their needs require specialist intervention, they will be referred to secondary mental health and addiction services and likely have to wait significant lengths of time for access to services as demand far exceeds supply[6]. DHBs fund treatment options, known as Primary Mental Health Services, for Māori, Pacific, low income and 12-19 year olds who do not meet the threshold for secondary mental health and addiction services. These options typically involve extended GP consultations and talking therapy

[3] New Zealand Health Survey 2016/17

[4] The Royal Australian & New Zealand College of Psychiatrists (2016). The economic costs of serious mental illness and comorbidities in Australia and New Zealand. Available at: https://www.ranzcp.org/Files/Publications/RANZCP-Serious-Mental-Illness.aspx

[5] Social Sector Science Advisors (2018). Towards an Evidence-Informed Plan of Action for Mental Health and Addiction in New Zealand: A response by the Social Sector Science Advisors to the request of the Government Inquiry into Mental Health and Addiction.

[6] For example, the number of people engaging with specialist mental health services has increased from 143,021 people (or 3.2% of the population) in 2011 to 173,933 people in 2016/17 (3.7% of the New Zealand population) in a system funded to provide services for the top 3% of mental health need. As a result, wait times for access to secondary services can be lengthy.

sessions (group and individual). In 2016/17, 16,261 young people (aged 12–19 years) and 114,402 adults (aged 20+ years) accessed these services, reaching 2.8% of the population. This compares to the estimated 17% of the population living with a mild to moderate diagnosable mental illness and/or addiction[7].

Medication becomes the most likely treatment for people with mild to moderate mental health issues if they cannot afford to purchase psychological services themselves. Since 2006, prescriptions for mental health medications have increased by 50% and continue to grow at a rate of around 5% each year[8]. However, medication may not be the most effective treatment, and can lead to long-term dependency.

Transformation of the primary care sector is required to improve access to mental health and AOD services and enhance capability to better respond to the mental health and AOD needs of the population

Health systems organised around a primary care response achieve better outcomes, improved equity and lower costs[9]. A variety of reports[10] including the Government Inquiry into Mental Health and Addiction have assessed the state of New Zealand's mental health system and made recommendations on the type of system shifts that are required to improve access and better respond to mental health needs. These recommendations include:

- Acknowledging primary care as a critical foundation for the development of mental health and addiction responses and for more accessible and affordable health services, and recommending that future strategies for the primary health care sector have an explicit focus on addressing mental health and addiction needs in primary and community settings.
- Shifting the balance of investment to earlier in the continuum of care, from secondary to primary care (to increase access and provide earlier treatment intervention to mitigate further deterioration), with associated increases in workforce capability to respond to mental health needs.
- Strengthening the focus on common mental disorders / distress, with less focus on diagnosis and more focus on the provision of non-stigmatising support.
- Responding to wider social needs (such as housing, education, employment, safety) as well as mental health issues, recognising the complexity of people's lives and the bi-directional effects of mental health and social wellbeing.

These kind of system shifts require three components, which are the basis for investments in this initiative:

- New service delivery models within primary care that provide universal access to mental health and AOD services, and include access to services in the wider social sector. This will increase the choice of mental health and AOD services available to New Zealanders.

[7] Mental Health Commissioner (2018). New Zealand's mental health and addiction services; the monitoring and advocacy report of the Mental Health Commissioner. Available at: https://www.hdc.org.nz/media/4688/mental-health-commissioners-monitoring-and-advocacy-report-2018.pdf

[8] Health & Disability Commissioner (2017). Key findings: New Zealand's mental health and addiction services. Available at: https://www.hdc.org.nz/media/4690/key-findings-mhc-monitoring-and-advocacy-report.pdf

[9] Royal College of Psychiatrist (2018). Primary Care Mental Health. Cambridge University Press, United Kingdom.

[10] Mental Health Commissioner (2018); Social Sector Science Advisors (2018); OECD (2018) Mental Health and Work: Aotearoa / New Zealand; Government Inquiry into Mental Health and Addiction (2018).

	• Enhanced workforce capability to respond to mental health and AOD needs, and provide culturally appropriate care. • Additional workforce capacity to manage increased access to mental health and AOD services, including the use of more diverse workforces.
Implementation, Monitoring and Evaluation	
How will the initiative be delivered?	**Establish the national support functions** The Ministry will employ s 9(2) that constitute the implementation team for this initiative. They will be responsible for: setting service specifications; procuring an evaluator in 2019 (to assist with designing data reporting requirements and output / outcome measures); establishing the IT infrastructure for data collection; assisting with co-design of enhanced primary mental health and AOD response models (including engagement with users and whānau); contracting training providers; monitoring and reporting on implementation progress; and conducting analysis of workforce expansion requirements for the future. Preparatory work for establishing this team is expected to commence following the announcement of Budget 2019. **Set up in each DHB** The National Coordinators will work with providers and stakeholders in each DHB to co-design an enhanced primary mental health and AOD response model that will best meet the needs of their district (taking into consideration workforce constraints in each area). Users and whānau will be an integral part of this co-design process to ensure that the model provides the range of primary mental health and AOD services that best respond to need. s 9(2)(f)(iv) **Contracting for workforce development** Workforce development to deliver the enhanced primary mental health and AOD response models and to train the existing primary care workforce to better respond to mental health and AOD need and build cultural competence, will occur from early 2020. s 9(2)(f)(iv) Cultural competence training will be specifically built into .
How will the implementation of the initiative be monitored?	This component of the package includes funding for Ministry of Health FTE that constitute the implementation team. Part of the role of this team will be to ensure regular (at least quarterly) reporting on implementation progress. More specifically: • s 9(2)(f)(iv)

	s 9(2)(f)(iv) [redacted]
Describe how the initiative will be evaluated	The Ministry will contract an external evaluator to conduct an impact evaluation of the initiative. s 9(2)(f)(iv) [redacted] The impact evaluation will draw on data collected throughout the implementation of the model, and further engagement with users and stakeholders. Data and information collected will likely include: • service utilisation data (# of service users, and their demographics such as gender, ethnicity, and age) • pre- and post-intervention measures of health (mental and physical) and social outcomes (employment, income, housing etc.) for those who access services. Note that standardised screening tools will be used for mental and physical health measurement • user (and family/whānau) satisfaction with the service response • stakeholder (service providers, NGOs, community support workers/providers, social services, DHBs) satisfaction with the enhanced responses.
Detailed funding breakdown	
Please provide a breakdown of the costs of this initiative	s 9(2)(f)(iv) [redacted]. Full funding would provide for: • full national coverage (all DHBs have an enhanced primary mental health and AOD response model) • training for [redacted] the primary care workforce • capacity for expected uptake of enhanced primary mental health and AOD responses [redacted] Full implementation would take [redacted] **Assumptions** <u>Departmental expenditure</u> Based on MoH pay bands for equivalent roles: • s 9(2)(f)(iv) [redacted] <u>IT infrastructure/data collection</u> Build on existing IT solutions to add functionality and support consistent data collection across sites. <u>Model re-design and implementation</u>

s 9(2)(f)(iv) [redacted]

Workforce development

Training costs for [redacted] of the primary care workforce to deliver enhanced primary mental health and AOD responses. Refer to attached workforce training details.

Co-design hui

National coordinators s 9(2)(f)(iv) [redacted] to help providers and stakeholders to co-design the enhanced primary mental health and AOD service for their community. [redacted]

[redacted]

Evaluation

An evaluator will be contracted to deliver the following outputs:

- Design evaluation standards and data reporting requirements [redacted]
- Ensure data collection is fit for purpose and relevant to each DHB's PMH model [redacted]
- Impact evaluation the year after full implementation [redacted]

Service delivery

- s 9(2)(f)(iv) [redacted]

Options for scaling and phasing

Scaling, phasing or deferring - including 75% and 50% scenarios

[redacted]

	s 9(2)(f)(iv) [redacted]

Workforce training

In order to develop enhanced primary mental health and AOD responses, training and development will be required for existing primary care staff, and for mental health and AOD practitioners. Testing an enhanced primary mental health and AOD response will require some roles to be filled by new staff, while existing staff receive additional training to improve capability to manage the mental health and AOD needs of patients.

s 9(2)(f)(iv) [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

11 A site' is considered a cluster of PHOs, general practice offices and NGOs, collectively covering approximately 50,000 people per site.

s 9(2)(f)(iv) [redacted]

[redacted]