The provision of mental health care by Primary Health Organisations in the northern region: Barriers and enablers

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ABSTRACT

AIM: To identify barriers and enablers to the provision of mental health care by Primary Health Organisations (PHOs) in the northern region.

METHODS: Information was generated from structured interviews with 22 of the 25 PHOs and the four District Health Boards (DHBs) in the northern region.

RESULTS: Of the 22 PHOs who participated in the study, 17 had at least one specific mental health initiative; others had up to five initiatives. PHOs that were funded to provide one of the 41 Ministry of Health mental health pilot projects had more mental health initiatives in place. Barriers and enablers to providing mental health care occurred in areas such as workforce capacity, funding, infrastructure, and limited interest in transfer of care from secondary to primary care.

CONCLUSIONS: Barriers to providing mental health care within the primary sector include stigma, lack of training, communication between sectors, funding and perceptions of sector roles. Factors which enable provision of mental health care are availability of training, good communication between sectors, use of available and new funding mechanisms and community involvement. Further research at the practice and practitioner level is necessary to fully understand development of mental health care within the primary care sector.

KEYWORDS: Mental health, primary care, Primary Health Organisations, health policy

J PRIMARY HEALTH CARE
2009;1(2):120–125.

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Introduction

The shift from institutional to community-based mental health care in Western countries since the 1960s has increased the importance of treatment and care for people with mental disorders within the context of primary health care.[1-2] A recent study conducted by the World Health Organization in 14 countries concluded that one in four people who consulted a GP had a mental health or addiction problem.[3] The complexity of mental health problems presenting in the primary health care setting, from mild to severe mental health problems and coexisting disorders, has introduced new competency requirements for health professionals.[4]

In New Zealand the role of primary health care in the provision of mental health care has become increasingly important, with figures indicating that 20% of the general population experience some form of mental disorder within their lifespan.[5] More recently, the 2006 *Te Rau Hinengaro: New Zealand Mental Health Survey* reported a 46.6% lifetime prevalence of mental disorder.[6] The National Mental Health and Addictions Plan[7] identified primary care as one of 10 key areas for the development of mental health services in New Zealand over the next decade. General practitioners are the first port of call for most people with mental illness and several New Zealand studies have shown that mental illnesses such as anxi-

ety, depression, and substance abuse are prevalent amongst people attending general practices.[8-9]

There are considerable advantages from general practitioners providing mental health services at a primary care level. By addressing the needs of people with mild to moderate mental illness, primary health care services can reduce the progression of illness and prevent significant disabilities and impairments.[10-12] Treatment of anxiety and depression is also likely to improve the functional health of people with chronic medical conditions.[13] Responsiveness of the primary health care sector is also part of the *New Zealand Suicide Prevention Strategy*.[14]

Beginning in 2005, the Ministry of Health funded mental health initiatives across 42 Primary Health Organisations (PHOs) throughout New Zealand in order to support the development of mental health care within primary care. Evaluations of these initiatives between 2006 and 2007 found most had been successfully implemented and were well received within the sector, particularly by service users.[15] Although several studies of case finding and intervention were reported over 2003–2004,[16-17] there has been no recently published literature on mental health provision within primary care. It has been suggested, however, that new initiatives in primary health care provide challenges for the sector to extend its role in mental health, and to develop new models of service delivery.[18]

In the northern region,* there are currently 25 PHOs providing health care for enrolled populations of 1 443 856.[19] These PHOs have developed mental health initiatives either through contracts with their respective DHBs, through specific contracts with the Ministry of Health, or through initiatives developed at PHO or practice level. Currently there is no overall picture available as to the extent of mental health provision in primary health care in the northern region.

This paper presents the results from a wider study commissioned by the Northern DHB Support Agency that aimed to provide a stock-take of current and planned primary mental health initiatives in the northern region.[20] The overall goal of this wider study was to develop a picture of current and planned service provision and of workforce development needs. This paper focuses on one aspect of the wider study: the barriers and enablers to the provision of mental health care by PHOs within the northern region. The paper also makes recommendations for further research into the provision of mental health within primary care.

WHAT GAP THIS FILLS

What we already know: Several New Zealand studies have indicated that mental health problems are prevalent in primary care settings. In response, mental health policy and Ministry of Health initiatives have sought to extend the provision of mental health care within the primary sector.

What this study adds: This research suggests that Primary Health Organisations in the northern region of New Zealand have a high level of awareness of the need to provide mental health care within primary care. It also explores a range of barriers and enabling factors that currently exist to the provision of mental health within primary care in the northern region.

Methods

Data for the wider study were collected between March and June of 2006. This included structured interviews with representatives of 22 of the 25 PHOs operating across the four DHBs that cover the northern region (Counties Manukau, Auckland, Waitemata and Northland). Three PHOs stipulated that they were not currently providing any mental health–related initiatives and did not wish to take part in the study. In order to gain insights into the role of secondary mental health services and the work PHOs were doing, interviews also took place with mental health service managers and/or funding and planning managers in each of these four DHBs. To ensure both the selection process and the content of the structured interviews were appropriate, consultation took place with the Northern DHB Support Agency's primary workstream group as well as an advisory group developed by the research team. The study received approval from the University of Auckland Human Participants Ethics Committee.

* Counties Manukau, Auckland, Waitemata and Northland

The research team used two structured templates to guide their interviews with PHO and DHB representatives. The PHO template required participants to answer a series of questions related to mental health workforce capacity; the characteristics of the PHOs; current and planned mental health initiatives; the profile of workforce developments in each PHO for those staff engaged in primary mental health care; and critical issues in relation to providing training and support for primary mental health staff. In contrast, the DHB template attended to current and planned initiatives that involved the DHBs. These initiatives could include mental health programmes provided by organisations other than PHOs, such as primary health care providers, NGOs, and community mental health teams. This paper is primarily focussed on the current initiatives taking place that are facilitated through PHOs in the northern region.

The templates were completed by a member of the research team as the interview took place. The interviews were recorded but not transcribed verbatim; rather they were used for follow-up purposes only. The interviews took 40–60 minutes to complete and largely took place by telephone, although there was an option for face-to-face interviews if representatives felt it more appropriate. Two representatives chose this option. Questions included short and extended answer items in order to elicit both specific information about initiatives, and to make more general comments about providing mental health responses. Using a general inductive approach, the data were divided and collated into categories.[21] These data largely were used to supplement the short answer items, expanding on the issue described by participants.

Findings

Of the 22 PHOs who participated in the study, 17 had at least one specific mental health initiative; others had up to five initiatives. Each of the four DHBs had initiatives in place to support the development of mental health care provision within primary care. In addition, a variety of planned initiatives were identified by the PHOs and DHBs. Overall the initiatives included programmes aimed at specific mental disorders, most notably depression, as well as health promotion programmes which could be expected to impact on mental health more generally. PHOs with Ministry of Health funded contracts were most likely to have initiatives focussed on the needs of people with mild or moderate, rather than severe, mental disorder. Similarly, workforce capacity was also most strongly evident in PHOs with Ministry of Health mental health contracts. Barriers and enablers to mental health service provision are presented below as narrative summaries.

Barriers to mental health initiatives and workforce development

Stigma

Some of the PHOs explained that the stigma of mental illness was one of the main barriers for staff thinking of undertaking training in this area, or when considering responding to clients' mental health needs. Others simply commented that mental health was not a priority, with a sense that mental health was regarded as an optional area of care, rather than an integral aspect of primary health care. Less than half of the PHOs identified specific anti-stigma initiatives or activities in place or planned for the future.

It was apparent, however, that many PHOs were attempting to 'normalise' mental health issues by acknowledging mental health as one of a range of health needs. Whilst it is clear that there was a desire from some PHOs to separate out specific mental health initiatives with a view to funding and development, there was much discussion around the practicality and implications of separating mental illness from physical illness. There was concern from some that this separation could contribute to the stigma of mental illness by creating an additional access barrier.

Training needs

The need for workforce development was identified as a barrier by many of the PHOs. In some PHOs staff were reluctant to become involved in mental health initiatives because they felt that they lacked the necessary skills. Some participants commented that many general practitioners and practice nurses felt that they lacked the

required knowledge to work with people with long-term mental illness. Particular areas of need were training in screening and assessment, use of brief interventions, and training in areas such as sexual abuse and domestic violence. Participants identified the need for follow-up training so that new skills could be integrated into day-to-day practice.

PHO–DHB communication

The study found that relationships between DHBs and PHOs were integral to the development of primary care mental health initiatives, as envisaged by the Primary Health Care Strategy.[22] On occasion, this relationship appeared to be perceived as a barrier, as some PHO representatives stated that providers commonly felt overloaded as they were expected to respond to multiple primary health priorities identified by the Ministry. In some cases there appeared to be a lack of clear communication between DHB and PHO participants, and differing reasons were given as to why specific contracts had not been agreed.

Funding

PHO representatives identified the need for funding of specific mental health initiatives, such as that provided under the Ministry of Health pilot projects. Initiatives were less likely to be prioritised if there was an expectation for the PHO to develop the initiative first with the possibility of later funding, as opposed to funding being available up front. The current fee-for-service model of GP funding was seen to be a barrier because of the limitations placed on contact time, and the longer time necessary to complete a mental health assessment.

The role of primary and secondary care

Providers perceived that the secondary services were funded to care for people with long-term mental illness, and so that is where they should be looked after. With no additional funding, these patients were often not viewed as an attractive addition to a primary care practice. It seemed that there was a different standard set for patients who used specialist mental health services regularly, compared to those who used other specialist services. Outside of mental health care, patients were perceived as using specialist services for defined periods of time and then returning to primary care. In the area of mental health, once they were seen by specialist health services they were commonly perceived as being transferred to secondary services, often for long-term care.

Enablers to mental health initiatives and workforce development

Training

PHOs with Ministry of Health contracts were in an advantaged position by being able to employ mental health coordinators who could support staff to develop mental health skills. A few PHOs also employed mental health clinicians to provide specific mental health services, to ensure this expertise was available within the PHO. Some PHOs demonstrated their commitment to the development of workforce capacity in mental health by having ongoing programmes of continuing education, and in some cases by having staff attend specific mental health training.

PHO–DHB communication

Where the DHB provided clear strategic guidelines for the PHOs to develop mental health capacity, PHOs showed a stronger commitment to providing mental health care, and were more likely to have developed specific initiatives. It would appear that guidelines give PHO staff a sense of direction, cohesive planning and collaboration, which acted as an enabler to the development and delivery of initiatives, and to workforce development. From the PHO perspective there seemed to be greater freedom to commit to a new initiative if the PHO also employed the general practitioners. Previous research has noted similar issues.[17-18]

Funding

The timing of the funding was important. To act as an enabler it needed to be available prior to the development of an initiative. This made it feasible to recruit, allocate or train staff, and to have time to develop, deliver and evaluate the initiative. There were several instances in which

PHOs stated that any increased responsiveness to mental health issues was dependent on new funding streams. Others used existing funding mechanisms to increase provision of mental health care.

Cultural and community involvement

In regions where Maori were involved in the initial establishment of a PHO, the ethos of the organisation was more likely to reflect Maori cultural values, and ensure that Maori providers were able to work in an appropriately supportive cultural environment. This seemed to be an effective way of enabling initiatives to occur which were acceptable to the community. In other PHOs that expressed a specific commitment to Maori health, cultural needs were met through the cultural knowledge and resources of Maori staff. Where Maori were not involved in the initial establishment or governance, PHOs stated they attempted to address this by providing cultural training and/or Treaty workshops. PHOs focussed on the health needs of Pacific people utilised a framework consistent with a Pacific view of health. Use of culturally-appropriate models was perceived as supporting the development of mental health initiatives.

Discussion

The Primary Health Care Strategy[22] envisaged DHBs working through PHOs to achieve population health goals. Further policy work has been specifically directed towards greater primary health care responsiveness to mental health problems[5,7] and, at a national level, the Ministry of Health has funded 41 mental health initiatives in primary health care. Our study found that there is a high level of awareness of mental health in primary care, and of the need for the sector to be responsive to mental health issues. This is reflected in the high proportion of PHOs providing mental health initiatives, and in the extent of primary care programmes provided by DHBs.

There is clearly a recognition within the DHB and primary care sectors that mental health is a priority area of service development. However, there is uncertainty about how general knowledge of mental health needs translates into local responses by the primary health care sector. Mental health initiatives are most strongly developed in PHOs that have been funded by the Ministry of Health to develop those initiatives, although it is notable that some PHOs are using a range of existing funding streams to develop their mental health responsiveness. The type and range of initiatives currently in place reflects both uncertainty about how best to deliver improved mental health care, and the need for responses to reflect local contexts.

In the primary health care sector, mental health is not always separated from more general initiatives, especially in the area of health promotion. For that reason our results may not reflect the true extent of mental health promotion activities. There may also be differences between what the PHO reports as an 'initiative' and development of greater responsiveness at the practice and clinician levels. More specific research into the practice of clinicians would be needed to fully answer that question. To some extent, the development of specific funding streams creates an expectation that any change in responsiveness to mental health issues should attract funding. We encountered more than one PHO response to the effect that changes were dependent on funding.

Study strengths and limitations

The study collected data from 22 out of 25 PHOs in the northern region, and so the data gathered can be considered representative of the level of PHO mental health–related activity in the region. All four secondary service funders were interviewed, so the dataset is almost complete. The data collected related to initiatives, i.e. activities occurring as part of a specific programme, not the practice of individual clinicians. The full extent of mental health care provided in the primary health care sector would need to take individual clinical practice into account.

A limitation of the study is that it did not collect data directly from the non-government organisation sector, thus any primary mental health initiatives not funded through PHO or DHB contracts have not been included. The non-government organisation sector controls around one-third of the national mental spending, but it

is not known how much of that spending is on primary mental health care.

Another limitation of the study is that some PHO representatives were not aware of all services provided by the practices enrolled in their PHO. No consumers of primary health care or mental health services were interviewed, nor were any primary health care or mental health clinicians. In some cases there was limited data, and in some instances the quality of data depended on the knowledge of the interviewee rather than any systematically compiled reports. In the case of mental health promotion, some activities with a mental health component may not have been reported if they were not specifically identified as mental health initiatives.

Conclusions

Policy initiatives aimed at increasing involvement of the primary health care sector in mental health issues appear to have had some impact. This is especially so in the case of PHOs that have contracts to develop mental health initiatives, but it is not limited to those PHOs, or to the Ministry-funded mental health initiatives. Whilst the variability of initiatives across the primary care sector may be understood in part, in terms of the need to develop locally applicable initiatives, it is also likely that this variability represents different levels of commitment to providing mental health care. Barriers such as workforce capacity and infrastructure will need continued monitoring if mental health within primary care is to continue to develop. Further research is needed to identify what is happening at a practice and practitioner level, to understand how mental health services provided in primary care are perceived by consumers, and to establish the clinical effectiveness of interventions.

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ACKNOWLEDGEMENTS
The research team acknowledges the funding provided by the Northern DHB Support Agency. The research team would like to thank all participants in this study, including representatives of PHOs and DHBs.

COMPETING INTERESTS
None declared.